High Frequency Chest Wall Oscillation Devices Clinical Coverage Criteria

Overview

Certain patients, such as those with cystic fibrosis (CF), produce large amounts of respiratory secretions, which may clog the airways, resulting in pneumonia or other problems. To help cough up and clear these secretions, patients often receive chest physiotherapy (CPT), consisting of clapping and pounding of the chest to loosen the secretions.

High frequency chest wall oscillation devices can be used as a replacement for or enhancement of CPT to help loosen pulmonary secretions. A large hose connects an inflatable vest to an air-pulse generator, and vibrations are transmitted to the patient's chest to loosen secretions. Typically, a person uses the vest for five minutes and then coughs or huff coughs to clear the mucus. Sessions last about 20 to 30 minutes.

U.S. Food and Drug Administration (FDA)-cleared high frequency chest wall oscillation devices include The Vest Airway Clearance System, (Hill-Rom, St. Paul, MN; previously manufactured by Advanced Respiratory, Inc., St. Paul, MN), SmartVest Airway Clearance System (Electromed, Inc., New Prague, MN) and inCourage System (RespirTech, Inc., St. Paul, MN).

Policy

This Policy applies to the following Fallon Health products:

☒ Medicare Advantage (Fallon Medicare Plus, Fallon Medicare Plus Central)
☒ MassHealth ACO
☒ NaviCare HMO SNP
☒ NaviCare SCO
☒ PACE (Summit Eldercare PACE, Fallon Health Weinberg PACE)
☒ Community Care

Prior authorization is required.

Medicare Advantage (Fallon Medicare Plus, Fallon Medicare Plus Central)
Fallon Health complies with CMS's national coverage determinations (NCDs), local coverage determinations (LCDs) of Medicare Contractors with jurisdiction for claims in the Plan's service area, and applicable Medicare statutes and regulations when making medical necessity determinations for Medicare Advantage members. When coverage criteria are not fully established in applicable Medicare statutes, regulations, NCDs or LCDs, Fallon Health may create internal coverage criteria under specific circumstances described at § 422.101(b)(6)(i) and (ii).

Medicare statutes and regulations do not have coverage criteria for high frequency chest wall oscillation devices. Medicare does not have an NCD for high frequency chest wall oscillation devices. Noridian Healthcare Solutions, LLC., the Medicare Durable Medical Equipment Medicare Administrative Contractor with jurisdiction in the Plan's service area has an LCD for High Frequency Chest Wall Oscillation Devices (L33785) (Medicare Coverage Database search 06/30/2024).

Coverage criteria for high frequency chest wall oscillation devices are fully established by Medicare, therefore the Plan's criteria are not applicable.

Link: **Noridian Healthcare Solutions, LLC. LCD High Frequency Chest Wall Oscillation Devices (L33785)**

MassHealth ACO
Fallon Health follows Medical Necessity Guidelines published by MassHealth when making medical necessity determinations for MassHealth members. In the absence of Medical Necessity Guidelines published by MassHealth, Fallon Health may create clinical coverage criteria in accordance with the definition of Medical Necessity in 130 CMR 450.204.

MassHealth has Guidelines for **Medical Necessity Determination for High Frequency Chest Wall Oscillation Air-Pulse Generator System (Vest)**, therefore, Fallon Health Clinical Coverage Criteria are not applicable (MassHealth website search 06/30/2024).

NaviCare HMO SNP, NaviCare SCO
For plan members enrolled in NaviCare, Fallon Health first follow's CMS's national coverage determinations (NCDs), local coverage determinations (LCDs) of Medicare Contractors with jurisdiction for claims in the Plan's service area, and applicable Medicare statutes and regulations when making medical necessity determinations.

When coverage criteria are not fully established in applicable Medicare statutes, regulations, NCDs or LCDs, or if the NaviCare member does not meet coverage criteria in applicable Medicare statutes, regulations, NCDs or LCDs, Fallon Health then follows Medical Necessity Guidelines published by MassHealth when making necessity determinations for NaviCare members.

