



Medica Central Utilization Management Policy

Title: High Frequency Chest Compression (HFCWC) Devices (Vest System) MP9235 (Ill-DEV.20)

Effective

Date: September 19, 2025

IMPORTANT INFORMATION – PLEASE READ BEFORE USING THIS POLICY

These services may or may not be covered by all Medica Central plans. Coverage is subject to requirements in applicable federal or state laws. Please refer to the member's plan document for other specific coverage information. If there is a difference between this general information and the member's plan document, the member's plan document will be used to determine coverage. With respect to Medicare, Medicaid, and other government programs, this policy will apply unless these programs require different coverage.

Members may contact Medica Customer Service at the phone number listed on their member identification card to discuss their benefits more specifically. Providers with questions may call the Provider Service Center. Please use the Quick Reference Guide on the Provider Communications page for the appropriate phone number. <https://mo-central.medica.com/Providers/SSM-employee-health-plan-for-IL-MO-OK-providers>

Medica Central coverage policies are not medical advice. Members should consult with appropriate health care providers to obtain needed medical advice, care, and treatment.

PURPOSE

To promote consistency between utilization management reviewers by providing the criteria that determines the medical necessity.

MEDICAL NECESSITY CRITERIA

For medical necessity criteria, The Health Plan uses MCG™ Care Guidelines, 29th edition, 2025: ACG: A-0356 (AC), High Frequency Chest Compression Device.

BENEFIT CONSIDERATIONS

1. Prior authorization **is required** for high frequency chest wall compression (HFCWC) devices. Please see the prior authorization list for product specific prior authorization requirements.
2. Coverage may vary according to the terms of the member's plan document.
3. High frequency chest wall compression *is investigative and therefore not covered* for all other indications, including but not limited to, neuromuscular disorders.
4. If the Medical Necessity Criteria and Benefit Considerations are met, The Health Plan will authorize benefits within the limits in the member's plan document.
5. If it appears that the Medical Necessity Criteria and Benefit Considerations criteria are not met, the individual's case will be reviewed by the medical director or an external reviewer. Practitioners are reminded of the appeals process in their Provider Administrative Manual.



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CENTERS FOR MEDICARE & MEDICAID SERVICES (CMS)

- For Medicare members, refer to the following, as applicable at:
<https://www.cms.gov/medicare-coverage-database/new-search/search.aspx>

	Committee/Source	Date(s)
Document Created:	Medical Policy Committee/Health Services Division	December 19, 2018
Revised:	Medical Policy Committee/Health Services Division	December 18, 2019
	Medical Policy Committee/Health Services Division	November 18, 2020
	Medical Policy Committee/Health Services Division	November 17, 2021
	Medical Policy Committee/Health Services Division	November 16, 2022
	Medical Policy Committee/Health Services Division	May 17, 2023
	Medical Policy Committee/Health Services Division	August 16, 2023
	Medical Policy Committee/Health Services Division	November 15, 2023
	Reviewed:	Medical Policy Committee/Health Services Division
Medical Policy Committee/Health Services Division		November 18, 2020
Medical Policy Committee/Health Services Division		November 17, 2021
Medical Policy Committee/Health Services Division		November 16, 2022
Medical Policy Committee/Health Services Division		May 17, 2023
Medical Policy Committee/Health Services Division		August 16, 2023
Medical Policy Committee/Health Services Division		November 15, 2023
Retired:		Medical Policy Committee/Health Services Division
Administrative Update(s):	Reinstated, format update	08/2024

Original Effective Date	May 10, 2000
MPC Endorsement Date(s)	
Began use of MCG™ Care Guidelines	12/01/2024
MCG Care Guidelines Edition Updates (<i>Effective Date</i>)	29 th edition 09/19/2025
Administrative Updates	