MO HealthNet Pre-certification Criteria

Medical Procedure Class:	**DME High frequency chest wall oscillation air-pulse generator system – E0483 EPRR**
Implementation Date:	**July 1, 2008**

☒ **New Criteria** ☐ **Revision of Existing Criteria**

Executive Summary

Purpose:	To allow a consistent and streamlined authorization process for chest wall oscillation devices.

Why was this Issue Selected:	Senate Bill 577 passed by the 94th General Assembly directs MO HealthNet to utilize an electronic web-based system to authorize Durable Medical Equipment using best medical evidence and care and treatment guidelines, consistent with national standards to verify medical need.
Procedures subject to Pre-Certification	E0483EPRR: High frequency chest wall oscillation air-pulse generator system, (includes hoses and vest), each.

Setting & Population:	All MO HealthNet fee-for-service participants under the age of 21.

Data Sources:	☒ **Medicare LCD**	☒ **MHN Policy**

Setting & Population

- All MO HealthNet fee-for-service participants under the age of 21.

Approval Criteria

High frequency chest wall oscillation devices (E0483) are covered for patients under the age of 21 who meet either criterion 1 or 2 and criterion 3.

1. There is a diagnosis of cystic fibrosis (277.00, 277.02).

2. There is a diagnosis of bronchiectasis, (011.50-011.56, 494.0, 494.1, 748.61)
(a) characterized by daily productive cough for at least 6 continuous, months or, frequent (i.e. more than 2/year) exacerbations requiring antibiotic therapy, and
(b) confirmed by high resolution or spiral CT scan.

3. There must be well-documented failure of standard treatments to adequately mobilize retained secretions.

Approval Diagnoses (Appendix A)			
Condition	**Submitted ICD-9 Diagnoses**	**Date Range**	**Client Approval (Initials)**
Cystic Fibrosis	277.00, 277.02	Past 24 months	
Bronchiectasis	011.50-011.56, 494.0, 494.1, 748.61	Past 24 months	

Denial Criterion

The approval criteria are not met.

Quantity Limitation

12 units (1 unit = 1 month rental)

Approval Period

The prescriber specified length of need up to twelve months.

Appendix A : Possible Step 1 and Step 2 Questions

****The following questions may be encountered as part of the approval and denial criteria. Depending on the patient's history and the way previous questions may be answered, not every question may be asked for every patient and may not be encountered in the exact order below.**

1. **Is there well documented failure of standard treatments to adequately mobilize retained secretions?**
2. **What is the duration of need in months?_____**
3. **Has patient had daily productive cough for at least 6 continuous months or frequent (more than 2/year) exacerbation is requiring antibiotic therapy?**
4. **Is this confirmed by high resolution or spiral CT scan?**