

Local Coverage Determination (LCD): High Frequency Chest Wall Oscillation Devices (L33785)

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Contractor Information

CONTRACTOR NAME	CONTRACT TYPE	CONTRACT NUMBER	JURISDICTION	STATE(S)
CGS Administrators, LLC	DME MAC	17013 - DME MAC	J-B	Illinois Indiana Kentucky Michigan Minnesota Ohio Wisconsin
CGS Administrators, LLC	DME MAC	18003 - DME MAC	J-C	Alabama Arkansas Colorado Florida Georgia Louisiana Mississippi North Carolina New Mexico Oklahoma Puerto Rico South Carolina Tennessee Texas Virginia Virgin Islands West Virginia
Noridian Healthcare Solutions, LLC	DME MAC	16013 - DME MAC	J-A	Connecticut District of Columbia Delaware Massachusetts Maryland Maine New Hampshire New Jersey New York - Entire State Pennsylvania Rhode Island Vermont

CONTRACTOR NAME	CONTRACT TYPE	CONTRACT NUMBER	JURISDICTION	STATE(S)
Noridian Healthcare Solutions, LLC	DME MAC	19003 - DME MAC	J-D	Alaska American Samoa Arizona California - Entire State Guam Hawaii Iowa Idaho Kansas Missouri - Entire State Montana North Dakota Nebraska Nevada Oregon South Dakota Utah Washington Wyoming Northern Mariana Islands

LCD Information

Document Information

LCD ID

L33785

Original ICD-9 LCD ID

[L27042](#)

[L12934](#)

[L12870](#)

[L12739](#)

LCD Title

High Frequency Chest Wall Oscillation Devices

Proposed LCD in Comment Period

N/A

Source Proposed LCD

N/A

Original Effective Date

For services performed on or after 10/01/2015

Revision Effective Date

For services performed on or after 01/01/2019

Revision Ending Date

N/A

Retirement Date

N/A

Notice Period Start Date

N/A

Notice Period End Date

N/A

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CMS National Coverage Policy

N/A

Coverage Guidance

Coverage Indications, Limitations, and/or Medical Necessity

For any item to be covered by Medicare, it must 1) be eligible for a defined Medicare benefit category, 2) be reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member, and 3) meet all other applicable Medicare statutory and regulatory requirements.

The purpose of a Local Coverage Determination (LCD) is to provide information regarding "reasonable and necessary" criteria based on Social Security Act § 1862(a)(1)(A) provisions.

In addition to the "reasonable and necessary" criteria contained in this LCD there are other payment rules, which are discussed in the following documents, that must also be met prior to Medicare reimbursement:

- The LCD-related Standard Documentation Requirements Article, located at the bottom of this policy under the Related Local Coverage Documents section.
- The LCD-related Policy Article, located at the bottom of this policy under the Related Local Coverage Documents section.
- Refer to the Supplier Manual for additional information on documentation requirements.
- Refer to the DME MAC web sites for additional bulletin articles and other publications related to this LCD.

For the items addressed in this LCD, the "reasonable and necessary" criteria, based on Social Security Act § 1862(a)(1)(A) provisions, are defined by the following coverage indications, limitations and/or medical necessity.

High frequency chest wall oscillation devices (HFCWO) (E0483) are covered for beneficiaries who meet:

- A. Criterion 1, 2, or 3, and
- B. Criterion 4
 1. There is a diagnosis of cystic fibrosis (refer to the "**ICD-10 Codes that are Covered**" section in the LCD-related Policy Article for applicable diagnoses).
 2. There is a diagnosis of bronchiectasis (refer to the "**ICD-10 Codes that are Covered**" section in the LCD-related Policy Article for applicable diagnoses) which has been confirmed by a high resolution, spiral, or standard CT scan and which is characterized by:
 - a. Daily productive cough for at least 6 continuous months; or
 - b. Frequent (i.e., more than 2/year) exacerbations requiring antibiotic therapy.Chronic bronchitis and chronic obstructive pulmonary disease (COPD) in the absence of a confirmed diagnosis of bronchiectasis do not meet this criterion.
 3. The beneficiary has one of the following neuromuscular disease diagnoses (refer to the "**ICD-10 Codes that are Covered**" section in the LCD-related Policy Article for applicable diagnoses):
 - Post-polio
 - Acid maltase deficiency
 - Anterior horn cell diseases
 - Multiple sclerosis
 - Quadriplegia
 - Hereditary muscular dystrophy
 - Myotonic disorders
 - Other myopathies
 - Paralysis of the diaphragm
 4. There must be well-documented failure of standard treatments to adequately mobilize retained secretions.

