### Contractor Information

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**LCD Information**

**Document Information**

**LCD ID**
L33785

**Original ICD-9 LCD ID**
L27042
L12934
L12870
L12739

**Original Effective Date**
For services performed on or after 10/01/2015

**Revision Effective Date**
For services performed on or after 01/01/2020

**Revision Ending Date**
N/A

**Retirement Date**
N/A

**Proposed LCD in Comment Period**
N/A

**Notice Period Start Date**
N/A

**Source Proposed LCD**
N/A
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 code list in the LCD-related Policy Article for applicable diagnoses).

2. There is a diagnosis of bronchiectasis (refer to the ICD-10 code list 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 code list 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 Standard Written Order (SWO) must be communicated to the supplier before a claim is submitted. If the supplier bills for an item addressed in this policy without first receiving a completed SWO, 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 have received a signed SWO before the DMEPOS item is delivered to a beneficiary. If a supplier delivers a DMEPOS item without first receiving a WOPD, the claim shall be denied as not reasonable and necessary. Refer to the LCD-related Policy Article, located at the bottom of this policy under the Related Local Coverage Documents section.

For DMEPOS base items that require a WOPD, and also require separately billed associated options, accessories, and/or supplies, the supplier must have received a WOPD which lists the base item and which may list all the associated options, accessories, and/or supplies that are separately billed prior to the delivery of the items. In this scenario, if the supplier separately bills for associated options, accessories, and/or supplies without first receiving a completed and signed WOPD of the base item prior to delivery, the claim(s) shall be denied as not reasonable and necessary.

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:
Contracts 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:
Contracts 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:
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:

- SWO
- 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

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**Revision History Information**

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| 01/01/2020            | R8                      | Revision Effective Date: 01/01/2020
|                       |                         | COVERAGE INDICATIONS, LIMITATIONS, AND/OR
|                       |                         | MEDICAL NECESSITY:
|                       |                         | Removed: Statement to refer to ICD-10 Codes that are
|                       |                         | Covered section in the LCD-related PA
|                       |                         | Added: Statement to refer to ICD-10 code list in the
|                       |                         | LCD-related Policy Article
|                       |                         | Revised: Order information as a result of Final Rule
|                       |                         | 1713
|                       |                         | GENERAL DOCUMENTATION REQUIREMENTS:
|                       |                         | Revised: Prescriptions (orders) to SWO |

