Airway Clearance Devices (for Kansas Only)

Policy Number: CS054KS.02
Effective Date: November 1, 2025

➲ Instructions for Use

Table of Contents **Page**

Related Policy

- Durable Medical Equipment, Orthotics, Medical Supplies, and Repairs/Replacements (for Kansas Only)

Application

This Medical Policy only applies to the state of Kansas.

Coverage Rationale

For medical necessity clinical coverage criteria for a high frequency chest wall oscillation system, refer to the Kansas Medical Assistance Program, Durable Medical Equipment Fee-for-Service Provider Manual.

For medical necessity clinical coverage criteria for an intrapulmonary percussive ventilation system, refer to the InterQual® CP: Durable Medical Equipment, Airway or Secretion Clearance Devices.

Click here to view the InterQual® criteria.

Applicable Codes

The following list(s) of procedure and/or diagnosis codes is provided for reference purposes only and may not be all inclusive. Listing of a code in this policy does not imply that the service described by the code is a covered or non-covered health service. Benefit coverage for health services is determined by federal, state, or contractual requirements and applicable laws that may require coverage for a specific service. The inclusion of a code does not imply any right to reimbursement or guarantee claim payment. Other Policies and Guidelines may apply.

HCPCS Code	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
E0481	Intrapulmonary percussive ventilation system and related accessories
E0483	High frequency chest wall oscillation system, with full anterior and/or posterior thoracic region receiving simultaneous external oscillation, includes all accessories and supplies, each

Diagnosis Code	Description
G35.A	Relapsing-remitting multiple sclerosis
G35.B0	Primary progressive multiple sclerosis, unspecified
G35.B1	Active primary progressive multiple sclerosis

Diagnosis Code	Description
G35.B2	Non-active primary progressive multiple sclerosis
G35.C0	Secondary progressive multiple sclerosis, unspecified
G35.C1	Active secondary progressive multiple sclerosis
G35.C2	Non-active secondary progressive multiple sclerosis
G35.D	Multiple sclerosis, unspecified
G71.036	Limb girdle muscular dystrophy due to fukutin related protein dysfunction

U.S. Food and Drug Administration (FDA)

This section is to be used for informational purposes only. FDA approval alone is not a basis for coverage.

High-Frequency Chest Wall Compression Devices

High-frequency chest wall compression devices are designed to promote airway clearance and improve bronchial drainage. They are indicated when external chest manipulation is the physician's treatment of choice to enhance mucus transport. Refer to the following website for more information (use product code BYI): http://www.accessdata.fda.gov/scripts/cdrh/cfdocs/cfPMN/pmn.cfm. (Accessed September 26, 2023)

References

Kansas Medical Assistance Program Durable Medical Equipment Fee-for-Service Provider Manual. Available at: https://portal.kmap-state-ks.us/Documents/Provider/Provider%20Manuals/DME_24171_24094.pdf. Accessed November 5, 2024.

Policy History/Revision Information

Date	Summary of Changes
11/01/2025	**Applicable Codes** • Updated list of applicable ICD-10 diagnosis codes to reflect annual edits; added G35.A, G35.B0, G35.B1, G35.B2, G35.C0, G35.C1, G35.C2, G35.D, and G71.036 **Supporting Information** • Archived previous policy version CS054KS.01

Instructions for Use

This Medical Policy provides assistance in interpreting UnitedHealthcare standard benefit plans. When deciding coverage, the federal, state, or contractual requirements for benefit plan coverage must be referenced as the terms of the federal, state, or contractual requirements for benefit plan coverage may differ from the standard benefit plan. In the event of a conflict, the federal, state, or contractual requirements for benefit plan coverage govern. Before using this policy, please check the federal, state, or contractual requirements for benefit plan coverage. UnitedHealthcare reserves the right to modify its policies and guidelines as necessary. This Medical Policy is provided for informational purposes. It does not constitute medical advice.

UnitedHealthcare uses InterQual® for the primary medical/surgical criteria, and the American Society of Addiction Medicine (ASAM) criteria for substance use disorder (SUD) services, in administering health benefits. If InterQual® does not have applicable criteria, UnitedHealthcare may also use UnitedHealthcare Medical Policies that have been approved by the Kansas Department of Health and Environment. The UnitedHealthcare Medical Policies are intended to be used in connection with the independent professional medical judgment of a qualified health care provider and do not constitute the practice of medicine or medical advice.