If all of the criteria are not met, the claim will be denied as not reasonable and necessary.

It is not reasonable and necessary for a beneficiary to use both a HFCWO device and a mechanical in-exsufflation device (E0482).

Replacement supplies, A7025 and A7026, used with beneficiary owned equipment, are covered if the beneficiary meets the criteria listed above for the base device, E0483. If these criteria are not met claims will be denied as not reasonable and necessary.

GENERAL

A Detailed Written Order (DWO) (if applicable) must be received by the supplier before a claim is submitted. If the supplier bills for an item addressed in this policy without first receiving a completed DWO, the claim shall be denied as not reasonable and necessary.

For Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) base items that require a Written Order Prior to Delivery (WOPD), the supplier must also obtain a DWO before submitting a claim for any associated options, accessories, and/or supplies that are separately billed. In this scenario, if the supplier bills for associated options, accessories, and/or supplies without first receiving a completed DWO, the claim shall be denied as not reasonable and necessary.

A WOPD (if applicable) must be received by the supplier before a DMEPOS item is delivered to a beneficiary. If a supplier delivers a DMEPOS item without first receiving a completed WOPD, the claim shall be statutorily denied. Refer to the LCD-related Policy Article, located at the bottom of this policy under the Related Local Coverage Documents section.

An item/service is correctly coded when it meets all the coding guidelines listed in CMS HCPCS guidelines, LCDs, LCD-related Policy Articles, or DME MAC articles. Claims that do not meet coding guidelines shall be denied as not reasonable and necessary/incorrectly coded.

Proof of delivery (POD) is a Supplier Standard and DMEPOS suppliers are required to maintain POD documentation in their files. Proof of delivery documentation must be made available to the Medicare contractor upon request. All services that do not have appropriate proof of delivery from the supplier shall be denied as not reasonable and necessary.

Summary of Evidence

N/A

Analysis of Evidence (Rationale for Determination)

N/A

Coding Information

Bill Type Codes:

Contractors may specify Bill Types to help providers identify those Bill Types typically used to report this service. Absence of a Bill Type does not guarantee that the policy does not apply to that Bill Type. Complete absence of all Bill Types indicates that coverage is not influenced by Bill Type and the policy should be assumed to apply equally to all claims.

N/A

Revenue Codes:

Contractors may specify Revenue Codes to help providers identify those Revenue Codes typically used to report this service. In most instances Revenue Codes are purely advisory. Unless specified in the policy, services reported under other Revenue Codes are equally subject to this coverage determination. Complete absence of all Revenue Codes indicates that coverage is not influenced by Revenue Code and the policy should be assumed to apply equally to all Revenue Codes.

N/A

CPT/HCPCS Codes**Group 1 Paragraph:**

The appearance of a code in this section does not necessarily indicate coverage.

HCPCS MODIFIERS:

EY - No physician or other licensed health care provider order for this item or service

GA - Waiver of liability statement issued as required by payer policy, individual case

GZ - Item or service expected to be denied as not reasonable and necessary

KX - Requirements specified in the medical policy have been met

HCPCS CODES:**Group 1 Codes:**

CODE	DESCRIPTION
A7025	HIGH FREQUENCY CHEST WALL OSCILLATION SYSTEM VEST, REPLACEMENT FOR USE WITH PATIENT OWNED EQUIPMENT, EACH

CODE	DESCRIPTION
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

ICD-10 Codes that Support Medical Necessity

N/A

ICD-10 Codes that DO NOT Support Medical Necessity

N/A

Additional ICD-10 Information

N/A

General Information

Associated Information

DOCUMENTATION REQUIREMENTS

Section 1833(e) of the Social Security Act precludes payment to any provider of services unless "there has been furnished such information as may be necessary in order to determine the amounts due such provider." It is expected that the beneficiary's medical records will reflect the need for the care provided. The beneficiary's medical records include the treating practitioner's office records, hospital records, nursing home records, home health agency records, records from other healthcare professionals and test reports. This documentation must be available upon request.

