

Secretion and Mucus Clearing Devices Benefit Criteria to Change Effective March 1, 2017

Overview of Benefit Changes

- The flutter valve (procedure code S8185) is no longer diagnosis restricted
- Rental or purchase of an IPPB (procedure code E0500) is a benefit without diagnosis restrictions and with prior authorization (Fee-For-Service)
- A high frequency chest wall oscillation (HFCWO) system replacement vest (procedure code A7025) is to become a benefit and is limited to once per lifetime with prior authorization (Fee-For-Service) when the HFCWO is owned by the client
- Procedure code A4481 is included in ventilator rental. For client owned ventilators, A4481 does not require prior authorization
- The following procedure codes *do not* require prior authorization when requested within the benefit limitations:
 - Incentive spirometers (procedure code A9284)
 - Mucous clearance valved chamber (oscillating positive expiratory pressure (PEP), such as the Flutter Valve) (procedure code S8185)
 - Moisture exchangers (procedure code A4483) only when used for mechanically ventilated clients who own their ventilator
 - Tracheostoma filters, such as Thermovent T (procedure code A4481) for clients with a tracheotomy who are not mechanically ventilated
- The following procedure codes *require* prior authorization (Fee-For-Service)
 - Insufflation-exsufflation devices (e.g. Cough Assist, Cofflator) (procedure code E0482)
 - Electrical percussors (procedure code E0480)
 - The high-frequency chest wall oscillation (HFCWO) system (procedure code E0483)
 - Percussion cup (use procedure code E1399)
 - Intermittent positive pressure breathing (IPPB) devices (procedure code E0500)

New Prior Authorization Form for Secretion and Mucus Clearance Devices (Fee-For-Service)

Effective March 1, 2017 all secretion and mucus clearance devices require either the:

- Texas Medicaid Prior Authorization Request for Secretion and Mucus Clearance Devices – *Initial Request* form, or
- Texas Medicaid Prior Authorization Request for Secretion and Mucus Clearance Devices – *Renewal Request* form

Prior authorization requests for the rental or purchase of equipment in this section requires submission of a “Texas Medicaid Prior Authorization Request for Secretion and Mucus Clearance Devices – Initial Request form,” or a “Texas Medicaid Prior Authorization Request for Secretion and Mucus Clearance Devices –Renewal Request form” completed, signed, and dated by the client's treating physician unless specified otherwise below. The original, completed, signed and dated prior authorization request form must be maintained by the prescribing physician. The completed prior authorization request form will not be accepted beyond 90 days from the date of the prescribing physician's signature.

Clients requiring more than one secretion and mucus clearance device must have a pulmonologist as the treating physician who submits a signed and dated letter of medical necessity (LMN) for the need of two devices on the physician's letterhead.

Secretion and mucus clearance devices are a benefit when medically necessary, and are typically needed by clients diagnosed with cystic fibrosis (CF), chronic bronchitis, bronchiectasis, and ciliary dyskinesia syndromes, some forms of asthma, neuromuscular degenerative disorders, post-operative atelectasis, or thoracic wall defects.

Secretion and mucus clearance devices may be considered when documentation clearly shows the client has one of the following indications for this form of therapy as described by the American Association for Respiratory Care (AARC)-in the Clinical Practices Guidelines for Postural Drainage Therapy (I) (199-1):

- Evidence of retained secretions
- Evidence that the client is having difficulty with the secretion clearance
- Presence of atelectasis caused by mucus plugging

Percussion Cups

Percussion cups, used when performing chest physiotherapy, may be medically necessary to loosen up thick mucus secretions, assist respiration, and prevent infections, require prior authorization (Fee-For-Service). Percussion cups should be requested using the miscellaneous durable medical equipment (DME) procedure code E1399.

Electrical Percussor

An electrical percussor (procedure code E0480) may be considered for rental or purchase with documentation of medical necessity, including a description of all previous courses of therapy (such as manual percussion and postural drainage or valved devices) and why they did not adequately assist the client in airway mucus clearance.

