High Frequency Chest Compression Device. Also known as Airway Clearance device.

Applies to: Missouri

Purpose: This DME device is covered by Missouri. Milliman guidelines indicate the device has an uncertain role, therefore these guidelines are used to determine coverage.

Effective date: February 1, 2012
Revision(s): April 30, 2014; May 11, 2015
Reviewed without changes:

Policy:
- Statement of coverage decision: CMPCN will authorize these devices through a PAR vendor when the DME codes are covered for the beneficiary when criteria are met. DME codes are: A7025, A7026, and E0483
- Criteria for coverage: Percussion vests are considered medically necessary only when ALL of the following criteria are met:
  - The patient must have a documented need of airway clearance
    - This would be manifested by history of congestion, congested cough, or poor/ineffective cough. Physical exam may or may not reflect chest congestion.
  - The patient must have any one of the following diagnoses:
    - Cystic Fibrosis (CF), or
    - Chronic bronchiectasis, or
    - As defined by daily productive cough or exacerbations requiring antibiotics at least twice a year, and a confirmatory CT scan
    - One of the following chronic neuromuscular disorders affecting respiration and clearance of secretions:
      - Acid maltase deficiency
      - Anterior horn cell diseases including amyotrophic lateral sclerosis (ALS)
      - Hereditary muscular dystrophy
      - Multiple sclerosis
      - Myotonic disorders
      - Paralysis of the diaphragm
      - Post-polio syndrome
      - Quadriplegia
  - Documentation of failure of other methods or inability to use other airway clearance therapies including chest physical therapy, or flutter valve use. Inability to perform may be due to:
    - two or more children with cystic fibrosis in the family;
    - inability of the caregiver (physical or mental) to perform chest physical therapy at the required frequency; or
    - no available parental or partner resource to perform chest physical therapy;
  - Patient/family compliance with the device as evidenced by an initial successful trial period
- Authorization period:
  - Initial: Rental only
Children’s Mercy Pediatric Care Network
Precertification Guidelines

- Extended: After at least one month rental and demonstrated compliance with stable to improved clinical condition during this period, device is authorized for rent to purchase
  - Vendor is responsible for repair and replacement vests
- Discontinuation of authorization: Lack of clinical response to the vest, or lack of use (typical use would be once or twice a day) for an extended period of time without medical reason to support suspension of use.
- Reasons for non-coverage: Does not meet above criteria
- Medical background: Patients with certain medical conditions create thick mucous that can be difficult to clear from the respiratory tract. The pooled mucous can lead to blockage and mechanical damage or promote bacterial growth and therefore infection. Treatments often include special nebulizer medications, oral treatments, or chest percussion and drainage to liquefy and mobilize the secretions. Certain devices, such as a flutter valve, can also help the patient maximize lung function and expel secretions. The most common condition that exemplifies this care need is cystic fibrosis. Manual chest therapy can be taught to lay caregivers, but it is time and energy consumptive, and may not be well done either due to patient issues or non-compliance with the time, schedule and/or technique. The high frequency chest compression devices are used as a substitute for manual chest compression, and have been shown to be effective in mobilizing secretions.

References:


MO HealthNet DME Precertification criteria, July 1, 2008, accessed at:

MO HealthNet Physician and Durable Medical Equipment Bulletin, Vol 30, No 68, “Rent to Purchase for Chest Wall Oscillation Devices”

UpToDate®, accessed May 2015, articles on bronchiectasis and cystic fibrosis

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Precertification Guidelines

Policy drafted by: PCN Clinical Services Integration Committee

Policy approved by: Tim Johnson, DO, CMPCN Medical Director

Update approved by:
   Clinical and Quality Management Committee – March 23, 2012; May 27, 2014; May 29, 2015
   Medical Management Committee – May 19, 2014, May 18, 2015

Disclaimer: Any coverage determination requires medical necessity, coverage by the member’s benefit plan, and eligibility. The sole purpose of this document is to address medical necessity.