GENERAL DOCUMENTATION REQUIREMENTS

In order to justify payment for DMEPOS items, suppliers must meet the following requirements:

- Prescription (orders)
- Medical Record Information (including continued need/use if applicable)
- Correct Coding
- Proof of Delivery

Refer to the LCD-related Standard Documentation Requirements article, located at the bottom of this policy under the Related Local Coverage Documents section for additional information regarding these requirements.

Refer to the Supplier Manual for additional information on documentation requirements.

Refer to the DME MAC web sites for additional bulletin articles and other publications related to this LCD.

POLICY SPECIFIC DOCUMENTATION REQUIREMENTS

Items covered in this LCD have additional policy-specific requirements that must be met prior to Medicare reimbursement.

Refer to the LCD-related Policy article, located at the bottom of this policy under the Related Local Coverage Documents section for additional information.

Miscellaneous

Appendices

Utilization Guidelines

Refer to Coverage Indications, Limitations and/or Medical Necessity.

Sources of Information

N/A

Bibliography

N/A

Revision History Information

REVISION HISTORY DATE	REVISION HISTORY NUMBER	REVISION HISTORY EXPLANATION	REASON(S) FOR CHANGE
01/01/2019	R7	Revision Effective Date: 01/01/2019 COVERAGE INDICATIONS, LIMITATIONS, AND/OR MEDICAL NECESSITY: Removed: Statement to refer to diagnosis code section below Added: Refer to Covered ICD-10 Codes in the LCD-related Policy Article HCPCS CODES: Revised: Code descriptor for E0483 ICD-10 CODES THAT SUPPORT MEDICAL NECESSITY: Moved: All diagnosis codes to the LCD-related Policy Article diagnosis code section per CMS instruction ICD-10 CODES THAT DO NOT SUPPORT MEDICAL NECESSITY: Moved: Statement about noncovered diagnosis codes moved to LCD-related Policy Article noncovered	<ul style="list-style-type: none">• Revisions Due To CPT/HCPCS Code Changes• Other (ICD-10 code relocation per CMS instruction)

REVISION HISTORY DATE	REVISION HISTORY NUMBER	REVISION HISTORY EXPLANATION	REASON(S) FOR CHANGE
		diagnosis code section per CMS instruction	
10/01/2018	R6	<p>Revision Effective Date: 10/01/2018</p> <p>ICD-10 CODES THAT SUPPORT MEDICAL NECESSITY:</p> <p>Removed: ICD-10 Code G71.0 due to annual ICD-10 Code updates</p> <p>Added: New expanded ICD-10 codes for those removed</p> <p><i>09/27/2018: At this time 21st Century Cures Act will apply to new and revised LCDs that restrict coverage which requires comment and notice. This revision is not a restriction to the coverage determination; and, therefore not all the fields included on the LCD are applicable as noted in this policy.</i></p>	<ul style="list-style-type: none"> • Revisions Due To ICD-10-CM Code Changes
10/01/2017	R5	<p>Revision Effective Date: 10/01/2017</p> <p>ICD-10 CODES THAT SUPPORT MEDICAL NECESSITY:</p> <p>Added: New ICD-10 codes</p> <p>Revised: ICD-10 code descriptions</p> <p><i>11/30/2017: At this time 21st Century Cures Act will apply to new and revised LCDs that restrict coverage which requires comment and notice. This revision is not a restriction to the coverage determination; and, therefore not all the fields included on the LCD are applicable as noted in this policy.</i></p>	<ul style="list-style-type: none"> • Revisions Due To ICD-10-CM Code Changes
01/01/2017	R4	<p>Revision Effective Date: 01/01/2017</p> <p>COVERAGE INDICATIONS, INDICATIONS, LIMITATIONS AND/OR MEDICAL NECESSITY:</p> <p>Removed: Standard Documentation Language</p> <p>Added: New reference language and directions to Standard Documentation Requirements</p> <p>Added: General Requirements</p> <p>DOCUMENTATION REQUIREMENTS:</p> <p>Removed: Standard Documentation Language</p>	<ul style="list-style-type: none"> • Provider Education/Guidance

