Clinical Policy: Nebulizer with Compressor

Reference Number: GA.CP.MP.501
Last Review Date: 03/2021

Coding Implications
RevisionLog

See Important Reminder at the end of this policy for important regulatory and legal information.

Description

The delivery of aerosolized medication is an important component of treatment for many respiratory disorders in children. Glucocorticoids, bronchodilators, antibiotics, mucus hydration agents, and mucolytic agents can be administered via aerosol.

Nebulizer devices are widely used to deliver aerosol therapy, especially in children. Nebulizers are used to provide aerosol therapy to patients too ill or too young to use handheld devices and in situations where large drug doses are necessary.

Peach State Health Plan (PSHP) follows the Georgia Medicaid Division Department of Community Health Durable Medical Equipment Services, Nebulizer and Accessories authorization guidelines. This clinical policy provides medical necessity guidelines for coverage of Nebulizers with compressor.

Policy/Criteria

I. It is the policy of Peach State Health Plan that Nebulizers with compressor are medically necessary for the following indications:
- A. Abnormal Sputum
- B. Acute bronchospasm
- C. Asthma
- D. Bronchiectasis
- E. Chronic bronchitis
- F. Chronic obstructive pulmonary disease (COPD)
- G. Chronic respiratory disease originating in the perinatal period
- H. Congenital Bronchiectasis
- I. Complications of a transplanted organ
- J. Cystic Fibrosis with pulmonary manifestations
- K. Emphysema
- L. Human Immunodeficiency Virus (HIV) Disease
- M. Acute obstructive laryngitis (croup)
- N. Adenoviral Pneumonia
- O. Pneumocytosis
- P. Respiratory conditions due to unspecified external agent
- Q. Respiratory Tuberculosis
- R. Wheezing

II. The Durable Medical Equipment (DME) provider must have a written order from the treating practitioner on file for a nebulizer with compressor and related supplies that includes all of the following:
A. The supporting diagnosis
B. Specific drug for which the nebulizer will be used
C. Signed and dated by the treating practitioner within the last 12 months

Background
This Utilization Review Guideline provides assistance in interpreting Peach State Health Plan benefit plans. When deciding coverage, the federal, state or contractual requirements for benefit plans, coverage must be referenced. The terms of the federal, state or contractual requirements for benefit plan coverage may differ greatly from the standard benefit plan upon which this Utilization Review Guideline is based. In the event of a conflict, the federal, state or contractual requirements for benefit plan coverage supersedes this Utilization Review Guideline. All reviewers must first identify member eligibility, any federal or state regulatory requirements, and the contractual requirements for benefit plan coverage prior to use of this Utilization Review Guideline. Other Policies and Guidelines may apply. Peach State Health Plan reserves the right, in its sole discretion, to modify its Policies and Guidelines as necessary. This Utilization Review Guideline is provided for informational purposes. It does not constitute medical advice.

Peach State Health Plan may also use tools developed by third parties, such as the Change Healthcare InterQual™ guidelines, and other consensus guidelines and evidence-based medicine, to assist us in administering health benefits. The Change Healthcare InterQual™ Care guidelines and other are intended to be used in connection with the independent professional medical judgment of a qualified health care provider and do not constitute the practice of medicine or medical advice.

Coding Implications
Codes referenced in this clinical policy are for informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

HCPCS Codes	Description
E0570	Nebulizer, with compressor

ICD-10-CM Diagnosis Codes that Support Coverage Criteria
+ Indicates a code requiring an additional character

ICD-10-CM Codes	Description
R09.3	Abnormal Sputum
J98.01	Acute bronchospasm
J45-J45.998	Asthma
J47-J47.9	Bronchiectasis

J41.0-J41.8	Simple and mucopurulent chronic bronchitis
J44-J44.9	Chronic obstructive pulmonary disease (COPD)
P27.0-P27.9	Chronic respiratory disease originating in the perinatal period
Q33.4	Congenital Bronchiectasis
T86-T86.898	Complications of a transplanted organ
E84.0	Cystic Fibrosis with pulmonary manifestations
J43-J43.9	Emphysema
B20	Human Immunodeficiency Virus (HIV) Disease
J05.0	Acute obstructive laryngitis (croup)
J12.0	Adenoviral Pneumonia
B59	Pneumocytosis
J70.9	Respiratory conditions due to unspecified external agent
A15-A15.9	Respiratory Tuberculosis
R06.2	Wheezing

Reviews, Revisions, and Approvals	Date	Approval Date
Policy developed 01/2020. Approved by the Georgia Medicaid Department of Community Health (DCH) on 04/28/2020.	01/2020	04/2020
ICD-10 table update. Updated range of ICD-10 codes: J44-J44.9 for COPD; 786-786.898 for Complications of a transplanted organ; J43-J43.9 for Emphysema; A15-A15.9 for Respiratory Tuberculosis. Updated References.	03/2021	03/2021

References

1. Moore RH. The use of inhaler devices in children. In: UpToDate, Redding G (Ed), Wood RA (Ed), TePas (Ed), UpToDate, Waltham, MA. Accessed 1/23/2020. https://www.uptodate.com/contents/the-use-of-inhaler-devices-in-children?search=nebulizers&source=search_result&selectedTitle=3~150&usage_type=default&display_rank=3
2. Moore RH. Use of medication nebulizers in children. In: UpToDate, Redding G (Ed), Wood RA (Ed), TePas (Ed), UpToDate, Waltham, MA. Accessed 1/23/2020. https://www.uptodate.com/contents/use-of-medication-nebulizers-in-children?search=nebulizers&sectionRank=1&usage_type=default&anchor=H14&source=machineLearning&selectedTitle=2~150&display_rank=2#H1
3. Part II Policies and Procedures for Durable Medical Equipment Services. Georgia Department of Community Health, Division of Medicaid. Policy 1112.4 Nebulizers and Accessories. 01/2020. 04/2020. 01/2021.
4. Clinical Pharmacology website: http://www.clinicalpharmacology-ip.com/. Accessed 1/17/2020.

Important Reminder

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. "Health Plan" means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan's affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members. This clinical policy is not intended to recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.

This clinical policy is the property of the Health Plan. Unauthorized copying, use, and distribution of this clinical policy or any information contained herein are strictly prohibited. Providers, members and their representatives are bound to the terms and conditions expressed herein through the terms of their contracts. Where no such contract exists, providers, members

and their representatives agree to be bound by such terms and conditions by providing services to members and/or submitting claims for payment for such services.

Note: For Medicaid members, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.

Note: For Medicare members, to ensure consistency with the Medicare National Coverage Determinations (NCD) and Local Coverage Determinations (LCD), all applicable NCDs, LCDs, and Medicare Coverage Articles should be reviewed prior to applying the criteria set forth in this clinical policy. Refer to the CMS website at http://www.cms.gov for additional information.