Medical Policy:
High Frequency Chest Wall Oscillation Devices and Intrapulmonary Percussive Ventilators (Commercial)

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<tr>
<th>POLICY NUMBER</th>
<th>LAST REVIEW DATE</th>
<th>APPROVED BY</th>
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<td>MG.MM.DM.09cC</td>
<td>09/11/2020</td>
<td>MPC (Medical Policy Committee)</td>
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**IMPORTANT NOTE ABOUT THIS MEDICAL POLICY:**

Property of ConnectiCare, Inc. All rights reserved. The treating physician or primary care provider must submit to ConnectiCare, Inc. the clinical evidence that the patient meets the criteria for the treatment or surgical procedure. Without this documentation and information, ConnectiCare will not be able to properly review the request for prior authorization. This clinical policy is not intended to pre-empt the judgment of the reviewing medical director or dictate to health care providers how to practice medicine. Health care providers are expected to exercise their medical judgment in rendering appropriate care. The clinical review criteria expressed below reflects how ConnectiCare determines whether certain services or supplies are medically necessary. ConnectiCare established the clinical review criteria based upon a review of currently available clinical information (including clinical outcome studies in the peer-reviewed published medical literature, regulatory status of the technology, evidence-based guidelines of public health and health research agencies, evidence-based guidelines and positions of leading national health professional organizations, views of physicians practicing in relevant clinical areas, and other relevant factors). ConnectiCare, Inc. expressly reserves the right to revise these conclusions as clinical information changes, and welcomes further relevant information. Identification of selected brand names of devices, tests and procedures in a medical coverage policy is for reference only and is not an endorsement of any one device, test or procedure over another. Each benefit plan defines which services are covered. The conclusion that a particular service or supply is medically necessary does not constitute a representation or warranty that this service or supply is covered and/or paid for by ConnectiCare, as some plans exclude coverage for services or supplies that ConnectiCare considers medically necessary. If there is a discrepancy between this guideline and a member's benefits plan, the benefits plan will govern. In addition, coverage may be mandated by applicable legal requirements of the State of CT and/or the Federal Government. Coverage may also differ for our Medicare members based on any applicable Centers for Medicare & Medicaid Services (CMS) coverage statements including including National Coverage Determinations (NCD), Local Coverage Determinations (LCD) and/or Local Medical Review Policies(LMRP). All coding and web site links are accurate at time of publication.

**Definition**

| High Frequency Chest Wall Oscillation (HFCWO) | A high frequency chest wall oscillation device (HFCWO) is an airway clearance device consisting of an inflatable vest connected by tubes to a small air-pulse generator. |

**Guideline**

Members are eligible for coverage of HFCWO when any of the following conditions/diagnoses met:

1. Acid maltase deficiency
2. Amyotrophic lateral sclerosis
3. Anterior horn cell diseases
4. Bronchiectasis
5. Cystic fibrosis
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6. Hereditary muscular dystrophy
7. Multiple sclerosis
8. Myotonic disorders
9. Other myopathies
10. Paralysis of the diaphragm
11. Post-polio
12. Quadriplegia
13. Any neuromuscular disease disorder with ineffective cough
14. Members with a gastrostomy tube and risk of aspiration if manual chest physical therapy (PT) is indicated on a case by case basis when other methods of daily chest PT have been tried and failed

Well-documented failure of standard treatments to adequately mobilize retained secretions must be made available to the Plan upon request

Limitation/Exclusion
High frequency chest wall oscillation devices are not covered for any conditions other than those listed above.
Intrapulmonary percussive ventilators (IPV) (e.g., the Impulsator F00012) are considered experimental and investigational for all indications due to insufficient evidence of therapeutic value (including but not limited to bronchiectasis, chronic obstructive pulmonary disease [COPD], cystic fibrosis, neuromuscular conditions associated with retained airway secretions or atelectasis, and post-operative pulmonary complications)

Coding Criteria:
To access the codes, please download the policy to your computer, and click on the paperclip icon within the policy

Applicable CPT and Diagnosis Codes

References


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Specialty-matched clinical peer review.


Revision history

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<th>DATE</th>
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<tr>
<td>09/13/2019</td>
<td>Added the following covered indications to HFDWOD:</td>
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<td>• Any neuromuscular disease disorder with ineffective cough</td>
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<td>• Members with a gastrostomy tube and risk of aspiration if manual chest</td>
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<td>methods of daily chest PT have been tried and failed</td>
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<td>• Reformatted and reorganized policy, transferred content to new CCI</td>
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<td>06/10/2016</td>
<td>Communicated noncoverage of IPVs</td>
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