



High Frequency Chest Wall Oscillation Devices Clinical Coverage Criteria

Overview

Certain patients, such as those with cystic fibrosis (CF), produce large amounts of respiratory secretions, which may clog the airways, resulting in pneumonia or other problems. To help cough up and clear these secretions, patients often receive chest physiotherapy (CPT), consisting of clapping and pounding of the chest to loosen the secretions.

High frequency chest wall oscillation devices can be used as a replacement for or enhancement of CPT to help loosen pulmonary secretions. A large hose connects an inflatable vest to an air-pulse generator, and vibrations are transmitted to the patient's chest to loosen secretions. Typically, a person uses the vest for five minutes and then coughs or huff coughs to clear the mucus. Sessions last about 20 to 30 minutes.

U.S. Food and Drug Administration (FDA)-cleared high frequency chest wall oscillation devices include The Vest Airway Clearance System, (Hill-Rom, St. Paul, MN; previously manufactured by Advanced Respiratory, Inc., St. Paul, MN), SmartVest Airway Clearance System (Electromed, Inc., New Prague, MN) and inCourage System (RespirTech, Inc., St. Paul, MN).

Policy

This Policy applies to the following Fallon Health products:

- Commercial
- Medicare Advantage
- MassHealth ACO
- NaviCare
- PACE

Fallon Health follows guidance from the Centers for Medicare and Medicaid Services (CMS) for organization (coverage) determinations for Medicare Advantage plan members. National Coverage Determinations (NCDs), Local Coverage Determinations (LCDs), Local Coverage Articles (LCAs) and guidance in the Medicare manuals are the basis for coverage determinations. When there is no NCD, LCD, LCA or manual guidance, Fallon Health Clinical Coverage Criteria are used for coverage determinations.

Medicare does not have an NCD for High Frequency Chest Wall Oscillation Devices. Noridian Healthcare Solutions, LLC., has an LCD for High Frequency Chest Wall Oscillation Devices (L33785) and an LCA for High Frequency Chest Wall Oscillation Devices (A52494) (MCD search 06-23-2021).

For plan members enrolled in NaviCare and PACE plans, Fallon Health follows guidance from CMS for coverage determinations. In the event that there is no Medicare guidance or if the plan member does not meet medical necessity criteria in Medicare guidance, Fallon Health will follow guidance published by MassHealth. When there is no Medicare or MassHealth guidance, Fallon Health Clinical Coverage Criteria are used for coverage determinations for NaviCare members. Each PACE plan member is assigned to an Interdisciplinary Team. When there is no Medicare or

MassHealth guidance, the member's Interdisciplinary Team is responsible for coverage determinations.

Fallon Health requires prior authorization for high frequency chest wall oscillation devices. Requests must be accompanied by supporting documentation.

Part I. Commercial and MassHealth members

Fallon Health covers high frequency chest wall oscillation devices for members who meet the following criteria:

1. There is well-documented failure of standard treatments to adequately mobilize retained secretions; AND
2. One of the following diagnoses exists;
 - Amyotrophic lateral sclerosis (ALS), OR
 - Cystic Fibrosis (CF), OR
 - Bronchiectasis
 - Characterized by daily productive cough for at least 6 continuous months or frequent (i.e., more than 2 per year) exacerbations requiring antibiotic therapy, and
 - Confirmed by CT scan.

Part II. Medicare members

Please refer to Noridian Healthcare Solutions, LLC Local Coverage Determination (LCD) for coverage criteria for high frequency chest wall oscillation devices:

[Local Coverage Determination \(LCD\): High Frequency Chest Wall Oscillation Devices \(L33785\)](#)

[Local Coverage Article: High Frequency Chest Wall Oscillation Devices \(A52494\)](#)

Exclusions

- Other applications of high-frequency chest wall oscillation vests are considered investigational.

Coding

The following codes are included below for informational purposes only; inclusion of a code does not constitute or imply coverage.

High frequency chest wall oscillation devices are capped rental durable medical equipment (DME). HCPCS Code E0483 describes a complete system. Billing of A7025 and/or A7026 with E0483 is incorrect coding.

Replacement supplies (A7025 and A7026) for a patient-owned high frequency chest wall oscillation device are covered when criteria for the device are met.

Code	Description
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
E0483	High Frequency chest wall oscillation air-pulse generator system, includes all accessories and supplies, each

References

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6. Noridian Healthcare Solutions, LLC. Local Coverage Determination (LCD) L33785. High Frequency Chest Wall Oscillation Devices. Original Effective Date 10/1/2015. Revision Effective Date 01/01/2020.
7. Noridian Healthcare Solutions, LLC. Local Coverage Article (LCA) A52494. High Frequency Chest Wall Oscillation Devices. Original Effective Date 10/01/2015. Revision Effective Date 10/1/2020.
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16. The Vest Airway Clearance System (Hill-Rom, Ltd., Bonita Springs, FL 34134) 510(k) K142482. May 7, 2016. Available at: https://www.accessdata.fda.gov/cdrh_docs/pdf14/K142482.pdf.
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Policy history

Origination date:	09/29/2003
Approval(s):	Technology Assessment Committee: 11/2003, 08/28/2013, 01/28/2015 (removed age criteria, updated template, updated references) 02/24/2016 (updated references, removed criteria related to additional non-medical indications), 03/22/2017 (updated references), 03/28/2018 (updated references), 02/27/2019 (updated references), 07/22/2020 (added link to Noridian Healthcare, LLC LCD L33785, updated coding and references)

06/25/2021 (Added clarifying language related to Medicare Advantage, NaviCare and PACE under policy section.

Not all services mentioned in this policy are covered for all products or employer groups. Coverage is based upon the terms of a member's particular benefit plan which may contain its own specific provisions for coverage and exclusions regardless of medical necessity. Please consult the product's Evidence of Coverage for exclusions or other benefit limitations applicable to this service or supply. If there is any discrepancy between this policy and a member's benefit plan, the provisions of the benefit plan will govern. However, applicable state mandates take precedence with respect to fully-insured plans and self-funded non-ERISA (e.g., government, school boards, church) plans. Unless otherwise specifically excluded, federal mandates will apply to all plans.