



Medica Central Utilization Management Policy

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

Effective Date: 12/01/2024

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, 28th edition, 2024: 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, Medica 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>

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