• Provider Education/Guidance
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<td>02/06/2020: Pursuant to the 21st Century Cures Act, these revisions do not require notice and comment because they are due to non-discretionary coverage updates reflective of CMS FR-1713.</td>
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<td>01/01/2019</td>
<td>R7</td>
<td>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 diagnosis code section per CMS instruction</td>
<td>• Revisions Due To CPT/HCPCS Code Changes • Other (ICD-10 code relocation per CMS instruction)</td>
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<td>10/01/2018</td>
<td>R6</td>
<td>Revision Effective Date: 10/01/2018 ICD-10 CODES THAT SUPPORT MEDICAL NECESSITY: Removed: ICD-10 Code G71.0 due to annual ICD-10 Code updates Added: New expanded ICD-10 codes for those removed 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.</td>
<td>• Revisions Due To ICD-10-CM Code Changes</td>
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<td>10/01/2017</td>
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| 07/01/2016            | R3                      | **Revision Effective Date 07/01/2016**  
COVERAGE INDICATIONS, LIMITATIONS AND/OR MEDICAL NECESSITY:  
Revised: Standard Documentation language - ACA order requirements – Effective 04/28/16  
DOCUMENTATION REQUIREMENTS:  
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 | • Provider Education/Guidance |
| 01/01/2017            | R4                      | **Revision Effective Date: 01/01/2017**  
COVERAGE INDICATIONS, INDICATIONS, LIMITATIONS AND/OR MEDICAL NECESSITY:  
Removed: Standard Documentation Language  
Added: New reference language and directions to Standard Documentation Requirements  
Added: General Requirements  
DOCUMENTATION REQUIREMENTS:  
Removed: Standard Documentation Language  
Added: General Documentation Requirements  
Added: New reference language and directions to Standard Documentation Requirements  
POLICY SPECIFIC DOCUMENTATION REQUIREMENTS:  
Removed: Standard Documentation Language  
Added: Direction to Standard Documentation Requirements  
Removed: Supplier Manual reference under Miscellaneous  
Removed: PIM reference under Appendices  
RELATED LOCAL COVERAGE DOCUMENTS:  
Added: LCD-related Standard Documentation Requirements article | • Provider Education/Guidance |
|                       |                         | Added: New ICD-10 codes  
Revised: ICD-10 code descriptions  
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. | |
| 07/01/2016            | R3                      | **Revision Effective Date 07/01/2016**  
COVERAGE INDICATIONS, LIMITATIONS AND/OR MEDICAL NECESSITY:  
Revised: Standard Documentation language - ACA order requirements – Effective 04/28/16  
DOCUMENTATION REQUIREMENTS:  
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 | • Provider Education/Guidance |
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<td>07/01/2016 R2</td>
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<td>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.</td>
<td>• Change in Assigned States or Affiliated Contract Numbers</td>
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| 10/01/2015 R1         |                         | **Revision Effective Date: 10/31/2014**  
**COVERAGE INDICATIONS, LIMITATIONS AND/OR MEDICAL NECESSITY:**  
Revised: Standard Documentation Language to add covered prior to a beneficiary’s Medicare eligibility  
Removed: Refill Requirements  
**DOCUMENTATION REQUIREMENTS:**  
Revised: Standard Documentation Language to add who can enter date of delivery date on the POD  
Removed: Request for refill documentation requirements  
Added: Instructions for Equipment Retained from a Prior Payer  
Added: Instruction for Repair Replacement | • 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 01/30/2020 with effective dates 01/01/2020 - N/A  
Updated on 02/07/2019 with effective dates 01/01/2019 - 12/31/2019  
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.
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**Article Information**

**General Information**

**Article ID**
A52494

**Original ICD-9 Article ID**
- A47080
- A25519
- A25231
- A25365

**Article Title**
High Frequency Chest Wall Oscillation Devices - Policy Article

**Original Effective Date**
10/01/2015

**Revision Effective Date**
04/03/2020

**Revision Ending Date**
N/A

**Retirement Date**
N/A

**Article Type**
Article
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 SPECIFIC DMEPOS ITEMS PURSUANT TO Final Rule 1713 (84 Fed. Reg Vol 217)**

Final Rule 1713 (84 Fed. Reg Vol 217) requires a face-to-face encounter and a Written Order Prior to Delivery (WOPD) for specified HCPCS codes. CMS and the DME MACs provide a list of the specified codes, which is periodically updated. The link will be located here once it is available.

Claims for the specified items subject to Final Rule 1713 (84 Fed. Reg Vol 217) that do not meet the face-to-face encounter and WOPD requirements specified in the LCD-related Standard Documentation Requirements Article (A55426) will be denied as not reasonable and necessary.

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

**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.

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

**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

For E0467 claims with dates of service before April 3, 2020:

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.

For E0467 claims with dates of service on or after April 3, 2020:

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 in a rental month for any of the items listed above are considered as a claim for same or similar equipment.

