Medical Policy

Northwood

High Frequency Chest Wall Oscillation (HFCWO) Devices

Description

The high frequency chest wall oscillation (HFWO) device is a product designed to assist in the mobilization of retained pulmonary secretions. It operates on the principle of chest percussion, but allows the individual to self administer the required treatments. It consists of an inflatable vest connected by tubes to an air pulse generator which is worn by the member.

Policy

The HFWO is considered **reasonable and necessary** for Members requiring airway clearance that meet coverage criteria.

Policy Guidelines

Coverage Criteria:

High frequency chest wall oscillation devices (HFCWO) (E0483) are covered for members who meet:

A. Criterion 1, 2, or 3, and

B. Criterion 4

    1. There is a diagnosis of cystic fibrosis (see diagnosis codes that support medical necessity section below).

    2. There is a diagnosis of bronchiectasis (see diagnosis codes that support medical necessity section below) which has been confirmed by a high resolution, spiral, or standard CT scan and which is characterized by:

        a. Daily productive cough for at least 6 continuous months; or

        b. Frequent (i.e., more than 2/year) exacerbations requiring antibiotic therapy.

Chronic bronchitis and chronic obstructive pulmonary disease (COPD) in the absence of a confirmed diagnosis of bronchiectasis do not meet this criterion.

3. The member has one of the following neuromuscular disease diagnoses (see diagnosis codes that support medical necessity section below):

Post-polio
Acid maltase deficiency
Anterior horn cell diseases
Multiple sclerosis
Quadriplegia
Hereditary muscular dystrophy
Myotonic disorders
Other myopathies
Paralysis of the diaphragm

4. There must be well-documented failure of standard treatments to adequately mobilize retained secretions.

If ALL of the criteria are not met, the claim will be denied as not reasonable and necessary.

It is not reasonable and necessary for a beneficiary to use both an HFCWO device and a mechanical in-exsufflation device (E0482).

Replacement supplies, A7025 and A7026, used with member owned equipment, are covered if the member meets the criteria listed above for the base device, E0483. If these criteria are not met claims will be denied as not reasonable and necessary.

HCPCS Level II Codes and 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 (includes hoses and vest), each

ICD-10 Codes that Support Medical Necessity

Group 1 Paragraph: The presence of an ICD-10 code listed in this section is not sufficient by itself to assure coverage. Refer to the section on "Coverage Indications, Limitation and/or Medical Necessity" for other coverage criteria and payment information.

Group 1 Codes:

ICD-10 Code	Description
A15.0	Tuberculosis of lung
B91	Sequelae of poliomyelitis
D81.810	Biotinidase deficiency
D84.1	Defects in the complement system
E84.0	Cystic fibrosis with pulmonary manifestations
E84.9	Cystic fibrosis, unspecified
G12.0	Infantile spinal muscular atrophy, type I [Werdnig-Hoffman]
G12.1	Other inherited spinal muscular atrophy
G12.20	Motor neuron disease, unspecified
G12.21	Amyotrophic lateral sclerosis
G12.22	Progressive bulbar palsy
G12.23	Primary lateral sclerosis
G12.24	Familial motor neuron disease
G12.25	Progressive spinal muscle atrophy
G12.29	Other motor neuron disease
G12.8	Other spinal muscular atrophies and related syndromes
G12.9	Spinal muscular atrophy, unspecified
G14	Postpolio syndrome
G35	Multiple sclerosis
G71.00	Muscular dystrophy, unspecified
G71.01	Duchenne or Becker muscular dystrophy
G71.02	Facioscapulohumeral muscular dystrophy
G71.09	Other specified muscular dystrophies
G71.11	Myotonic muscular dystrophy
G71.12	Myotonia congenita
G71.13	Myotonic chondrodystrophy
G71.14	Drug induced myotonia
G71.19	Other specified myotonic disorders
G71.2	Congenital myopathies
G71.3	Mitochondrial myopathy, not elsewhere classified

G71.8	Other primary disorders of muscles
G72.0	Drug-induced myopathy
G72.1	Alcoholic myopathy
G72.2	Myopathy due to other toxic agents
G72.89	Other specified myopathies
G73.7	Myopathy in diseases classified elsewhere
G82.50	Quadriplegia, unspecified
G82.51	Quadriplegia, C1-C4 complete
G82.52	Quadriplegia, C1-C4 incomplete
G82.53	Quadriplegia, C5-C7 complete
G82.54	Quadriplegia, C5-C7 incomplete
J47.0	Bronchiectasis with acute lower respiratory infection
J47.1	Bronchiectasis with (acute) exacerbation
J47.9	Bronchiectasis, uncomplicated
J98.6	Disorders of diaphragm
M33.02	Juvenile dermatopolymyositis with myopathy
M33.12	Other dermatopolymyositis with myopathy
M33.22	Polymyositis with myopathy
M33.92	Dermatopolymyositis, unspecified with myopathy
M34.82	Systemic sclerosis with myopathy
M35.03	Sicca syndrome with myopathy
Q33.4	Congenital bronchiectasis

ICD-10 Codes that DO NOT Support Medical Necessity

Group 1 Paragraph: All ICD-10 codes that are not specified in the previous section.

