Respiratory Devices

Spacers,  
Peak Flow Meters  
Pulse Oximeters

When services are covered
We cover the following respiratory devices:

- Spacers for use with metered dose inhalers (MDIs).¹

Note: All members have benefits either through their pharmacy or DME benefits.

- Peak flow meters for patients with respiratory disorders.¹
- Home pulse oximeters for diagnoses other than asthma.

When services are not covered
We do not cover pulse oximeters for home use in asthma management, because they are not recommended according to the NIH.²

We do not cover computerized peak flow meters.

Note: Special features such as computerized recording devices are considered convenience enhancements, and are not eligible for additional coverage. The AirWatch® peak flow meter is computerized, and measures both peak flow and FEV₁. There is no evidence to suggest that this device leads to improved patient outcomes (such as better breathing ability, less illness, and less hospitalization) than regular peak flow meters.

Individual consideration
All our medical policies are written for the majority of people with a given condition. Each policy is based on medical science. For many of our medical policies, each individual’s unique clinical circumstances may be considered in light of current scientific literature. For example, for patients with no option for chest physical therapy, alternative therapies may be explored.⁴ For consideration of an individual patient, physicians may send relevant clinical information to:

<table>
<thead>
<tr>
<th>For services already billed</th>
<th>Prior to performance of service</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blue Cross Blue Shield of Massachusetts</td>
<td>Blue Cross Blue Shield of Massachusetts</td>
</tr>
<tr>
<td>Provider Appeals</td>
<td>Appeals Unit</td>
</tr>
<tr>
<td>P. O. Box 986075 (For Ancillary/Behavioral Health)</td>
<td>One Enterprise Drive</td>
</tr>
<tr>
<td>P. O. Box 986065 (For Professional Providers)</td>
<td>Quincy, MA 02171</td>
</tr>
<tr>
<td>P. O. Box 986070 (For Institutional Providers)</td>
<td>Tel: 1-800-327-6716</td>
</tr>
<tr>
<td>Boston, MA 02298</td>
<td>Fax: 1-888-641-5330</td>
</tr>
</tbody>
</table>
**Managed care guidelines**

- **Spacers**: Most managed care members receive coverage for spacers through their pharmacy benefit. A physician’s prescription for a spacer may be filled at any participating pharmacy, and is subject to a co-pay. Effective 1/2002, spacers will be covered under the drug benefit for all plans. Spacers will continue to be covered under the DME benefit for those plans without pharmacy benefits.
- Referrals are not required.

**Indemnity and PPO guidelines**

All authorization requirements are determined by the individual’s subscriber certificate, however:

- Authorizations are required for all inpatient services
- Authorizations are not required for most outpatient services as determined by the individual’s subscriber certificate
- Referrals to a specialist are not required.
- **Spacers**: Most indemnity plans cover spacers. For members with pharmacy benefits, a physician’s prescription for a spacer may be filled at any participating pharmacy. For those without pharmacy benefits, spacers may be available through their durable medical equipment (DME) benefit. Effective 1/2002, spacers will be covered under the drug benefit for all plans. Spacers will continue to be covered under the DME benefit for those plans without pharmacy benefits.

**Coding information**

*Procedure codes are from current CPT, HCPCS Level II, Revenue Code, and/or ICD-9-CM manuals, as recommended by the American Medical Association, Centers for Medicare and Medicaid Services and American Hospital Associations. Blue Cross Blue Shield Association national codes may be developed when appropriate.*

The following codes are included below for informational purposes. Inclusion or exclusion of a code does not constitute or imply member coverage or provider reimbursement. Please refer to the member’s contract benefits in effect at the time of service to determine coverage or non-coverage as it applies to an individual member.

**HCPCS codes:**

- **A4614**: peak expiratory flow rate meter, hand held
- **A4627**: spacer, bag or reservoir, with or without mask, for use with metered dose inhaler.
  
  **Note**: Procedure code A4627 can be processed as a DME benefit or a pharmacy benefit according to the member’s contract.
- **S8096**: portable peak flow meter.
  
  **Note**: Physicians may bill and be reimbursed for a peak flow meter dispensed in the office, when these supplies are purchased from a DME vendor.
- **S8100**: holding chamber or spacer for use with an inhaler or nebulizer; without mask.
- **S8101**: holding chamber or spacer for use with an inhaler or nebulizer; with mask.

**Modifiers:**

- **RR**: rental
- **NU**: purchase.

**Other information**

- Pulse oximeters, HCPCS Level II code E0445, will deny, with no patient balance, when submitted with a diagnosis of asthma.
Reimbursement information

- BCBSMA will consider CPT procedure code 94760 to be included in the payment for an Evaluation and management (E&M) procedure code, **Effective 12/1/07**
- CPT procedure code 94761, i.e. during exercise, will remain eligible for separate reimbursement with E&M codes (code ranges 99201-99215, and 99241-99245, **Effective 12/1/07**
- Pulse oximetry, CPT code 94762, is not eligible for separate reimbursement. The reimbursement for this service is included in the payment for the overall care of the patient.

Benefit Information

- E0445 will process as a DME benefit and is subject to any applicable DME co-insurance and benefit maximums.