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

**Coding Information**

**CPT/HCPCS Codes**

**Group 1 Paragraph:**

**Group 1 Codes:**

N/A

**ICD-10 Codes that Support Medical Necessity**

**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:**

<table>
<thead>
<tr>
<th>ICD-10 CODE</th>
<th>DESCRIPTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>A15.0</td>
<td>Tuberculosis of lung</td>
</tr>
<tr>
<td>B91</td>
<td>Sequelae of poliomyelitis</td>
</tr>
<tr>
<td>ICD-10 CODE</td>
<td>DESCRIPTION</td>
</tr>
<tr>
<td>------------</td>
<td>-------------</td>
</tr>
<tr>
<td>D81.810</td>
<td>Biotinidase deficiency</td>
</tr>
<tr>
<td>D84.1</td>
<td>Defects in the complement system</td>
</tr>
<tr>
<td>E84.0</td>
<td>Cystic fibrosis with pulmonary manifestations</td>
</tr>
<tr>
<td>E84.9</td>
<td>Cystic fibrosis, unspecified</td>
</tr>
<tr>
<td>G12.0</td>
<td>Infantile spinal muscular atrophy, type I [Werdnig-Hoffman]</td>
</tr>
<tr>
<td>G12.1</td>
<td>Other inherited spinal muscular atrophy</td>
</tr>
<tr>
<td>G12.20</td>
<td>Motor neuron disease, unspecified</td>
</tr>
<tr>
<td>G12.21</td>
<td>Amyotrophic lateral sclerosis</td>
</tr>
<tr>
<td>G12.22</td>
<td>Progressive bulbar palsy</td>
</tr>
<tr>
<td>G12.23</td>
<td>Primary lateral sclerosis</td>
</tr>
<tr>
<td>G12.24</td>
<td>Familial motor neuron disease</td>
</tr>
<tr>
<td>G12.25</td>
<td>Progressive spinal muscle atrophy</td>
</tr>
<tr>
<td>G12.29</td>
<td>Other motor neuron disease</td>
</tr>
<tr>
<td>G12.8</td>
<td>Other spinal muscular atrophies and related syndromes</td>
</tr>
<tr>
<td>G12.9</td>
<td>Spinal muscular atrophy, unspecified</td>
</tr>
<tr>
<td>G14</td>
<td>Postpolio syndrome</td>
</tr>
<tr>
<td>G35</td>
<td>Multiple sclerosis</td>
</tr>
<tr>
<td>G71.00</td>
<td>Muscular dystrophy, unspecified</td>
</tr>
<tr>
<td>G71.01</td>
<td>Duchenne or Becker muscular dystrophy</td>
</tr>
<tr>
<td>G71.02</td>
<td>Facioscapulohumeral muscular dystrophy</td>
</tr>
<tr>
<td>G71.09</td>
<td>Other specified muscular dystrophies</td>
</tr>
<tr>
<td>G71.11</td>
<td>Myotonic muscular dystrophy</td>
</tr>
<tr>
<td>G71.12</td>
<td>Myotonia congenita</td>
</tr>
<tr>
<td>G71.13</td>
<td>Myotonic chondrodystrophy</td>
</tr>
<tr>
<td>G71.14</td>
<td>Drug induced myotonia</td>
</tr>
<tr>
<td>G71.19</td>
<td>Other specified myotonic disorders</td>
</tr>
<tr>
<td>G71.2</td>
<td>Congenital myopathies</td>
</tr>
<tr>
<td>G71.3</td>
<td>Mitochondrial myopathy, not elsewhere classified</td>
</tr>
<tr>
<td>G71.8</td>
<td>Other primary disorders of muscles</td>
</tr>
<tr>
<td>G72.0</td>
<td>Drug-induced myopathy</td>
</tr>
<tr>
<td>G72.1</td>
<td>Alcoholic myopathy</td>
</tr>
<tr>
<td>G72.2</td>
<td>Myopathy due to other toxic agents</td>
</tr>
<tr>
<td>ICD-10 CODE</td>
<td>DESCRIPTION</td>
</tr>
<tr>
<td>------------</td>
<td>-------------</td>
</tr>
<tr>
<td>G72.89</td>
<td>Other specified myopathies</td>
</tr>
<tr>
<td>G73.7</td>
<td>Myopathy in diseases classified elsewhere</td>
</tr>
<tr>
<td>G82.50</td>
<td>Quadriplegia, unspecified</td>
</tr>
<tr>
<td>G82.51</td>
<td>Quadriplegia, C1-C4 complete</td>
</tr>
<tr>
<td>G82.52</td>
<td>Quadriplegia, C1-C4 incomplete</td>
</tr>
<tr>
<td>G82.53</td>
<td>Quadriplegia, C5-C7 complete</td>
</tr>
<tr>
<td>G82.54</td>
<td>Quadriplegia, C5-C7 incomplete</td>
</tr>
<tr>
<td>J47.0</td>
<td>Bronchiectasis with acute lower respiratory infection</td>
</tr>
<tr>
<td>J47.1</td>
<td>Bronchiectasis with (acute) exacerbation</td>
</tr>
<tr>
<td>J47.9</td>
<td>Bronchiectasis, uncomplicated</td>
</tr>
<tr>
<td>J98.6</td>
<td>Disorders of diaphragm</td>
</tr>
<tr>
<td>M33.02</td>
<td>Juvenile dermatomyositis with myopathy</td>
</tr>
<tr>
<td>M33.12</td>
<td>Other dermatomyositis with myopathy</td>
</tr>
<tr>
<td>M33.22</td>
<td>Polymyositis with myopathy</td>
</tr>
<tr>
<td>M33.92</td>
<td>Dermatopolymyositis, unspecified with myopathy</td>
</tr>
<tr>
<td>M34.82</td>
<td>Systemic sclerosis with myopathy</td>
</tr>
<tr>
<td>M35.03</td>
<td>Sicca syndrome with myopathy</td>
</tr>
<tr>
<td>Q33.4</td>
<td>Congenital bronchiectasis</td>
</tr>
</tbody>
</table>

