Sentara Health Plans

Medicaid

High Frequency Chest Wall Compression, DME 14

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Implementation	7/1/2025
Next Review Date	4/2026
Coverage Policy	DME 14
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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.*.

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 are NOT COVERED for ANY of the following:

- 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) and supplies
- Mechanical percussors (e.g., Fluid Flo, Frequencer, and VibraLung Acoustical Percussor)
- Postural drainage board

Document History:

Revised Dates:

- 2025: April 08 – Implementation date of July 1, 2025. Annual review completed. No criteria changes, updated not medically necessary to align with previous coding updates.
- 2025: January – Procedure coding updated to align with changes in service authorization status.
- 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:

- 2024: August – no changes references updated
- 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

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
A7021	Supplies and accessories for lung expansion airway clearance, continuous high frequency oscillation, and nebulization device (e.g., handset, nebulizer kit, biofilter)
E0480	Percussor, electric or pneumatic, home model
E0481	Intrapulmonary percussive ventilation system and related accessories
E0606	Postural drainage board
E1399	Durable medical equipment, miscellaneous

The preceding codes are included above for informational purposes only and may not be all inclusive. Additionally, inclusion or exclusion of a treatment, procedure, or device code(s) does not constitute or imply member coverage or provider reimbursement.

Special Notes: *

- Coverage: See the appropriate benefit document for specific coverage determination. Individual specific benefits take precedence over medical policy.
- Application to Products: Policy is applicable to Sentara Health Plan Virginia Medicaid products.
- Authorization Requirements: Pre-certification by the Plan is required.
- 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.

- **Documentation Requirements** DME Chapter IV (updated 10.24.24)_Final.pdf appendix-b-21-excel-version-with-all-categories-of-appendix-b-2025.xlsx
  - All durable medical equipment (DME) and supplies must be ordered by a practitioner on the form: CMN/DMAS-352 (revised 2017) and must be medically necessary to treat a health condition. The CMN/DMAS352 may be completed by the practitioner, DME provider, or other health care professionals, but the practitioner must sign and date the completed Certification of Medical Necessity (CMN).
  - The CMN and any supporting verifiable documentation must be completed (signed and dated by the practitioner) within 60 days.
  - The CMN shall be valid for a maximum period of six (6) months for Medicaid individuals under 21 years of age. The CMN shall be valid for a maximum period of twelve (12) months for Medicaid individuals 21 years and older.
- **Repair vs. Replacement Guidelines**
  - If individual owned equipment needs to be replaced prior to the service limit (Per Appendix B) expiring the provider will be required to justify and obtain service authorization.
  - Documentation for service authorization should include the required information as stated in this manual and the provider shall also include additional documentation as stated below:
    - What equipment the individual is currently using and why that equipment is no longer appropriate for the individual. This description shall include the reason why repairs could not be done or why the option to repair the equipment was not cost effective.
    - The provider shall include a breakdown of what items need to be repaired and include the cost to repair the items to justify why the purchase of new equipment would be more cost effective; and
    - If the item is no longer appropriate due to a change in medical condition, limitations and symptoms, or if the equipment was provided inappropriately, the provider shall give justification to describe the circumstances.
- **Rental vs. Purchase Guideline**
  - When determined to be cost effective by SHP, payment may be made for rental of the equipment in lieu of purchase. (12 VAC 30-50-165)
  - When usage is anticipated to be long-term, and the individual's need or condition is not expected to change, the items must be considered for purchase

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).

§ 868.5665 Powered percussor. (2003, Jun 23). Retrieved Mar 14, 2025, from Code of Federal Regulations: https://www.ecfr.gov/current/title-21/chapter-I/subchapter-H/part-868/subpart-F/section-868.5665

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Medicaid Durable Medical Equipment and Supplies and Listing - Appendix B Apnea, Respiratory, Oxygen And Vents F2F July 2024. (2024). Retrieved Mar 14, 2025, from Virginia Department of Medical Assistance Services: https://www.dmas.virginia.gov/media/hxnfdvr3/appendix-b-apnea-respiratory-oxygen-and-vents-f2f-july-2024-v2.pdf

NCD: Durable Medical Equipment Reference List (280.1). (2023, May 16). Retrieved Mar 14, 2025, from Centers for Medicare and Medicaid Services: https://www.cms.gov/medicare-coverage-database/view/ncd.aspx?ncdid=190&ncdver=3&keyword=percussor&keywordType=starts&areaId=s53&docType=NCA,CAL,NCD,MEDCAC,TA,MCD,6,3,5,1,F,P&contractOption=all&sortBy=relevance&bc=1

LCD: High Frequency Chest Wall Oscillation Devices (L33785). (2022, Oct 01). Retrieved Mar 14, 2025, from Centers for Medicare and Medicaid Services: https://www.cms.gov/medicare-coverage-database/view/lcd.aspx?lcdid=33785&ver=40&keyword=high%20frequency%20chest&keywordType=starts&areaId=s53&docType=NCA,CAL,NCD,MEDCAC,TA,MCD,6,3,5,1,F,P&contractOption=all&sortBy=relevance&bc=1

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Therapies Clinical Care Guidelines. (2021, Jul). Retrieved Mar 14, 2025, from Cystic Fibrosis Foundation: https://www.cff.org/medical-professionals/cf-airway-clearance-therapies-clinical-care-guidelines

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