**Policy update history**

Issued 5/96. Revised 11/96 to combine with pulse oximeter policy, and to exclude coverage for oximeters for home use in asthma. Revised 8/97 to include information in the billing section re: pharmacy or DME benefit clarification for spacers. Reviewed 5/98 to clarify coverage for pulse oximeters and authorization requirement for managed care. Updated 12/98 to include new authorization information and 1999 HCPCS codes for peak flow meter. Revised 3/99: no changes in coverage were made. Effective 1/2002, spacers will be covered under the drug benefit for all plans. Spacers will continue to be covered under the DME benefit for those plans without pharmacy benefits. Reviewed 3/02 (MPG - Pulmonology), no changes in coverage were made. Reviewed 11/02 MPG Pediatrics, no changes in coverage were made. Reviewed 3/03 MPG Pulmonology, no changes in coverage were made. Updated 6/03 to clarify correct billing code to report pulse oximeter device. Reviewed 11/03 MPG pediatrics, no changes in coverage were made. Updated 12/03 to include coverage for high frequency chest wall oscillation devices for Blue Care 65 (Medicare HMO Blue) members, effective 10/1/2003. Reviewed 3/04 MPG Pulmonology, Allergy and ENT/Otolaryngology, no changes in coverage were made. Reviewed 5/04 MPG pediatrics, no changes in coverage were made. Revised 3/05 MPG Pulmonology, Allergy and ENT/Otolaryngology, no changes in coverage were made. Reviewed 5/05 MPG-Pediatrics, no changes in coverage were made. Reviewed 3/06 MPG-Pulmonology, Allergy, ENT/Otolaryngology, no changes in coverages in coverage were made. Reviewed 5/06 MPG-Pediatrics, no changes in coverage were made. Reviewed 3/07 MPG- Pulmonology, Allergy and ENT/Otolaryngology, no changes in coverage were made. Revised 5/07 MPG pediatrics, no changes in coverage were made. Revised 5/07 policy edited to include change in reimbursement information for CPT procedure code 94760, effective 12/1/07. Reviewed 3/08 MPG- Pulmonology, Allergy and ENT/Otolaryngology, no changes in coverage were made. Reviewed 5/08 MPG-Pediatrics, no changes in coverage were made. Reviewed 3/09 MPG – Pulmonology, Allergy/Asthma/Immunology and ENT/Otolaryngology, no changes in coverage were made. Updated 12/09 to remove references to oscillatory and flutter devices. The coverage information for these devices is now addressed on medical policy #120, Oscillatory Devices for the Treatment of Cystic Fibrosis and Other Respiratory Disorders. Removed deleted HCPCS codes S8105 and E0445 from the Coding Information section, effective 2/2003. Reviewed 3/2010 MPG – Pulmonology, Allergy/Asthma/Immunology, ENT and Otolaryngology, no changes in coverages in coverage were made. Revised 5/2010 MPG-Pediatrics no changes in coverage were made. Reviewed 3/2011 MPG – Allergy/Asthma/Immunology and ENT/Otolaryngology, no changes in coverage were made. Reviewed 4/2011 MPG – Cardiology and Pulmonology, no changes in coverage were made. Reviewed 5/2011 MPG Pediatrics and Endocrinology, no changes in coverage were made. Reviewed 3/2012 MPG – Allergy, Asthma, Immunology and ENT/Otolaryngology, no changes in coverage were made. Reviewed 4/2012 MPG-Cardiology and Pulmonology, no changes in coverage were made.

**Scientific background, Rationale and References**

Based upon the NIH Global Initiative for Asthma, published by the National Heart, Lung, and Blood Institute, Publication No. 95-3659, January 1995. Regarding oximetry and asthma (pp. 73-4), the workgroup concluded that the more extensive information obtained from a blood gas (particularly if pulse ox is normal) may be important: hypoxemia may not accurately reflect the underlying degree of ventilation-perfusion (V-Q) mismatch. Pulse oximetry should not replace close supervision. According to the NIH, no studies have demonstrated that pulse oximetry is a sufficiently valid monitoring system during acute asthma exacerbations. An ABG, however, may provide important measurements of severity. During a mild-moderate exacerbation, hypocapnia (low CO₂) is the primary effect; hypoxemia develops as exacerbations worsen. Hypercapnia occurs rarely, but denotes high mortality and potential need for mechanical ventilation. ABGs are not necessary for all patients, but should be considered for those seen in the ER, especially if the exacerbation is severe (FEV₁ or peak flow < 40% predicted) and/or there is a poor response to initial treatment.

For further information, see the report by MW Konstan et al. in J Pediatrics 1994;124:689-93. 18 CF patients were aged 8-38, with no hospitalization in the last month, who had productive sputum, FEV₁ ranging 30-70% predicted. 17 patients completed the protocol consisting of randomization to voluntary coughing, postural drainage, and Flutter device therapy at a supervised setting evaluated by a single respiratory therapist. One technique was used per session, and each patient rotated between different techniques at subsequent sessions. Expectorated sputum was weighed after centrifugation. For a given technique, weights were consistent between weeks. For the entire group, the sputum weight with the flutter device was significantly greater (p<0.001) with the Flutter device than with either of the other two techniques (which were equal to each other). These results did not depend upon the results of the most productive patients.

Recommendations from the 3/01 Medical Policy Group meeting.

This document is designed for informational purposes only and is not an authorization, or an explanation of benefits, or a contract. Receipt of benefits is subject to satisfaction of all terms and conditions of the coverage. Medical technology is constantly changing, and we reserve the right to review and update our policies periodically.

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