TITLE: HIGH FREQUENCY CHEST WALL COMPRESSION (HFCWC) DEVICES

EFFECTIVE DATE: March 1, 2017

This policy was developed with input from specialists in pulmonology and endorsed by the Medical Policy Committee.

IMPORTANT INFORMATION – PLEASE READ BEFORE USING THIS POLICY
These services may or may not be covered by all Medica plans. Please refer to the member’s plan document for specific coverage information. If there is a difference between this general information and the member’s plan document, the member’s plan document will be used to determine coverage. With respect to Medicare and Minnesota Health Care Programs, this policy will apply unless these programs require different coverage. Members may contact Medica Customer Service at the phone number listed on their member identification card to discuss their benefits more specifically. Providers with questions about this Medica utilization management policy may call the Medica Provider Service Center toll-free at 1-800-458-5512.

Medica utilization management policies are not medical advice. Members should consult with appropriate health care providers to obtain needed medical advice, care and treatment.

PURPOSE
To promote consistency between reviewers in utilization management decision-making by providing the criteria that generally determine the medical necessity of high frequency chest wall compression (HFCWC) devices. The Coverage Issues box below outlines the process for addressing the needs of individuals who do not meet these criteria.

BACKGROUND
Definitions:
A. **High frequency chest wall compression** (HFCWC) is a mechanical form of chest physical therapy (CPT) used as an alternative to conventional chest physical therapy in patients with impaired ability to clear pulmonary secretions. HFCWC can be delivered using a vest-like inflatable device that fits over the patient’s chest. These devices consist of an air-pulse generator, connector hose, and an inflatable vest that covers the thorax. The inflatable vest is connected to a small air-pulse generator by two tubes, which rapidly inflate and deflate the vest, compressing and releasing the chest wall up to 20 times per second. HFCWC may also be described as High Frequency Chest Wall Oscillation (HFCWO).

B. **Chest Physiotherapy** (CPT) also known as **postural drainage therapy** (PDT) is a treatment program that attempts to compensate for abnormal airway clearance. The method may involve clapping, vibration and compression, together with postural drainage and assisted coughing. CPT sessions are usually done one to three times a day for 20 to 30 minutes, depending on the severity of disease and the presence of infection.

C. **Cystic Fibrosis** (CF) is a genetic disease characterized by dehydration of airway surface liquid and impaired mucociliary clearance. As a result, there is difficulty clearing pathogens from the lung, and patients experience chronic pulmonary infections and inflammation, the principle causes of morbidity and mortality of cystic fibrosis.

D. **Bronchiectasis**: irreversible dilation and destruction of one or more bronchi with inadequate drainage/clearance of mucus in the airways. Often bronchiectasis is a clinical diagnosis; however, a high resolution CT scan may be indicated.

E. **Flutter valve** is a positive expiratory pressure device designed to create oscillations within the pulmonary system that result in a loosening of secretions.
MEDICAL NECESSITY CRITERIA

I. Indications
High frequency chest wall compression is considered medically necessary when documentation in the medical record shows all of the following criteria are met:

A. Device has been ordered by a pulmonologist
B. The member has one of the following diagnoses:
   1. Cystic fibrosis
   2. Bronchiectasis characterized by one of the following:
      a. Daily productive cough for at least six continuous months
      b. Frequent (more than two times per year) exacerbations requiring antibiotic therapy
C. The member is on optimal medical management [e.g. antibiotics, bronchodilators, and techniques to enhance mucus clearance such as use of a flutter valve and/or chest physiotherapy (CPT)].
D. Standard treatments to mobilize secretions have failed or cannot be performed.
E. Written documentation from the medical record, including:
   1. Detailed clinical history of a frequent productive cough for at least three continuous months
   2. Frequent exacerbations (more than two times per year) requiring medical management such as antibiotic therapy
   3. Failure of standard treatments to mobilize secretions (e.g. CPT/PDT).

COVERAGE ISSUES

1. Prior authorization is required for high frequency chest wall compression (HFCWC) devices.
2. Coverage may vary according to the terms of the member’s plan document.
3. High frequency chest wall compression is investigational and therefore not covered for all other indications, including but not limited to neuromuscular disorders.
4. For Medicare members, refer to the following, as applicable:
   - Centers for Medicare and Medicaid Services (CMS). Local Coverage Determination (LCD): High Frequency Chest Wall OSCILLATION Devices (L33785)
     erageSelection=Both&ArticleType=All&PolicyType=Final&s=All&KeyWord=oscillation&KeyWordLookUp=T
     itle&KeyWordSearchType=And&FriendlyError=NoLCIDVersion&bc=gAAAAA%3d%3d&. Accessed August 31, 2016.
5. If the Medical Necessity and Coverage Criteria are met, Medica will authorize benefits within the limits in the member’s plan document.
6. If it appears that the Medical Necessity and Coverage Criteria are not met, the individual’s case will be reviewed by the medical director or an external reviewer. Practitioners are reminded of the appeals process in their Medica Provider Administrative Manual.

DOCUMENT HISTORY

<table>
<thead>
<tr>
<th>Original Effective Date</th>
<th>January 2012</th>
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<tbody>
<tr>
<td>Administrative updates(s)</td>
<td>05/01/2017</td>
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References:
Pre-11/2015 MPC:


**11/2015 MPC:**

**11/2016 MPC:**