Geisinger

# Geisinger Health Plan Policies and Procedure Manual

**Policy: MP045**

**Section: Medical Benefit Policy**

**Subject: High Frequency Chest Percussion Vest**

**Applicable Lines of Business**

| | | | |
|---|---|---|---|
| **Commercial** | **X** | **CHIP** | **X** |
| **Medicare** | **X** | **ACA** | **X** |
| **Medicaid** | **X** | | |

**I. Policy:** High Frequency Chest Percussion Vest

**II. Purpose/Objective:**
To provide a policy of coverage regarding High Frequency Chest Percussion Vest

**III. Responsibility:**
A. Medical Directors
B. Medical Management

**IV. Required Definitions**

1. Attachment – a supporting document that is developed and maintained by the policy writer or department requiring/authoring the policy.
2. Exhibit – a supporting document developed and maintained in a department other than the department requiring/authoring the policy.
3. Devised – the date the policy was implemented.
4. Revised – the date of every revision to the policy, including typographical and grammatical changes.
5. Reviewed – the date documenting the annual review if the policy has no revisions necessary.

**V. Additional Definitions**
Medical Necessity or Medically Necessary means Covered Services rendered by a Health Care Provider that the Plan determines are:

a. appropriate for the symptoms and diagnosis or treatment of the Member's condition, illness, disease or injury;
b. provided for the diagnosis, and the direct care and treatment of the Member's condition, illness disease or injury;
c. in accordance with current standards of good medical treatment practiced by the general medical community.
d. not primarily for the convenience of the Member, or the Member's Health Care Provider; and
e. the most appropriate source or level of service that can safely be provided to the Member. When applied to hospitalization, this further means that the Member requires acute care as an inpatient due to the nature of the services rendered or the Member's condition, and the Member cannot receive safe or adequate care as an outpatient.

**Medicaid Business Segment**
Medically Necessary — A service, item, procedure, or level of care that is necessary for the proper treatment or management of an illness, injury, or disability is one that:

- Will, or is reasonably expected to, prevent the onset of an illness, condition, injury or disability.
- Will, or is reasonably expected to, reduce or ameliorate the physical, mental or developmental effects of an

illness, condition, injury or disability.
- Will assist the Member to achieve or maintain maximum functional capacity in performing daily activities, taking into account both the functional capacity of the Member and those functional capacities that are appropriate for Members of the same age.

**DESCRIPTION:**
High frequency chest wall percussion is a machine that delivers chest physiotherapy by means of pulsed pressure, helping the patient to mobilize airway secretions. This bronchial drainage system includes a vest connected to a pulse generator and enables patients to self-administer the technique of high frequency chest compression to assist with mucocilliary clearance.

**INDICATIONS:**
**High frequency chest compression systems (HFCWS)**
HFCWS will be considered medically necessary when the following criteria are met:

A diagnosis of:
1. Cystic fibrosis; **or**
2. Bronchiectasis, characterized by daily productive cough for at least 6 continuous months, or frequent (more than 2/year) exacerbations requiring antibiotic therapy and confirmed by high resolution, spiral or standard CT scan; **or**
3. One of the following neuromuscular diseases with respiratory function weakness: Post-polio, Acid maltase deficiency,
   Anterior horn cell diseases, Multiple sclerosis, Quadriplegia, Hereditary muscular dystrophy, Myotonic disorders, other myopathies affecting respiratory clearance, or Paralysis of the diaphragm.

**and**

4. Well documented failure of standard treatments to adequately mobilize retained secretions; **and**
5. Must be recommended by an Adult or Pediatric Pulmonologist or upon exception, approved by a Medical Director

**Oscillating positive expiratory pressure (PEP) devices:**
Oscillating PEP device (e.g., the Flutter device, Acapella device and the Positive Expiratory Pressure (PEP) mask) will be considered medically necessary for members with hypersecretory lung disease with documented difficulty clearing secretions which is causing recurrent exacerbations.

**EXCLUSION:**
It is not medical necessary for an insured individual to use both a high frequency chest wall percussion device and a mechanical in-exsufflation device (E0482).

Requests for coverage for insured individuals with the approved diagnoses and not meeting the above criteria, or requests for insured individuals with ANY other diagnosis must be authorized by a Plan Medical Director or designee.