REVISION HISTORY DATE	REVISION HISTORY NUMBER	REVISION HISTORY EXPLANATION	REASON(S) FOR CHANGE
		<p>Added: General Documentation Requirements</p> <p>Added: New reference language and directions to Standard Documentation Requirements</p> <p>POLICY SPECIFIC DOCUMENTATION REQUIREMENTS:</p> <p>Removed: Standard Documentation Language</p> <p>Added: Direction to Standard Documentation Requirements</p> <p>Removed: Supplier Manual reference under Miscellaneous</p> <p>Removed: PIM reference under Appendices</p> <p>RELATED LOCAL COVERAGE DOCUMENTS:</p> <p>Added: LCD-related Standard Documentation Requirements article</p>	
07/01/2016	R3	<p>Revision Effective Date 07/01/2016</p> <p>COVERAGE INDICATIONS, LIMITATIONS AND/OR MEDICAL NECESSITY:</p> <p>Revised: Standard Documentation language - ACA order requirements – Effective 04/28/16</p> <p>DOCUMENTATION REQUIREMENTS:</p> <p>Revised: Standard documentation language for orders, ACA order requirements, added New order requirements, and Correct coding instructions; revised Proof of delivery instructions – Effective 04/28/16</p>	<ul style="list-style-type: none"> • Provider Education/Guidance
07/01/2016	R2	<p>Effective July 1, 2016 oversight for DME MAC LCDs is the responsibility of CGS Administrators, LLC 18003 and 17013 and Noridian Healthcare Solutions, LLC 19003 and 16013. No other changes have been made to the LCDs.</p>	<ul style="list-style-type: none"> • Change in Assigned States or Affiliated Contract Numbers
10/01/2015	R1	<p>Revision Effective Date: 10/31/2014</p> <p>COVERAGE INDICATIONS, LIMITATIONS AND/OR MEDICAL NECESSITY:</p> <p>Revised: Standard Documentation Language to add covered prior to a beneficiary’s Medicare eligibility</p> <p>Removed: Refill Requirements</p> <p>DOCUMENTATION REQUIREMENTS:</p> <p>Revised: Standard Documentation Language to add who can enter date of delivery date on the POD</p> <p>Removed: Request for refill documentation requirements</p> <p>Added: Instructions for Equipment Retained from a Prior Payer</p> <p>Added: Instruction for Repair Replacement</p>	<ul style="list-style-type: none"> • Provider Education/Guidance

Associated Documents

Attachments

N/A

Related Local Coverage Documents

Article(s)

A52494 - High Frequency Chest Wall Oscillation Devices - Policy Article

A55426 - Standard Documentation Requirements for All Claims Submitted to DME MACs

Related National Coverage Documents

N/A

Public Version(s)

Updated on 02/07/2019 with effective dates 01/01/2019 - N/A

Updated on 09/20/2018 with effective dates 10/01/2018 - 12/31/2018

Updated on 11/21/2017 with effective dates 10/01/2017 - 09/30/2018

Some older versions have been archived. Please visit the [MCD Archive Site](#) to retrieve them.

Keywords

N/A

END OF LOCAL COVERAGE DETERMINATION

Per the Code of Federal Regulations, 42 C.F.R § 426. 325, only those portions of the currently effective Local Coverage Determination (LCD) that are based on section 1862(a)(1)(A) of the Social Security Act, may be challenged through an acceptable complaint as described in 42 C.F.R § 426.400. Also, per 42 C.F.R § 426.325 items that are not reviewable, and therefore cannot be challenged, include the Policy Article. Please note the distinction of the documents when reviewing the materials.

