Medical Necessity Guidelines:
High-Frequency Chest Wall Oscillation Devices

Effective: October 21, 2020

Prior Authorization Required If REQUIRED, submit supporting clinical documentation pertinent to service request.	**Yes ☒ No ☐**

Applies to:
COMMERCIAL Products
☒Tufts Health Plan Commercial products; Fax: 617.972.9409
☒Tufts Health Freedom Plan products; Fax: 617.972.9409
- CareLink℠ – Refer to CareLink Procedures, Services and Items Requiring Prior Authorization

TUFTS HEALTH PUBLIC PLANS Products
☒Tufts Health Direct – A Massachusetts Qualified Health Plan (QHP) (a commercial product); Fax:888.415.9055
☒Tufts Health Together – MassHealth MCO Plan and Accountable Care Partnership Plans; Fax: 888.415.9055
☒ Tufts Health RITogether – A Rhode Island Medicaid Plan; Fax: 857.304.6404
☒Tufts Health Unify* – OneCare Plan (a dual-eligible product); Fax: 857.304.6304
*The MNG applies to Tufts Health Unify members unless a less restrictive LCD or NCD exists.

SENIOR Products
- Tufts Health Plan Senior Care Options (SCO), (a dual-eligible product) **–** Refer to the Tufts Health Plan SCO Prior Authorization List
- Tufts Medicare Preferred HMO, (a Medicare Advantage product) – Refer to the Tufts Medicare Preferred HMO Prior Authorization and Inpatient Notification List

Note: While you may not be the provider responsible for obtaining prior authorization, as a condition of payment you will need to make sure that prior authorization has been obtained.

OVERVIEW

High-frequency chest wall oscillation (HFCWO) devices deliver compression pulses to the chest wall through an inflatable vest which is connected to an air pulse generator. These high frequency compressions lead to changes in airway volume and flow, which helps to mobilize and remove lung secretions. Typical treatment performed at home lasts 20–30 minutes and consists of short periods of vest compression followed by coughing.

CLINICAL COVERAGE CRITERIA

NOTE: High-frequency chest wall oscillation devices are covered when member has a diagnosis of cystic fibrosis. Prior authorization is not required.

Tufts Health Plan may cover high-frequency chest wall oscillation (HFCWO) devices when all of the following criteria are met:

1. Member has a diagnosis of bronchiectasis and the following criteria are met:
   a. Diagnosis is confirmed by a high resolution, spiral, or standard CT scan
   and
   b. Member has had daily productive cough for at least 6 continuous months **or** frequent (i.e., more than 2 per year) exacerbations requiring antibiotic therapy.

OR

2. The beneficiary has one of the following neuromuscular disease diagnoses:
   a. Post-polio
   b. Acid maltase deficiency
   c. Anterior horn cell diseases
   d. Multiple sclerosis
   e. Quadriplegia
   f. Hereditary muscular dystrophy

g. Myotonic disorders
h. Other myopathies
i. Paralysis of the diaphragm

AND

3. There is well-documented failure of standard treatments (i.e., chest physical therapy) to adequately mobilize retained secretions.

Replacement supplies: Tufts Health Plan will cover replacement supplies, A7025 and A7026, when criteria above are met.

LIMITATIONS

Tufts Health Plan will not cover:

- HWFO device for chronic lung disease, including chronic bronchitis and chronic obstructive pulmonary disease (COPD), in the absence of a confirmed diagnosis of bronchiectasis
- Use of both a HFCWO device and a mechanical in-exsufflation device (E0482)

CODES

The following HCPCS codes require prior authorization:

Table 1: HCPCS Codes

CPT Code	Description
E0483	High frequency chest wall oscillation system, includes all accessories and supplies, each
A7025	High frequency chest wall oscillation system vest, replacement for use with patient owned equipment, each
A7026	High frequency chest wall oscillation system hose, replacement for use with patient owned equipment, each

Prior authorization for above HCPCS codes is **not** required when submitted with the following ICD-10 diagnosis codes:

Table 2: ICD-10 Codes

ICD-10 Code	Description
E84.0	Cystic fibrosis with pulmonary manifestations
E84.11	Meconium ileus in cystic fibrosis
E84.19	Cystic fibrosis with other intestinal manifestations
E84.8	Cystic fibrosis with other manifestations
E84.9	Cystic fibrosis, unspecified

REFERENCES

1. Nicolini A, Grecchi B, Banfi P. Effectiveness of two high frequency chest wall oscillation techniques in patients with bronchiectasis: a randomized controlled preliminary study [published online ahead of print, 2020 Mar 19]. Panminerva Med. 2020;10.23736/S0031-0808.20.03735-0. doi:10.23736/S0031-0808.20.03735-0.
2. Sievert CE, Beaner CA. Cost-effective analysis of using high frequency chest wall oscillation (HFCWO) in patients with non-cystic bronchiectasis. Respiratory Therapy 2017;1:12 45-49.
3. Barker A, MD. Treatment of bronchiectasis in adults. UpToDate.com/login [via subscription only]. Published April 1, 2020. Accessed August 13, 2020.
4. Centers for Medicare and Medicaid Services Local Coverage Determination (LCD): High Frequency Chest Wall Oscillation Devices (L33785). med.noridianmedicare.com/documents/2230703/7218263/High+Frequency+Chest+Wall+Oscillation+Devices/2c8213bc-6773-4dcf-9fa5-80557b80b888. Accessed July 23, 2020.
5. Centers for Medicare and Medicaid Services Local Coverage Determination (LCD): Mechanical In-exsufflation Devices (L33795). med.noridianmedicare.com/documents/2230703/7218263/Mechanical+In-

exsufflation+Devices+LCD+and+PA/3bf8ac84-3e64-4785-80d1-b4c4d2931eca. Accessed July 23, 2020.

APPROVAL HISTORY

September 18, 2019: Reviewed by the Integrated Medical Policy Advisory Committee

Subsequent endorsement date(s) and changes made:

- November 19, 2019: Effective November 19, 2019, Medical Necessity Guideline (MNG) is applicable to Tufts Health Together, MassHealth MCO Plan and Accountable Care Partnership Plans
- August 27, 2020: References updated
- October 21, 2020: Reviewed by IMPAC, renewed without changes
- December 7, 2020: Fax number for Unify updated

BACKGROUND, PRODUCT AND DISCLAIMER INFORMATION

Medical Necessity Guidelines are developed to determine coverage for benefits, and are published to provide a better understanding of the basis upon which coverage decisions are made. We make coverage decisions using these guidelines, along with the Member's benefit document, and in coordination with the Member's physician(s) on a case-by-case basis considering the individual Member's health care needs.

Medical Necessity Guidelines are developed for selected therapeutic or diagnostic services found to be safe and proven effective in a limited, defined population of patients or clinical circumstances. They include concise clinical coverage criteria based on current literature review, consultation with practicing physicians in our service area who are medical experts in the particular field, FDA and other government agency policies, and standards adopted by national accreditation organizations. We revise and update Medical Necessity Guidelines annually, or more frequently if new evidence becomes available that suggests needed revisions.

For self-insured plans, coverage may vary depending on the terms of the benefit document. If a discrepancy exists between a Medical Necessity Guideline and a self-insured Member's benefit document, the provisions of the benefit document will govern.

Treating providers are solely responsible for the medical advice and treatment of Members. The use of this guideline is not a guarantee of payment or a final prediction of how specific claim(s) will be adjudicated. Claims payment is subject to eligibility and benefits on the date of service, coordination of benefits, referral/authorization, utilization management guidelines when applicable, and adherence to plan policies, plan procedures, and claims editing logic.