Documentation Requirements

Items in this policy may be subject to the Affordable Care Act (ACA) 6407 requirements.

The Affordable Care Act (ACA) 6407 requires that the treating physician conduct a face-to-face examination during the six month period preceding the written order. The documentation must be received by the provider prior to delivery for certain DME items. The documentation must describe a medical condition for which the DME is being prescribed.

Important Note:

Northwood's Medical Policies are developed to assist Northwood in administering plan benefits and determining whether a particular DMEPOS product or service is reasonable and necessary. Equipment that is used primarily and customarily for a non-medical purpose is not considered durable medical equipment.

Coverage determinations are made on a case-by-case basis and are subject to all of the terms, conditions, limitations, and exclusions of the member's contract including medical necessity requirements.

The conclusion that a DMEPOS product or service is reasonable and necessary does not constitute coverage. The member's contract defines which DMEPOS product or service is covered, excluded or limited. The policies provide for clearly written, reasonable and current criteria that have been approved by Northwood's Medical Director.

The clinical criteria and medical policies provide guidelines for determining the medical necessity for specific DMEPOS products or services. In all cases, final benefit determinations are based on the applicable contract language. To the extent there are any conflicts between medical policy guidelines and applicable contract language, the contract language prevails. Medical policy is not intended to override the policy that defines the member's benefits, nor is it intended to dictate to providers how to direct care. Northwood Medical policies shall not be interpreted to limit the benefits afforded to Medicare or Medicaid members by law and regulation and Northwood will use the applicable state requirements to determine required quantity limit guidelines.

Northwood's policies do not constitute medical advice. Northwood does not provide or recommend treatment to members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

References

Centers for Medicare and Medicaid Services, Medicare Coverage Database, National Coverage Documents; October 2015 Accessed December 15, 2017.

CGS Administrators, LLC. Jurisdiction B DME MAC, High Frequency Chest Wall Oscillation Devices. Local Coverage Determination No. L33785; revised date October 1, 2015. Updated December 3, 2018.

Noridian Healthcare Solutions, LLC, High Frequency Chest Wall Oscillation Devices. Local Coverage Determination No. L33785. Durable Medical Equipment Medicare Administrative Carrier Jurisdiction A; revised January 1, 2011. Updated December 3, 2018.

Applicable URAC Standard

Core 8	Staff operational tools and support

Change/Authorization History

Revision Number	Date	Description of Change	Prepared/Reviewed by	Approved by	Review Date:
A	Nov.2006	Initial Release	Rosanne Brugnoni	Ken Fasse	n/a
01	Oct.2008	Added: Coverage for specified neuromuscular diseases. Added: Statement about concurrent use of mechanical in-exsufflation device. Added:ICD-9 codes for neuromuscular diseases	Susan Glomb	Ken Fasse	n/a
02		Annual Review	Susan Glomb	Ken Fasse	Dec.2008
03	12-22-09	Annual Review/ no changes	Susan Glomb	Ken Fasse	Dec. 2009
04	12-02-10	Annual Review – No changes	Susan Glomb	Ken Fasse	Dec.2010
05	07-20-11	Added Important Note to all Medical Policies	Susan Glomb	Dr. B. Almasri	
06	11-08-11	Annual Review. Added References to Policy	Susan Glomb	Dr. B. Almasri	Nov. 2011
07	04-03-12	Added reference to NH Medicaid	Susan Glomb	Dr. B. Almasri	
08	11-29-12	Annual Review – No changes	Susan Glomb	Dr. B. Almasri	Nov 2012
09	12-18-13	Annual Review. No changes	Susan Glomb	Dr. B. Almasri	
10	11-24-14	Annual Review. No changes	Susan Glomb	Dr. B. Almasri	
11	12-4-14	Annual Review. Added: Items in this policy may be subject to the Affordable Care Act (ACA) 6407 requirements.	Susan Glomb	Dr. B. Almasri	
12	12-9-15	Annual Review. References updated. Removed ICD-9 codes and added ICD-10 codes.	Susan Glomb	Dr. B. Almasri	12-9-15
13	12-05-16	Annual Review. No Changes.	Lisa Wojno	Dr. B. Almasri	December 2016

14	04-06-17	Policy reviewed per CMS memo. No changes required at this time.	Susan Glomb	Dr. C. Lerchin	
15	12-15-17	Annual review. Added: New ICD-10 codes G12.23, G12.24, G12.25.	Carol Dimech	Dr. C. Lerchin	December 2017
16	12-3-18	Annual review. Removed: ICD-10 Code G71.0 due to annual ICD-10 Code updates. Added: New expanded ICD-10 codes G71.00, G71.01, G71.02, G71.09. Updated references.	Carol Dimech	Dr. C. Lerchin	December 2018