Local Coverage Article: High Frequency Chest Wall Oscillation Devices - Policy Article (A52494)

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Contractor Information

CONTRACTOR NAME	CONTRACT TYPE	CONTRACT NUMBER	JURISDICTION	STATE(S)
CGS Administrators, LLC	DME MAC	17013 - DME MAC	J-B	Illinois Indiana Kentucky Michigan Minnesota Ohio Wisconsin
CGS Administrators, LLC	DME MAC	18003 - DME MAC	J-C	Alabama Arkansas Colorado Florida Georgia Louisiana Mississippi North Carolina New Mexico Oklahoma Puerto Rico South Carolina Tennessee Texas Virginia Virgin Islands West Virginia
Noridian Healthcare Solutions, LLC	DME MAC	16013 - DME MAC	J-A	Connecticut District of Columbia Delaware Massachusetts Maryland Maine New Hampshire New Jersey New York - Entire State Pennsylvania Rhode Island

CONTRACTOR NAME	CONTRACT TYPE	CONTRACT NUMBER	JURISDICTION	STATE(S)
				Vermont
Noridian Healthcare Solutions, LLC	DME MAC	19003 - DME MAC	J-D	Alaska American Samoa Arizona California - Entire State Guam Hawaii Iowa Idaho Kansas Missouri - Entire State Montana North Dakota Nebraska Nevada Oregon South Dakota Utah Washington Wyoming Northern Mariana Islands

Article Information

General Information

Article ID

A52494

Original Article Effective Date

10/01/2015

Original ICD-9 Article ID

[A47080](#)

[A25519](#)

[A25231](#)

[A25365](#)

Revision Effective Date

01/01/2019

Revision Ending Date

N/A

Article Title

High Frequency Chest Wall Oscillation Devices - Policy Article

Retirement Date

N/A

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Article Guidance

Article Text:

NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES

For any item to be covered by Medicare, it must 1) be eligible for a defined Medicare benefit category, 2) be reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member, and 3) meet all other applicable Medicare statutory and regulatory requirements. Information provided in this policy article relates to determinations other than those based on Social Security Act §1862(a)(1)(A) provisions (i.e. "reasonable and necessary").

High frequency chest wall oscillation devices are covered under the Durable Medical Equipment benefit (Social Security Act §1861(s)(6)). In order for a beneficiary's equipment to be eligible for reimbursement the reasonable and necessary (R&N) requirements set out in the related Local Coverage Determination must be met. In addition, there are specific statutory payment policy requirements, discussed below, that also must be met.

Requirements for specified DMEPOS items pursuant to 42 CFR 410.38(g)

42 CFR 410.38(g) requires a face-to-face evaluation and a specific written order prior to delivery for specified HCPCS codes. CMS provides a list of the specified codes, which is periodically updated, located [here](#).

Claims for the specified items subject to 42 CFR 410.38(g) that do not meet the requirements specified in the LCD-related Standard Documentation Requirements Article will be denied as statutorily noncovered – failed to meet statutory requirements.

If the supplier delivers the item prior to receipt of a written order, it will be denied as statutorily noncovered. If the written order is not obtained prior to delivery, payment will not be made for that item even if a written order is subsequently obtained. If a similar item is subsequently provided by an unrelated supplier who has obtained a written order prior to delivery, it will be eligible for coverage.

The diagnosis code that justifies the need for these items must be included on the claim.

POLICY SPECIFIC DOCUMENTATION REQUIREMENTS

In addition to policy specific documentation requirements, there are general documentation requirements that are applicable to all DMEPOS policies. These general requirements are located in the DOCUMENTATION REQUIREMENTS section of the LCD.

Refer to the LCD-related Standard Documentation Requirements article, located at the bottom of this Policy Article under the Related Local Coverage Documents section for additional information regarding GENERAL DOCUMENTATION REQUIREMENTS and the POLICY SPECIFIC DOCUMENTATION REQUIREMENTS discussed below.

