Medical Coverage Policy | High Frequency Chest Compression

EFFECTIVE DATE: 09/17/2000
POLICY LAST UPDATED: 10/01/2013

OVERVIEW

This policy documents coverage criterion for the use of a high frequency chest compression system which is an oscillatory device designed to provide self-administered airway clearance for individuals with respiratory disorders.

PRIOR AUTHORIZATION

Prior authorization is required for BlueCHiP for Medicare and recommended for Commercial Products.

POLICY STATEMENT

BlueCHiP for Medicare and Commercial Products

High-frequency chest compression system is considered medically necessary for patients who meet the medical criteria.

High frequency chest compression system is considered not medically necessary for all other uses not listed in the medical criteria.

If approved, the air-pulse generator will be rented for a period of six months. At the end of the sixth month, the ordering physician must notify the BCBSRI of the patient's response and compliance with the device. Compliance is defined as use of the vest for a minimum of three to four times per week, 20 minutes per session. Subject to this review, the rental will be extended through the end of the rental period (a total of 10 months).

Coverage is not extended for respiratory therapy while the member has the high-frequency chest compression system, as this is considered to be a duplicate service.

Coverage is not provided for any training and outcomes monitoring program. This program is designed to evaluate compliance with therapy and the impact of the device on a patient's health status and quality of life.

MEDICAL CRITERIA

Use of a high-frequency chest compression system is considered medically necessary for patients who have one of the following medical conditions:

- Cystic fibrosis; or
- Extensive bronchiectasis secondary to another cause; or
- Neuromuscular impairment resulting in poor mucociliary clearance causing recurrent pneumonia or other severe respiratory disease in which mucociliary clearance is causing significant lung disease; and

One of the following existing conditions:

- Child: The family or other caregiver is not physically able to perform chest percussion, or the child cannot be positioned properly due to a medical rather than behavioral condition (e.g., GERD).
- Adult: There is no willing caregiver.

- Well-documented failure of standard treatments to adequately mobilize retained secretions (e.g., hospitalization).

BACKGROUND

Patients with respiratory disorders such as cystic fibrosis, bronchiectasis, and diffuse panbrochiolitis have excessive respiratory secretions and impaired airway clearance. Neuromuscular disease (e.g., muscular dystrophy, spinal muscular atrophy, amyotrophic lateral sclerosis, multiple sclerosis) may also result in a patient's inability to effectively clear mucus from the airways. Blocked airways result in decreased oxygenation and may result in partial or complete lung collapse. Effective airway clearance is critical for treatment of these respiratory and neuromuscular disorders.

Postural drainage therapy (PDT), also known as chest physiotherapy, is the standard of care for mucus clearance. PDT uses postural drainage in various positions, percussion, vibration, compression, deep breathing, and coughing to loosen and move secretions out of the lungs. A competent caregiver is required to perform conventional chest physiotherapy. In situations when a caregiver is unavailable or unable to perform chest physiotherapy, alternative methods may be used.

A high-frequency chest compression system is an oscillatory device designed to provide self-administered airway clearance. These systems provide chest compression using an inflatable vest connected to an air-pulse generator by large-bore tubing. The air-pulse generator creates inflates and deflates the vest, compressing and releasing the chest wall to create airflow within the lungs. The vibrations help loosen and mobilize lung secretions.

COVERAGE

Benefits may vary among groups. Please refer to the appropriate Evidence of Coverage or Subscriber Agreement for applicable durable medical equipment benefits/coverage.

CODING

The following codes are covered; preauthorization is required for BlueCHiP for Medicare and recommended for Commercial products:

A7025	
A7026	
E0483	

The following CPT code is covered only when filed when oscillation is approved for BlueCHiP for Medicare and Commercial products. Professional providers are separately reimbursed and services are bundled for facilities:

94669	

The following modifier must be appended to the related approved code when criteria are met:

KX	Requirements specified in the medical policy have been met

RELATED POLICIES

None

PUBLISHED

Provider Update	Dec 2013
Provider Update	Dec 2012
Provider Update	Oct 2011
Provider Update	Oct 2010

Provider Update	Jul 2009
Policy Update	Nov 2000
Policy Update	Sep 1997

REFERENCES

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Cystic Fibrosis Foundation (1997) Clinical practice guidelines for cystic fibrosis. Cystic Fibrosis Foundation. Bethesda, MD Arens, R, Gozal, D, Omlin, KJ, et al Comparison of high frequency chest compression and conventional chest physiotherapy in hospitalized patients with cystic fibrosis.

Am J Respir Crit Care Med 1994;150,1154-1157

Blue Cross Blue Shield Association, Medical Policy Reference Manual, Policy 1.01.1, Oscillatory Devices for the Treatment of Cystic Fibrosis and Other Respiratory Disorders

Mayo Foundation for Medical Education and Research (MFMER), Cystic Fibrosis, 04/2004, available at www.mayoclinic.com/invoke.cfm?id=DS00287, accessed 02/25/05

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