Medical Policy

Northwood

Airway Clearance Devices - Positive Expiratory Pressure Device, Oscillating Positive Expiratory Pressure Device and Percussor

Description

Airway clearance devices assist members with respiratory disorders characterized by excessive respiratory secretions and impaired airway clearance by loosening thick, sticky lung mucus so it can be cleared from the airway. Two types of airway clearance devices are the positive expiratory pressure device (PEP) and the oscillating positive pressure device.

A PEP device increases resistance to expiratory airflow to promote mucus clearance by preventing airway closure and increasing collateral ventilation. Examples of this type of device include the TheraPEP®, Resistex PEP Mask, and the Pari RC Cornet Mucus Clearing Device™.

An oscillating (or vibratory) positive expiratory pressure device is a form of PEP that combines high-frequency air flow oscillations with positive expiratory pressure via a small hand-held device. Examples of this device include the Flutter® and the Acapella®.

A percussor is a device used for a diagnosis requiring percussion, consisting of a hammer with a rubber or metal head.

Policy

Positive expiratory pressure device, oscillating positive expiratory pressure device and percussor are considered **medically necessary** for members with excessive respiratory secretions and impaired airway clearance.

Policy Guidelines

Coverage Criteria:

1. Must be ordered by the member's treating practitioner.
2. A positive expiratory pressure device, an oscillating positive expiratory pressure device or a percussor will be covered for members with a diagnosis that is characterized by excessive mucus production and difficulty in clearing secretions.

Examples of diagnoses creating excessive mucus production include, but are not limited to:

- Asthma
- Bronchiectasis
- Chronic bronchitis
- Chronic lower respiratory diseases
- Chronic obstructive asthma
- Chronic obstructive lung disease
- Congenital bronchiectasis
- Cystic fibrosis
- Disorders of the diaphragm
- Emphysema
- Lung transplant status
- Motor neuron disease
- Muscular dystrophies
- Myoneural disorders (ALS)
- Obstructive chronic bronchitis
- Situs inversus (immotile cilia syndrome)

Limitations:

1. The powered Percussor is provided only when the member or operator has received appropriate training by a physician, treating practitioner or therapist, and no one is available to administer manual therapy.

2. Repair of a Percussor will be covered for restoration to a serviceable condition which is not the result from misuse, non-intentional or intentional when member owned.

3. The replacement of a Percussor is covered if any of the following criteria are met:

a. When necessitated by irreparable damage not due to misuse, intentional or non-intentional.

b. An irreparable change in the condition of the Percussor.

c. The cost of repairs to the Percussor would exceed the purchase price.

4. The following devices are considered experimental and investigational:

a. The Simeox Airway Clearance Technology bronchial drainage device for the treatment of cystic fibrosis.

b. High-frequency chest compression systems for the treatment of anoxic brain injury, CFTR-related metabolic syndrome, dyspnea in chronic obstructive pulmonary disease, and plastic bronchitis.

c. The Volara System Oscillation & Lung Expansion (OLE) therapy device for the treatment of asthma and middle lobe syndrome.

HCPCS Level II Codes and Description

E0480	Percussor, electric or pneumatic, home model
E0484	Oscillatory positive expiratory pressure device, nonelectric, any type, each
S8185	Flutter device (non-Medicare code)

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 practitioner in connection with diagnosis and treatment decisions.

Northwood follows all CMS National Coverage Determinations (NCD) and Local Coverage Determinations (LCD), as applicable.

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Change/Authorization History

Revision Number	Date	Description of Change	Prepared/Reviewed by	Approved by	Review Date:	Effective Date:
A	11-20-06	Initial Release	Rosanne Brugnoni	Ken Fasse	n/a	
01		Annual Review – no changes	Susan Glomb	Ken Fasse	Dec.2008	
02	12-22-09	Annual Review- no changes	Susan Glomb	Ken Fasse	Dec. 2009	
03	12-03-10	Annual Review – no changes	Susan Glomb	Ken Fasse	Dec.2010	
04	07-20-11	Added Important Note to all Medical Policies	Susan Glomb	Dr. B. Almasri		
05	11-16-11	Annual Review. Added References to Policy	Susan Glomb	Dr. B. Almasri	Nov. 2011	
06	04-03-12	Added reference to NH Medicaid	Susan Glomb	Dr. B. Almasri		
07	11-26-12	Annual review. No changes.	Susan Glomb	Dr. B. Almasri	Nov. 2012	
08	12-18-13	Annual review. No changes	Susan Glomb	Dr. B. Almasri	Dec 2013	
09	11-24-14	Annual Review. No change	Susan Glomb	Dr. B. Almasri		
10	11-23-15	Annual Review. Updated policy to reflect that S8185 is a non-Medicare code.	Lisa Wojno	Dr. B. Almasri	November 2015	

11	11-21-16	Annual Review. No Changes.	Lisa Wojno	Dr. B. Almasri	November 2016	
12	11-14-17	Annual review. No changes.	Carol Dimech	Dr. C. Lerchin	November 2017	
13	11-14-18	Annual Review. No Changes.	Lisa Wojno	Dr. C. Lerchin	November 2018	
14	11-05-19	Annual Review. No Changes.	Lisa Wojno	Dr. C. Lerchin	November 2019	11-2019
15	11-04-20	Annual review. Added Aetna to the references list.	Carol Dimech	Dr. C. Lerchin	November 4, 2020	November 4, 2020
16	11-1-21	Annual review. Added NCD to reference list. Added asthma to diagnosis examples list. Removed URAC reference.	Carol Dimech	Dr. C. Lerchin	November 1, 2021	November 1, 2021
17	11-8-21	Added NCD, LCD verbiage to “Important Note”.	Carol Dimech	Dr. C. Lerchin	November 8, 2021	
18	11-2-22	Annual review. Added to diagnosis example list for clarification. Changed physician to treating practitioner.	Carol Dimech	Dr. C. Lerchin	11-2-22	11-2-22
19	11-1-23	Annual review. Per national benchmark guidelines (Aetna), added under Limitations 4. a, b, c, devices considered experimental and investigational.	Carol Dimech	Dr. C. Lerchin	11-1-23	11-1-23