MODIFIERS

KX, GA, AND GZ MODIFIERS:

Suppliers must add a KX modifier to codes for an HFCWO device and accessories only if all of the criteria in the Coverage Indications, Limitations, and/or Medical Necessity section of the related LCD have been met.

If all of the criteria in the Coverage Indications, Limitations and/or Medical Necessity section of the related LCD have not been met, the GA or GZ modifier must be added to the code. When there is an expectation of a denial as not reasonable and necessary, suppliers must enter GA on the claim line if they have obtained a properly executed Advance Beneficiary Notice (ABN) or GZ if they have not obtained a valid ABN.

There must be information in the beneficiary's medical record that describes in detail the underlying medical condition(s) that cause the accumulation of pulmonary secretions, the treatment interventions (for example, chest physiotherapy, postural drainage, medications used, mechanical modalities such as in-exsufflation devices, etc. (not all-inclusive)) and the effectiveness of the treatment. This information must be available upon request.

Claim lines billed without a KX, GA, or GZ modifier will be rejected as missing information.

CODING GUIDELINES

HCPCS Code E0483 (HIGH FREQUENCY CHEST WALL OSCILLATION SYSTEM, INCLUDES ALL ACCESSORIES AND SUPPLIES, EACH) devices (HFCWO) use positive and negative pressure changes to augment peripheral and tracheal

mucus movement towards the airway opening. This function is performed by extra-thoracic oscillations generated by forces external to the respiratory system. External chest wall oscillations are applied using a vest worn around the torso, which vibrates at variable frequencies and intensities, as set by the operator. E0483 devices may use differing technologies, e.g. air-pulse generators and an inflatable vest, an array of mechanical oscillators in a vest providing synchronized oscillation, etc. E0483 is all-inclusive regardless of the technique used to produce HFCWO.

HCPCS Code A7025 (HIGH FREQUENCY CHEST WALL OSCILLATION SYSTEM VEST, REPLACEMENT FOR USE WITH PATIENT OWNED EQUIPMENT, EACH) describes a complete replacement vest. This includes all components such as mechanical oscillators, electrical componentry, inflatable air sacs, connectors, etc. Separate billing of vest components when an entire vest is replaced is incorrect coding – unbundling.

HCPCS Code A7026 (HIGH FREQUENCY CHEST WALL OSCILLATION SYSTEM HOSE, REPLACEMENT FOR USE WITH PATIENT OWNED EQUIPMENT, EACH) describes the tubing used with an air pulse generator type of HFCWO device.

HCPCS Code E0483 describes a complete system. Separate billing of A7025 and/or A7026 in combination with E0483 is incorrect coding – unbundling.

Code E0467 (HOME VENTILATOR, MULTI-FUNCTION RESPIRATORY DEVICE, ALSO PERFORMS ANY OR ALL OF THE ADDITIONAL FUNCTIONS OF OXYGEN CONCENTRATION, DRUG NEBULIZATION, ASPIRATION, AND COUGH STIMULATION, INCLUDES ALL ACCESSORIES, COMPONENTS AND SUPPLIES FOR ALL FUNCTIONS) describes a ventilator that integrates the function of multiple types of equipment into a single device. Code E0467 combines the function of a ventilator with those of any combination or all of the following:

- Oxygen equipment
- Nebulizer and compressor
- Aspirator (suction device)
- Cough stimulator (multiple products)
- Positive airway pressure devices (PAP and RAD)
- Custom fabricated oral appliances

The following high frequency chest wall oscillation devices HCPCS codes for individual items are included in the functionality of code E0467:

- HCPCS codes E0483, A7025, A7026

Claims for any of the HCPCS codes listed above that are submitted on the same claim or that overlap any date(s) of service for E0467 is considered to be unbundling.

In addition, any claim for repair (HCPCS code K0739 for labor and any HCPCS code for replacement items) of beneficiary-owned equipment identified by HCPCS codes listed above is considered as unbundling if the date(s) of service for the repair overlaps any date(s) of service for code E0467.