Cough Augmentation Device (e.g., mechanical insufflation-exsufflation cough assist machine)

A cough augmentation device (procedure code E0482) may be considered for prior authorization (Fee-For-Service) for rental only for those clients who have chronic

pulmonary disease or neuromuscular disorders (including spinal cord injury) that affect the respiratory musculature, causing a weak, ineffectual, or absent cough.

Prior authorization (Fee-For-Service) of a cough augmentation device may be considered for an initial three-month rental period with all of the following documentation completed, signed, and dated by the client's treating physician:

- Diagnosis and background history including, as applicable, recent illnesses, complications, medications used, history of recent hospitalizations, and results of pulmonary function studies (if applicable) due to diagnosis-related complications.
- History of school, work, or extracurricular activity absences or other clinical evidence supporting natural deterioration to the level of requiring the use of a cough augmentation device to clear the airways, such as a weak, ineffective cough as demonstrated by pulmonary function studies (PFTs).
- Medical reasons why the client, parent, guardian, or caregiver cannot perform chest physiotherapy, or why such therapies were previously not effective.

Requests for prior authorization (Fee-For-Service) recertification must include documentation by the client's treating physician that the client is compliant with the use of the equipment and that the treatment is effective.

High-Frequency Chest Wall Oscillation (HFCWO) System

A high-frequency chest wall oscillation (HFCWO) system (procedure code E0483) will not be prior authorized as first line treatment. The client must have trialed other percussion and postural drainage therapy for a minimum of three months before a request for a HFCWO system will be considered for prior authorization (Fee-For-Service).

A request for a HFCWO system may be considered for prior authorization (Fee-For-Service) for rental or purchase when submitted with documentation addressing why prior therapy was ineffective and documentation of one of the following conditions:

- Bronchiectasis when it is confirmed by computerized tomography (CT) scan and characterized by either a continuous daily productive cough for six months or frequent exacerbations of pulmonary infections (i.e., more than two times per year) requiring antibiotic therapy.
- Cystic fibrosis or other documented chronic suppurative endobronchitis
- Chronic neuromuscular disorder affecting the client's ability to cough or clear respiratory secretions
- Weak ineffective or absent cough caused by chronic pulmonary disease or a neuromuscular disorder

Rental of the HFCWO System

An initial three-month rental may be prior authorized (Fee-For-Service) for the HFCWO system with hose and vest (procedure code E0483) when submitted with the following documentation of medical necessity that is completed, signed, and dated by the client's treating physician:

- A Texas Medicaid Prior Authorization Request for Secretion and Mucus Clearance Devices – Initial Request form or a Texas Medicaid Prior Authorization Request for Secretion and Mucus Clearance Devices –Renewal Request form
- Client history of a chronic respiratory illness with exacerbation or change in baseline respiratory condition in the past six months , including extra nebulizer treatments for respiratory secretions, I.V. antibiotics, and hospitalizations
- Client history of school, work, or extracurricular activity absences due to diagnosis related symptoms, or pulmonary function testing in (PFTs) in past 6 months, if applicable
- Other appropriate (age, ability, skill) modes of chest physiotherapy (such as percussion and postural drainage therapy or mechanical device) that have been trialed by the client, parent, guardian, or caregiver for a minimum of three months before the HFCWO request and the reasons the trialed therapy was ineffective or contraindicated
- Documentation that any previous use of an HFCWO device did not result in aspiration, exacerbation of a gastrointestinal or pulmonary issue, or an exacerbation of seizure activity.

If at the end of the initial three-month rental a determination of purchase cannot be made, an additional three month-rental may be considered for prior authorization (Fee-For-Service) when the request is submitted with the above documentation and documentation of compliance with ordered therapy.

