Baxter

COVERAGE CRITERIA FOR HFCWO AIRWAY CLEARANCE THERAPY

THE VEST APX AIRWAY CLEARANCE SYSTEM
MONARCH AIRWAY CLEARANCE SYSTEM

DISEASE STATE	CRITERIA*	RECOMMENDED DOCUMENTATION*
Bronchiectasis	☐ Diagnosis of bronchiectasis, confirmed by a CT scan, which is characterized by: ☐ Daily productive cough for at least six continuous months; OR ☐ Frequent (i.e., three or more in a year) exacerbations requiring antibiotic therapy ☐ Well-documented failure of standard treatments to adequately mobilize retained secretions and need for airway clearance.	MEDICAL RECORDS (PAST 6-12 MONTHS) ☐ Clinic visit notes ☐ Hospitalization/discharge summaries ☐ Antibiotics and medications ☐ Pulmonary function tests (PFTs) IMAGING ☐ Medical imaging reports of the lungs including CT scans, x-ray, and bronchoscopy (as applicable) OTHER ☐ Face-to-face encounter with the patient within the last 6 months documenting the medical need for the product (as applicable)
Cystic Fibrosis	☐ Diagnosis of cystic fibrosis ☐ Well-documented failure of standard treatments to adequately mobilize retained secretions and need for airway clearance.	
Neuromuscular Disease	☐ Diagnosis of neuromuscular disease (refer to ICD-10 code for list of applicable diagnoses.) ☐ Well-documented failure of standard treatments to adequately mobilize retained secretions and need for airway clearance.	

STANDARD TREATMENTS FOR TRIED AND FAILED:

Examples from publicly available payor policies request documentation of failure, intolerance, or contraindication to effectively clear retained mucus in the airway with standard or less intensive treatments (such as chest physiotherapy, mucolytic agents, postural drainage, mechanical modalities i.e., exsufflation devices)

*Some payers may have additional requirements including, but not limited to, face-to face encounter, prior authorization, on-going medical need, and continued use of the device. Payors, including Medicare, require documentation of continued medical necessity for these products.

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TYPES OF NEUROMUSCULAR CONDITIONS

INCLUDING, BUT NOT LIMITED TO THE FOLLOWING:*

- Amyotrophic Lateral Sclerosis
- Biotinidase Deficiency
- Congenital Myopathy
- Defects in the Complement System
- Dermatopolymyositis with Myopathy
- Disorders of Diaphragm**
- Duchenne or Becker Muscular Dystrophy
- Limb Girdle Muscular Dystrophy
- Motor Neuron Disease
- Multiple Sclerosis
- Muscular Dystrophy
- Myotonic Muscular Dystrophy
- Postpolio Syndrome
- Quadriplegia
- Sequelae of Poliomyelitis
- Sjogren Syndrome with Myopathy
- Spastic Quadriplegic Cerebral Palsy
- Spinal Muscular Atrophy
- Other Spinal Muscular Atrophies and Related Syndromes
- Systemic Sclerosis with Myopathy

* Any spinal disease state which could result in adverse events should be stabilized prior to use of this device.

** CMS guidance states Disorders of the Diaphragm diagnosis must include documentation to support one of the following:

- Diaphragmatitis
- Paralysis of Diaphragm
- Relaxation of Diaphragm

The information provided in this document is for educational purposes only and is not intended to serve as reimbursement advice. It is the responsibility of the provider to consult with the Medicare Program or other applicable health plan for appropriate coding and reporting of all items and services. In all cases, items and services billed must be medically necessary, actually furnished as reported and appropriately documented in conformance with applicable standards. Billing codes (e.g., E0290) and coverage criteria are subject to change. Consult the appropriate Medicare contractor with questions related to Medicare coverage, including the Pricing, Data Analysis & Coding (PDAC) contractor for product coding questions and the respective DMEMAC for other coding or criteria questions.

For more information, please contact your Baxter Sales Representative at **1-800-426-4224.**

Rx Only. For safe and proper use of product mentioned herein, please refer to the Instructions for Use or Operator's Manual.

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