Mass General Brigham
Health Plan

Medical Policy
Outpatient Chest Physical Therapy

Policy Number: 040

	Commercial and Qualified Health Plans	MassHealth	Medicare Advantage
Authorization required	X	X	X
No Prior Authorization			

Overview
The purpose of this document is to describe the guidelines Mass General Brigham Health Plan utilizes to determine medical appropriateness for outpatient chest physical therapy for Mass General Brigham Health Plan members.

Coverage Guidelines
Outpatient chest physical therapy may be considered medically necessary in members with a clinically documented underlying disease or condition (as listed below) as well as documentation of recent medical deterioration (illness/injury/exacerbation/surgery within last 30 days). Outpatient chest physical therapy is generally not considered medically necessary for persons whose pulmonary condition is stable, as chest physical therapy can usually be competently administered at home by a family member or caregiver.

Mass General Brigham Health Plan will consider coverage of outpatient chest physical therapy in members when both I and II are met:

I. Chronic respiratory disease caused by one of the following:

- Cystic Fibrosis
- Bronchiectasis
- Neuromuscular diseases (e.g. Guillain-Barre)
- Progressive muscular weakness (e.g. Myasthenia Gravis)
- Chronic Obstructive Pulmonary Disease (COPD)
- Cerebral Palsy
- Muscular Dystrophy
- Primary ciliary dyskinesia

II. Either A or B:

A. Acute exacerbation, acute respiratory illness, injury, or surgery causing deterioration of lung function within the past 30 days
B. All of the following:
   i. Two or more hospitalizations for respiratory illness within the past year
   ii. Documented failure of airway clearance therapy with at least two oscillatory positive airway pressure devices (eg, Acapella, Aerobika, Flutter, Shaker, Thera-PEP), or contraindication to all of oscillatory positive airway pressure devices
   iii. Documented failure of high-frequency chest wall oscillation (eg, the Vest), or contraindication to high-frequency chest wall oscillation (eg, rib fractures)

iv. Family members, partners, and caregivers are unable to perform chest physical therapy at the required frequency; OR there is no available family member, partner, or caregiver

Documentation Requirements
All member requests require an explicit order from the authorized treating pulmonologist including diagnosis and clinical indications along with a detailed explanation for the inability of a caregiver to provide the services. Correspondence from the treating respiratory therapist alone will not suffice.

Duration of Services

- Acute exacerbation of cystic fibrosis exacerbation: up to 12 visits within a 2-week period
- Acute exacerbation of other chronic diseases: up to 8 visits within a 2-week period
- Chronic management of patients meeting criterion II.B. above: up to 60 visits within a 6-month period

Exclusions

- The member's disease has progressed to the stage where chest physical therapy is not possible.
- If the member has significant learning impairments, medical co-morbidities, or behavioral health conditions (e.g. severe psychiatric disease) that would interfere with the member's ability to participate in, or benefit from, outpatient chest physical therapy. Such conditions include, but are not limited to:
    - Dementia/organic brain syndrome/disabling stroke
    - Unstable angina
    - Myocardial infarction within the last 3 months
    - Uncontrolled arrhythmia
    - Metastatic cancer
    - Severe arthritis limited exercise capacity
    - Insufficiently treated psychiatric disease
    - Active substance abuse
- The member exhibits poor motivation, inability to learn, and/or non-compliance

Medicare Variation
Mass General Brigham Health Plan uses guidance from the Centers for Medicare and Medicaid Services (CMS) for coverage determinations for its Medicare Advantage plan members. National Coverage Determinations (NCDs), Local Coverage Determinations (LCDs), Local Coverage Articles (LCAs) and documentation included in the Medicare manuals are the basis for coverage determinations. When there is no guidance from CMS for the requested service, Mass General Brigham Health Plan's medical policies are used for coverage determinations.

Definitions
Chest Physiotherapy (Physical Therapy): Chest physiotherapy consists of external mechanical maneuvers, such as chest percussion, postural drainage, and vibration, to augment mobilization and clearance of airway secretions. It is indicated for patients in whom cough is insufficient to clear thick, tenacious, copious, or loculated secretions.

Codes

The following codes are included below for informational purposes only; inclusion of a code does not constitute or imply coverage.

This list of codes applies to commercial and MassHealth plans only.

Authorized CPT/HCPCS Codes	Code Description

94667	Manipulation chest wall, such as cupping, percussing, and vibration to facilitate lung function; initial demonstration and/or evaluation
94668	Manipulation chest wall, such as cupping, percussing, and vibration to facilitate lung function; subsequent

Effective
April 2024: Annual Review. Coverage expanded to increase the number of allowable visits for acute exacerbations. Coverage expanded to allow chronic therapy in members with recent hospitalizations, failure of airway clearance devices, and no family member or caretaker available to provide therapy at the required frequency.
April 2023: Annual review. Medicare Advantage added to table. Medicare variation language added.
April 2022: Annual review.
April 2021: Annual review.
March 2020: Annual review. References updated.
March 2019: Annual review.
May 2018: Annual review. Added clarifying sentence following medical deterioration. Added duration of services. Edited Documentation Requirements section.
November 2017: Effective date.

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