Purchase of the HFCWO System

If at the end of the initial three-month rental, the HFCWO system is documented to be effective, purchase of the system may be considered for prior authorization (Fee-For-Service) when submitted with all the following required documentation:

- A physician's statement of a trial of the HFCWO system in a clinic, hospital, or the home setting documenting:
 - The results of the HFCWO system therapy
 - The effectiveness and tolerance of the system that includes evidence of vest tolerance
 - An explanation of the trial outcome
- The treating physician's description and assessment of the effectiveness and tolerance of the system that includes:
 - The client's diagnosis and background history, including the following:
 - Respiratory-related complications and evidence of a decrease in these complications
 - Medications used, including intravenous therapy (IV) antibiotic therapy with dosage, frequency and duration, including evidence of decreased respiratory-related medication use
 - Recent hospitalizations related to the client's respiratory condition and evidence of shorter hospital length(s) of stay

- Evidence of decreased hospitalizations
- Evidence of fewer school, work, or extracurricular activity absences due to a diagnostic-related condition or other clinical evidence supporting natural deterioration to the level of requiring the use of a HFCWO system to clear the airways, such as a weak, ineffective cough as demonstrated by pulmonary function studies (PFTs)
- ⊖ Evidence of the frequency and compliance graphs for the 3-month period showing the frequency prescribed by the physician for each day and use of the system at least 50 percent of the time
- A statement from the treating physician that the previous use of the HFCWO device has not resulted in aspiration, exacerbation of a gastrointestinal or pulmonary issue, or exacerbation of seizure activity.

A HFCWO system purchase will be reimbursed only once per lifetime, due to the lifetime warranty provided by the manufacturer. Requests for a vest replacement (procedure code A7025) must include documentation that supports the client can no longer wear the vest due to changes in the client's condition such as changes in height, weight, or skin abrasions.

Intermittent Positive-Pressure Breathing (IPPB) Devices

IPPB is not the therapy of first choice for delivering aerosol or as a method of lung hyperinflation when other therapies can reliably meet the clinical objectives prescribed for the client. Prior authorization (Fee-For-Service) of an IPPB device (procedure code E0500) is available for rental or purchase and will be considered with documentation of ineffective response with use of other modalities such as treatment with a cough assist device.

Rental of the IPPB device includes all supplies, such as humidification and tubing.

In accordance with the AARC recommendations, IPPB may be considered when one of the following indications is documented:

- The client has a need to improve lung expansion.
- The need to deliver aerosol medication to a client when other methods of delivery have been unsuccessful.

IPPB (procedure code E0550) requires prior authorization (Fee-For-Service) and may be considered with documentation of ineffective response to treatment when other modalities such as a cough assist device have failed, when prescribed in accordance with the AARC recommendations and there is medical necessity for one of the following:

- Improve lung expansion due to:
 - The presence of clinically significant pulmonary atelectasis when other forms of therapy have been unsuccessful or the client cannot cooperate with the treatment.
 - The inability to clear secretions adequately due to pathology that severely limits the client's ability to ventilate or cough effectively and failure to respond to other modes of treatment, including but not limited to:

- Neuromuscular disorders or kyphoscoliosis with associated decreases in lung volumes and capacities.
- Presence of acute severe bronchospasm or exacerbated chronic obstructive pulmonary disease (COPD) that fails to respond to other therapy.
- Deliver aerosol medication when other methods of delivery have been unsuccessful including, but not limited to:
 - The client who has fatigue as a result of ventilatory muscle weakness such as neuromuscular disease, kyphoscoliosis, or spinal cord injury.
 - The client with severe hyperinflation where IPPB may decrease dyspnea and discomfort during nebulized therapy.

Providers may refer to the “Covered Procedure Codes and Benefit Limitations” table in the article titled “Benefit Criteria to Change for Respiratory Equipment and Supplies Effective March 1, 2017,” for additional details for each procedure code. These details include maximum quantity limitations, rental versus purchase options, and prior authorization requirements.