MEDICAID POLICY INFORMATION SHEET

Policy Analyst: Lisa Trumbell

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Initial ☐ Public Comment ☒ Final ☐

Brief description of policy:

This policy revises current Medicaid coverage of high frequency chest wall oscillating (HFCWO) device and accessory standards of coverage, documentation, prior authorization and payment rules.

Reason for policy (problem being addressed):

The purpose of this policy is to revise the HFCWO device policy to align with current standards of care and other payers.

Budget implication:

☒ budget neutral
☐ will cost MDHHS $, and (select one) budgeted in current appropriation
☐ will save MDHHS $

Is this policy change mandated per federal requirements?

No

Does policy have operational implications on other parts of MDHHS?

No

Does policy have operational implications on other departments?

No

Summary of input:

☐ controversial
☒ acceptable to most/all groups
☐ limited public interest/comment

Supporting Documentation:

State Plan Amendment Required: ☐ Yes ☒ No If Yes, please provide status: ☐ Approved ☐ Pending ☐ Denied Date: Approval Date:	Public Notice Required: ☐ Yes ☒ No If yes, Submission Date:

DRAFT FOR PUBLIC COMMENT Michigan Department of Health and Human Services		
	Project Number: 2318-DMEPOS	**Date:** April 26, 2023

Comments Due: May 31, 2023
Proposed Effective Date: August 1, 2023
Direct Comments To: Lisa Trumbell
Address:
E-Mail Address: trumbelll@michigan.gov
Phone: 517-284-1226 **Fax:**

Policy Subject: Revisions to High Frequency Chest Wall Oscillating (HFCWO) Device and Accessories Policy

Affected Programs: Medicaid, Children's Special Health Care Services (CSHCS), Healthy Michigan Plan

Distribution: Medical Suppliers, Medicaid Health Plans (MHPs), Integrated Care Organizations (ICOs), Practitioners, Hospitals, Clinics

Summary: This policy revises current Medicaid coverage of HFCWO device and accessory standards of coverage, documentation, prior authorization and payment rules.

Purpose: The purpose of this policy is to revise the HFCWO device policy to align more with current standards of care and other payers.

Cost Implications: Budget neutral

Potential Hearings & Appeal Issues: No

State Plan Amendment Required: Yes ☐ **No** ☒ **If yes, date submitted:**	**Public Notice Required: Yes** ☐ **No** ☒ **Submitted date:**

Tribal Notification: Yes ☐ **No** ☒ **- Date:**

THIS SECTION COMPLETED BY RECEIVER

☐ **Approved**	☐ **No Comments**
	☐ **See Comments Below**
☐ **Disapproved**	☐ **See Comments in Text**

Signature:	**Phone Number**
Signature Printed:	
Bureau/Administration *(please print)*	**Date**

Proposed Policy Draft

Michigan Department of Health and Human Services
Behavioral & Physical Health and Aging Services Administration

Distribution: Medical Suppliers, Medicaid Health Plans (MHPs), Integrated Care Organizations (ICOs), Practitioners, Hospitals, Clinics

Issued: July 1, 2023 (Proposed)

Subject: Revisions to High Frequency Chest Wall Oscillating (HFCWO) Device and Accessories Policy

Effective: August 1, 2023 (Proposed)

Programs Affected: Medicaid, Children's Special Health Care Services (CSHCS), Healthy Michigan Plan

This policy applies to Medicaid Fee-for-Service (FFS). MHPs and ICOs must provide the full range of covered services described in this policy at a minimum and may choose to provide services over and above those specified. For beneficiaries enrolled in an MHP or ICO, the provider must check with the beneficiary's health plan for prior authorization (PA) requirements.

The purpose of this bulletin is to announce revisions to the high frequency chest wall oscillating (HFCWO) device and accessories policy. Changes in this policy are effective August 1, 2023.

Definition

An HFCWO device is an airway clearance device consisting of an inflatable vest connected by two tubes to a small air-pulse generator that is easy to transport. The air-pulse generator rapidly inflates and deflates the vest, gently compressing and releasing the chest wall to create mini-coughs that dislodge mucus from the bronchial walls, increase mucus mobilization, and facilitate its movement toward central airways.

Standards of Coverage

An HFCWO device may be covered up to four months for the following when all other treatment modalities have not been effective (e.g., chest physiotherapy, medication, mechanical in-exsufflation device, etc.):

- Cystic Fibrosis (CF)
- Bronchiectasis that has been confirmed by a high resolution, spiral, or standard CT scan and which is characterized by:
  - Daily productive cough for at least six continuous months; or

  - Frequent (i.e., more than two per year) exacerbations requiring antibiotic therapy.
- Neuromuscular and/or neurological disorders affecting ability to mobilize secretions (e.g., muscular dystrophy, spastic quadriplegic cerebral palsy, spinal muscular atrophy, quadriplegia, etc.).

Chronic bronchitis and chronic obstructive pulmonary disease (COPD) in the absence of a confirmed diagnosis of bronchiectasis do not meet the policy standards of coverage criteria.

Documentation

Submitted documentation must be from a Neurology, Physical Medicine & Rehabilitation, or a Pulmonology practitioner. The documentation must be less than 180 days old and include:

- Diagnosis pertaining to the need for the HFCWO device.
- Severity of condition (e.g., frequency of hospitalizations, pulmonary function test, etc.).
- Current treatment modalities and other treatments already tried.
- Plan of care by the authorized physician subspecialist substantiating the need for the device is required under the CSHCS program.

For continuation beyond the initial four months, the following must be provided:

- Documentation of any change in the prescribed treatment plan;
- Documentation from equipment use logs demonstrating ongoing utilization in accordance with the current, prescribed treatment plan; and
- For CSHCS beneficiaries, the CSHCS program requires a medical statement from the authorized physician subspecialist substantiating the continued effectiveness of the vest.

Prior Authorization

PA is not required for the diagnosis of CF if the standards of coverage are met.

PA is required for:

- All other medical conditions.
- Replacement of the device or accessories (e.g., vest, hose, etc.).
- Repairs to the device.

Although PA is not required for CF beneficiaries when the standards of coverage are met, all required documentation indicated above and in the MDHHS Medicaid Provider Manual must be kept in the beneficiary's file and be available upon request. Failure to keep required documentation in the beneficiary's file may result in provider audit and/or post-payment recovery of funds.

Payment Rules

The HFCWO device is considered a capped rental item and is inclusive of the following during the rental period:

- All accessories necessary to use the equipment (hoses, vest, electrical components, etc.).
- Education on the proper use and care of the equipment.
- Routine servicing, repairs, replacements to make the equipment functional.

For purchased items, the manufacturer's warranty must be exhausted prior to requesting a repair to the device or for replacement of the device or part(s).

All other HFCWO device policy requirements remain unchanged.