**ICD-10 Codes that DO NOT Support Medical Necessity**

**Group 1 Paragraph:**

All ICD-10 codes that are not specified in the previous section.

**Group 1 Codes:**

N/A

**Additional ICD-10 Information**

N/A

**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.
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.

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**Revision History Information**

<table>
<thead>
<tr>
<th>REVISION HISTORY DATE</th>
<th>REVISION HISTORY NUMBER</th>
<th>REVISION HISTORY EXPLANATION</th>
</tr>
</thead>
</table>
| 04/03/2020            | R10                     | Revision Effective Date: 04/03/2020  
CODING GUIDELINES:  
Revised: Guidance for billing HCPCS code E0467 based on DOS  

*07/16/2020: 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.* |
| 01/01/2020            | R9                      | Revision Effective Date: 01/01/2020  
REQUIREMENTS FOR SPECIFIC DMEPOS ITEMS PURSUANT TO 42 CFR 410.38(g):  
Removed: Statement that the diagnosis code, that justifies the need for the items, must be billed on the claim  
Removed: Section due to Final Rule 1713  
REQUIREMENTS FOR SPECIFIC DMEPOS ITEMS PURSUANT TO FINAL RULE 1713 (84 Fed. Reg Vol 217):  
Added: Section and related information based on Final Rule 1713  
POLICY SPECIFIC DOCUMENTATION REQUIREMENTS:  
Added: Statement that the diagnosis code, that justifies the need for the items, must be billed on the claim  
ICD-10 CODES THAT SUPPORT MEDICAL NECESSITY:  
Revised: Section header “ICD-10 Codes that are Covered” updated to “ICD-10 Codes that Support Medical Necessity”  
ICD-10 CODES THAT DO NOT SUPPORT MEDICAL NECESSITY:  
Revised: Section header “ICD-10 Codes that are Not Covered” updated to “ICD-10 Codes that DO NOT Support Medical Necessity” |
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</tr>
</thead>
<tbody>
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<td></td>
<td>02/06/2020: 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.</td>
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| 01/01/2019            | R8                      | Revision Effective Date: 01/01/2019  
CODING GUIDELINES:  
Added: E0467 Coding Guidelines  
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. |
| 01/01/2019            | R7                      | 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  
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. |
| 01/01/2018            | R6                      | Revision Effective Date: 01/01/2018  
CODING GUIDELINES:  
Added: Coding guidelines for HCPCS codes E0483, A7025, A7026  
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. |
| 01/01/2017            | R5                      | Revision Effective Date: 01/01/2017  
NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES:  
Added: REQUIREMENTS FOR SPECIFIC DMEPOS ITEMS PERSUANT TO 42 CFR 410.38(g), previously in the Policy Specific Documentation Requirements section  
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. |
### 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 07/09/2020 with effective dates 04/03/2020 - N/A
- Updated on 01/30/2020 with effective dates 01/01/2020 - N/A