Sentara Health Plans

Medicaid

High Frequency Chest Wall Compression

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Effective Date	06/2000
Next Review Date	08/2024
Coverage Policy	DME 14
Version	4

All requests for authorization for the services described by this medical policy will be reviewed per Early and Periodic Screening, Diagnostic and Treatment (EPSDT) guidelines. These services may be authorized under individual consideration for Medicaid members under the age of 21-years if the services are judged to be medically necessary to correct or ameliorate the member's condition. Department of Medical Assistance Services (DMAS), Supplement B - EPSDT (Early and Periodic Screening, Diagnosis and Treatment) Manual.*.

Purpose:

This policy addresses High Frequency Chest Wall Compression.

Description & Definitions:

High frequency chest wall compression is a device like a vest that vibrates to expel mucus from the lungs.

Criteria:

High frequency chest wall oscillation devices and replacement supplies are considered medically necessary for **ALL** of the following:

- Individual with diagnosis of **1 or more** of the following:
  - Cystic fibrosis
  - Bronchiectasis which has been confirmed by high-resolution, spiral, or standard CT scan and which is characterized by **1 or more** of the following:
    - Daily productive cough for at least 6 continuous months
    - Frequent (ie, more than 2 per year) exacerbations requiring antibiotic therapy
  - Neuromuscular disease as indicated by **1 or more** of the following:
    - Acid maltase deficiency
    - Anterior horn cell diseases
    - Hereditary muscular dystrophy
    - Multiple sclerosis
    - Myotonic disorders
    - Other myopathies

        - Paralysis of the diaphragm
        - Post-polio
        - Quadriplegia
    - Well-documented failure of standard treatments to adequately mobilize retained secretions

High frequency chest wall oscillation devices **do not meet the definition of medical necessity**, to include but not limited to:

- Intrapulmonary Percussive Ventilation (IPV)
- Chronic bronchitis and chronic obstructive pulmonary disease in the absence of confirmed diagnosis of bronchiectasis
- Use of both high frequency chest wall oscillation device and mechanical in-exsufflation device (HCPCS E0482 will be denied if billed with E0483)
- High frequency chest wall oscillation devices (e.g., Volara System)

Coding:

Medically necessary with criteria:

Coding	Description
A7025	High frequency chest wall oscillation system vest, replacement for use with patient owned equipment, each
A7026	High frequency chest wall oscillation system hose, replacement for use with patient owned equipment, each
E0483	High frequency chest wall oscillation system, includes all accessories and supplies, each

Considered Not Medically Necessary:

Coding	Description
E0481	Intrapulmonary percussive ventilation system and related accessories
E1399	Durable medical equipment, miscellaneous

Document History:

Revised Dates:

- 2022: August
- 2021: April
- 2019: October, November
- 2016: March
- 2014: October
- 2013: June, August
- 2012: March, June
- 2011: June, October
- 2010: June, September
- 2005: February, May
- 2004: November
- 2003: March, September

Reviewed Dates:

- 2023: August
- 2021: November
- 2020: November

- 2018: August
- 2017: November
- 2016: July
- 2015: June, July
- 2014: June
- 2009: June
- 2008: June
- 2007: December
- 2006: October
- 2004: October
- 2003: August
- 2002: October

Effective Date:

- June 2000

References:

Including but not limited to: Specialty Association Guidelines; Government Regulations; Winifred S. Hayes, Inc; UpToDate; Literature Review; Specialty Advisors; National Coverage Determination (NCD); Local Coverage Determination (LCD).

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Special Notes: *

This medical policy express Sentara Health Plan's determination of medically necessity of services, and they are based upon a review of currently available clinical information. These policies are used when no specific guidelines for coverage are provided by the Department of Medical Assistance Services of Virginia (DMAS). Medical Policies may be superseded by state Medicaid Plan guidelines. Medical policies are not a substitute for clinical judgment or for any prior authorization requirements of the health plan. These policies are not an explanation of benefits.

Medical policies can be highly technical and complex and are provided here for informational purposes. These medical policies are intended for use by health care professionals. The medical policies do not constitute medical advice or medical care. Treating health care professionals are solely responsible for diagnosis, treatment and medical advice. Sentara Health Plan members should discuss the information in the medical policies with their treating health care professionals. Medical technology is constantly evolving and these medical policies are subject to change without notice, although Sentara Health Plan will notify providers as required in advance of changes that could have a negative impact on benefits.

The Early and Periodic Screening, Diagnostic and Treatment (EPSDT) covers services, products, or procedures for children, if those items are determined to be medically necessary to "correct or ameliorate" (make better) a defect, physical or mental illness, or condition (health problem) identified through routine medical screening or examination, regardless of whether coverage for the same service or support is an optional or limited service under the state plan. Children enrolled in the FAMIS Program are not eligible for all EPSDT treatment services. All requests for authorization for the services described by this medical policy will be reviewed per EPSDT guidelines. These services may be authorized under individual consideration for Medicaid members under the age of 21-years if the services are judged to by medically necessary to correct or ameliorate the member's condition. *Department of Medical Assistance Services (DMAS), Supplement B - EPSDT (Early and Periodic Screening, Diagnosis and Treatment) Manual.*

All medically necessary medical equipment and supplies under the Virginia Administrative Code (12VAC30-50-165) may be covered only if they are necessary to carry out a treatment prescribed by a practitioner. Only supplies, equipment, and appliances that are determined medically necessary may be covered for reimbursement by DMAS. (12VAC30-50-165) The following criteria must be satisfied through the submission of adequate and verifiable documentation satisfactory to DMAS, or its contractor. Medically necessary DME and supplies shall be:

- Ordered by the practitioner on the CMN/DMAS-352;
- A reasonable and medically necessary part of the individual's treatment plan;
- Consistent with the individual's diagnosis and medical condition, particularly the functional limitations and symptoms exhibited by the individual; • Not furnished for the safety or restraint of the individual, or solely for the convenience of the family, attending practitioner, or other practitioner or supplier;
- Consistent with generally accepted professional medical standards (i.e., not experimental or investigational);
- Furnished at a safe, effective, and cost-effective level; and
- Suitable for use, and consistent with 42 CFR 440.70(b)(3), that treats a diagnosed condition or assists the individual with functional limitations.

Keywords:

SHP High Frequency Chest Wall Compression, SHP DME 14, Ventilator, cough, assist, mucous, mucus, chest, frequency, stimulate, stimulating, pulse, compression, neuromuscular disease, polio, Acid maltase deficiency, Anterior horn cell disease, Multiple sclerosis, Quadriplegia, muscular dystrophy, Myotonic disorders, bronchiectasis, lung transplant