Claims for code E0467 with a date(s) of service that overlaps date(s) of service for any of the following scenarios are considered as a claim for same or similar equipment when the beneficiary:

- Is currently in a rental month for any of the items listed above
- Owns any of the equipment listed above that has not reached the end of its reasonable useful lifetime.

Suppliers should contact the Pricing, Data Analysis, and Coding (PDAC) contractor for guidance on the correct coding of these items.

Coding Information

Bill Type Codes:

Contractors may specify Bill Types to help providers identify those Bill Types typically used to report this service. Absence of a Bill Type does not guarantee that the policy does not apply to that Bill Type. Complete absence of all Bill Types indicates that coverage is not influenced by Bill Type and the policy should be assumed to apply equally to all claims.

N/A

Revenue Codes:

Contractors may specify Revenue Codes to help providers identify those Revenue Codes typically used to report this service. In most instances Revenue Codes are purely advisory. Unless specified in the policy, services reported under other Revenue Codes are equally subject to this coverage determination. Complete absence of all Revenue Codes indicates that coverage is not influenced by Revenue Code and the policy should be assumed to apply equally to all Revenue Codes.

N/A

CPT/HCPCS Codes

N/A

ICD-10 Codes that are Covered

Group 1 Paragraph:

The presence of an ICD-10 code listed in this section is not sufficient by itself to assure coverage. Refer to the LCD section on "**Coverage Indications, Limitations, and/or Medical Necessity**" for other coverage criteria and payment information.

Group 1 Codes:

ICD-10 CODE	DESCRIPTION
A15.0	Tuberculosis of lung
B91	Sequelae of poliomyelitis
D81.810	Biotinidase deficiency

ICD-10 CODE	DESCRIPTION
D84.1	Defects in the complement system
E84.0	Cystic fibrosis with pulmonary manifestations
E84.9	Cystic fibrosis, unspecified
G12.0	Infantile spinal muscular atrophy, type I [Werdnig-Hoffman]
G12.1	Other inherited spinal muscular atrophy
G12.20	Motor neuron disease, unspecified
G12.21	Amyotrophic lateral sclerosis
G12.22	Progressive bulbar palsy
G12.23	Primary lateral sclerosis
G12.24	Familial motor neuron disease
G12.25	Progressive spinal muscle atrophy
G12.29	Other motor neuron disease
G12.8	Other spinal muscular atrophies and related syndromes
G12.9	Spinal muscular atrophy, unspecified
G14	Postpolio syndrome
G35	Multiple sclerosis
G71.00	Muscular dystrophy, unspecified
G71.01	Duchenne or Becker muscular dystrophy
G71.02	Facioscapulohumeral muscular dystrophy
G71.09	Other specified muscular dystrophies
G71.11	Myotonic muscular dystrophy
G71.12	Myotonia congenita
G71.13	Myotonic chondrodystrophy
G71.14	Drug induced myotonia
G71.19	Other specified myotonic disorders
G71.2	Congenital myopathies
G71.3	Mitochondrial myopathy, not elsewhere classified
G71.8	Other primary disorders of muscles
G72.0	Drug-induced myopathy
G72.1	Alcoholic myopathy
G72.2	Myopathy due to other toxic agents
G72.89	Other specified myopathies

ICD-10 CODE	DESCRIPTION
G73.7	Myopathy in diseases classified elsewhere
G82.50	Quadriplegia, unspecified
G82.51	Quadriplegia, C1-C4 complete
G82.52	Quadriplegia, C1-C4 incomplete
G82.53	Quadriplegia, C5-C7 complete
G82.54	Quadriplegia, C5-C7 incomplete
J47.0	Bronchiectasis with acute lower respiratory infection
J47.1	Bronchiectasis with (acute) exacerbation
J47.9	Bronchiectasis, uncomplicated
J98.6	Disorders of diaphragm
M33.02	Juvenile dermatomyositis with myopathy
M33.12	Other dermatomyositis with myopathy
M33.22	Polymyositis with myopathy
M33.92	Dermatopolymyositis, unspecified with myopathy
M34.82	Systemic sclerosis with myopathy
M35.03	Sicca syndrome with myopathy
Q33.4	Congenital bronchiectasis