Combination oscillation and lung expansion (OLE) devices for the treatment of respiratory conditions (e.g., the Volara System, BiWaze Clear System, and MetaNeb4 System) **(E1399)** as an alternative to conventional chest physical therapy to promote the clearance of respiratory secretions are considered to be of unproven value and not medically necessary, therefore **NOT COVERED**. There is insufficient evidence in the peer-reviewed published medical literature to draw conclusions regarding improvements in health outcomes of these devices compared to established alternatives.

**CONTRAINDICATIONS:**
Unstabilized head and/or neck injury
Active hemorrhage with hemodynamic instability
Subcutaneous emphysema
Recent epidural spinal infusion or spinal anesthesia
Recent skin grafts, or flaps, on the thorax
Burns, open wounds, and skin infections of the thorax
Recently placed transvenous pacemaker or subcutaneous pacemaker
Suspected pulmonary tuberculosis
Lung contusion

**LIMITATIONS**:
Requires pre-certification through the Plan's Medical Management Department. Equipment must be obtained through an approved Durable Medical Equipment vendor(s).

Additional Key Words
Vest™ Airway Clearance System, SmartVest® Airway Clearance System, ABI Vest®, ThAIRapy Vest®, Flutter device, Acapella device

## Medicaid Business Segment:
Any requests for services, that do not meet criteria set in the PARP, may be evaluated on a case by case basis

**CODING ASSOCIATED WITH:** High Frequency Chest Percussion Vest

***The following codes are included below for informational purposes and may not be all inclusive. Inclusion of a procedure or device code(s) does not constitute or imply coverage nor does it imply or guarantee provider reimbursement. Coverage is determined by the member specific benefit plan document and any applicable laws regarding coverage of specific services. Please note that per Medicare coverage rules, only specific CPT/HCPCS Codes may be covered for the Medicare Business Segment. Please consult the CMS website at*** www.cms.gov ***or the local Medicare Administrative Carrier (MAC) for more information on Medicare coverage and coding requirements.***

94669 Mechanical chest wall oscillation to facilitate lung function, per session
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
E0480 Percussor, electric or pneumatic, home model
E0481 Intrapulmonary percussive ventilation system and related accessories
E0482 Cough stimulating device, alternating positive and negative airway pressure.
E0483 High frequency chest wall oscillation system, with full anterior and/or posterior thoracic region receiving simultaneous external oscillation, includes all accessories and supplies, each
E0484 Oscillatory positive expiratory pressure device, non-electric, any type, each



**LINE OF BUSINESS:**
**Eligibility and contract specific benefits, limitations and/or exclusions will apply. Coverage statements found in the line of business specific benefit document will supersede this policy. For Medicare, applicable LCD's and NCD's will supercede this policy. For PA Medicaid Business segment, this policy applies as written.**

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This policy will be revised as necessary and reviewed no less than annually**.**

**Devised:** 3/00

**Revised:** 01/02; 2/04 (criteria, coding); 2/08 (wording); 5/17, 5/18 (Removed Prior Auth); 5/23 (clarify indications); 5/24 ( add OLE exclusion)

**Reviewed:** 01/03; 2/05; 2/06; 2/07; 2/09; 2/10; 6/11, 6/12, 6/13, 6/14, 6/15, 6/16, 5/19, 5/20, 5/21, 5/22

**CMS UM Oversight Committee Approval:** 12/23, 7/24

Geisinger Health Plan may refer collectively to health care coverage sponsors Geisinger Health Plan, Geisinger Quality Options, Inc., and Geisinger Indemnity Insurance Company, unless otherwise noted. Geisinger Health Plan is part of Geisinger, an integrated health care delivery and coverage organization.

Coverage for experimental or investigational treatments, services and procedures is specifically excluded under the member's certificate with Geisinger Health Plan. Unproven services outside of an approved clinical trial are also specifically excluded under the member's certificate with Geisinger Health Plan. This policy does not expand coverage to services or items specifically excluded from coverage in the member's certificate with Geisinger Health Plan. Additional information can be found in MP015 Experimental, Investigational or Unproven Services.

Prior authorization and/or pre-certification requirements for services or items may apply. Pre-certification lists may be found in the member's contract specific benefit document. Prior authorization requirements can be found at https://www.geisinger.org/health-plan/providers/ghp-clinical-policies