Sentara Health Plans

Commercial

High Frequency Chest Wall Compression, DME 14

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Implementation	8/1/2026
Next Review Date	4/2027
Coverage Policy	DME 14
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Member-specific benefits take precedence over medical policy and benefits may vary across plans. Refer to the individual's benefit plan for details *.

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) E0481
- 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 (E0469)
- Mechanical percussors (e.g., Fluid Flo, Frequencer, and VibraLung Acoustical Percussor)
- Postural drainage board

Document History:

Revised Dates:

- 2026: April – Implementation date of August 1, 2026. Annual review. No changes to criteria
- 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

Origination 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)
E0469	Lung expansion airway clearance, continuous high frequency oscillation, and nebulization device
E0480	Percussor, electric or pneumatic, home model
E0481	Intrapulmonary percussive ventilation system and related accessories

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. Please refer to the member's contract benefits in effect at the time of service to determine coverage or non-coverage of these services as it applies to an individual member.

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 Commercial products.
- Authorization Requirements: Pre-certification by the Plan is required.
- Special Notes:
    - 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.
    - Services mean both medical and behavioral health (mental health) services and supplies unless We specifically tell You otherwise. We do not cover any services that are not listed in the Covered Services section unless required to be covered under state or federal laws and regulations. We do not cover any services that are not Medically Necessary. We sometimes give examples of specific services that are not covered but that does not mean that other similar services are covered. Some services are covered only if We authorize them. When We say You or Your We mean You and any of Your family members covered under the Plan. Call Member Services if You have questions.
    - **MUST SEE MEMBER BENEFIT FOR DETERMINATION.** We only cover DME that is Medically Necessary and prescribed by an appropriate Provider. We also cover colostomy, ileostomy, and tracheostomy supplies, and suction and urinary catheters. We do not cover DME used primarily for the comfort and wellbeing of a Member. We will not cover DME if We deem it useful, but not absolutely necessary for Your care. We will not cover DME if there are similar items available at a lower cost that will provide essentially the same results as the more expensive items.

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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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