ICD-10 Codes that are Not Covered

N/A

Revision History Information

REVISION HISTORY DATE	REVISION HISTORY NUMBER	REVISION HISTORY EXPLANATION
01/01/2019	R8	<p>Revision Effective Date: 01/01/2019 CODING GUIDELINES: Added: E0467 Coding Guidelines</p> <p><i>04/11/2019: At this time 21st Century Cures Act applies to new and revised LCDs which require comment and notice. This revision is to an article that is not a local coverage determination.</i></p>

REVISION HISTORY DATE	REVISION HISTORY NUMBER	REVISION HISTORY EXPLANATION
01/01/2019	R7	<p>Revision Effective Date: 01/01/2019 CODING GUIDELINES: Revised: Code descriptor for E0483 ICD-10 CODES THAT ARE COVERED: Added: All diagnosis codes formerly listed in the LCD ICD-10 CODES THAT ARE COVERED: Added: Notation excluding all unlisted diagnosis codes from coverage</p> <p><i>02/14/2019: At this time 21st Century Cures Act applies to new and revised LCDs which require comment and notice. This revision is to an article that is not a local coverage determination.</i></p>
01/01/2018	R6	<p>Revision Effective Date: 01/01/2018 CODING GUIDELINES: Added: Coding guidelines for HCPCS codes E0483, A7025, A7026</p> <p><i>04/05/18: At this time 21st Century Cures Act applies to new and revised LCDs that restrict coverage, which require comment and notice. This revision is to an article that is not a local coverage determination.</i></p>
01/01/2017	R5	<p>Revision Effective Date: 01/01/2017 NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES:</p> <p>Added: REQUIREMENTS FOR SPECIFIC DMEPOS ITEMS PURSUANT TO 42 CFR 410.38(g), previously in the Policy Specific Documentation Requirements section</p> <p><i>11/23/17: At this time 21st Century Cures Act applies to new and revised LCDs that restrict coverage, which require comment and notice. This revision is to an article that is not a local coverage determination.</i></p>
01/01/2017	R4	<p>Revision Effective Date: 01/01/2017 POLICY SPECIFIC DOCUMENTATION REQUIREMENTS: Added: 42 CFR 410.38(g) and Modifier instructions RELATED LOCAL COVERAGE DOCUMENTS: Added: LCD-related Standard Documentation Requirements Language Article</p>
07/01/2016	R3	<p>Revision Effective Date: 07/01/2016 NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES: Revised Standard Language to add Statutory Prescription (Order) Requirements, revised Face to Face and ACA requirements (Effective 04/28/2016)</p>
07/01/2016	R2	<p>Effective July 1, 2016 oversight for DME MAC Articles is the responsibility of CGS Administrators, LLC 18003 and 17013 and Noridian Healthcare Solutions, LLC 19003 and 16013. No other changes have been made to the Articles.</p>

REVISION HISTORY DATE	REVISION HISTORY NUMBER	REVISION HISTORY EXPLANATION
10/01/2015	R1	<p>Revision Effective Date: 10/31/2014</p> <p>NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES</p> <p>Removed: "When required by state law" from ACA new prescription requirements</p> <p>Revised: Face-to-Face Requirements for treating practitioner</p>

Associated Documents

Related Local Coverage Document(s)

Article(s)

A55426 - Standard Documentation Requirements for All Claims Submitted to DME MACs

LCD(s)

L33785 - High Frequency Chest Wall Oscillation Devices

Related National Coverage Document(s)

N/A

Statutory Requirements URL(s)

N/A

Rules and Regulations URL(s)

N/A

CMS Manual Explanations URL(s)

N/A

Other URL(s)

N/A

Public Version(s)

Updated on 04/02/2019 with effective dates 01/01/2019 - N/A

Updated on 02/07/2019 with effective dates 01/01/2019 - N/A

Updated on 03/28/2018 with effective dates 01/01/2018 - N/A

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Keywords

N/A