PACE (Summit Eldercare PACE, Fallon Health Weinberg PACE)
Each PACE plan member is assigned to an Interdisciplinary Team. PACE provides participants with all the care and services covered by Medicare and Medicaid, as authorized by the interdisciplinary team, as well as additional medically necessary care and services not covered by Medicare and Medicaid. With the exception of emergency care and out-of-area urgently needed care, all care and services provided to PACE plan members must be authorized by the interdisciplinary team.

Fallon Health Clinical Coverage Criteria

Fallon Health considers high frequency chest wall oscillation devices medically necessary when the following criteria are met:

1. There is well-documented failure of standard treatments to adequately mobilize retained secretions; AND
2. One of the following diagnoses exists;
    - Amyotrophic lateral sclerosis (ALS), OR
    - Cystic Fibrosis (CF), OR
    - Bronchiectasis
        - Characterized by daily productive cough for at least 6 continuous months or frequent (i.e., more than 2 per year) exacerbations requiring antibiotic therapy, and
        - Confirmed by CT scan.

Exclusions

- Other applications of high-frequency chest wall oscillation vests are considered investigational.
- Use of both a high frequency chest wall oscillation device (E0483) and a mechanical in-exsufflation device, e.g., CoughAssist (E0482).

Coding

The following codes are included below for informational purposes only; inclusion of a code does not constitute or imply coverage.

High frequency chest wall oscillation devices are capped rental durable medical equipment (DME) items. HCPCS Code E0483 describes a complete system. Billing of A7025 and/or A7026 with E0483 is incorrect coding. E0483 devices may use differing technologies, e.g. air-pulse generators and an inflatable vest, an array of mechanical oscillators in a vest providing synchronized oscillation. E0483 is all-inclusive regardless of the technique used to produce high frequency chest wall oscillation.

Replacement supplies (A7025 and A7026) for a patient-owned high frequency chest wall oscillation device are covered when criteria for the device are met.

HCPCS code A7025 (High frequency chest wall oscillation system vest, replacement for use with patient owned equipment, each) describes a complete replacement vest. This includes all components such as mechanical oscillators, electrical componentry, inflatable air sacs, connectors. Separate billing of vest components when an entire vest is replaced is incorrect coding – unbundling.

HCPCS code A7026 (High frequency chest wall oscillation system hose, replacement for use with patient owned equipment, each) describes the tubing used with an air pulse generator type of HFCWO device.

Code	Description
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
E0483	High Frequency chest wall oscillation air-pulse generator system, includes all accessories and supplies, each

References

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Policy history

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Approval(s):	Technology Assessment Committee: 11/2003, 08/28/2013, 01/28/2015 (removed age criteria, updated template, updated references) 02/24/2016 (updated references, removed criteria related to additional non-medical indications), 03/22/2017 (updated references), 03/28/2018 (updated references), 02/27/2019 (updated references), 07/22/2020 (added link to Noridian Healthcare, LLC LCD L33785, updated coding and references), 06/25/2021 (Added clarifying language related to Medicare Advantage, NaviCare and PACE under policy section), 07/02/2024 (annual review; updated Medicare and MassHealth information in Policy section, no changes to coverage criteria).

Not all services mentioned in this policy are covered for all products or employer groups. Coverage is based upon the terms of a member's particular benefit plan which may contain its own specific provisions for coverage and exclusions regardless of medical necessity. Please consult the product's Evidence of Coverage for exclusions or other benefit limitations applicable to this service or supply. If there is any discrepancy between this policy and a member's benefit plan, the provisions of the benefit plan will govern. However, applicable state mandates take precedence with respect to fully-insured plans and self-funded non-ERISA (e.g., government, school boards, church) plans. Unless otherwise specifically excluded, federal mandates will apply to all plans.