



BILLING POLICY No. 171

High Frequency Chest Wall Oscillation Devices

Date of origin: Dec 2025

Review dates: 3/26

DEFINITION

High- frequency Chest Wall Oscillation (HFCWO) is a type of chest physical therapy that uses an inflatable vest connected to a machine that vibrates the chest at a high frequency.

For Medicare

For indications that do not meet criteria of NCD, local LCD or specific medical policy, a Pre-Service Organization Determination (PSOD) will need to be completed. Click [here](#) for additional details on PSOD.

POLICY SPECIFIC INFORMATION

Reimbursement rates

Find reimbursement rates for the codes listed on this page in our standard fee schedules for your contract. [Go to the fee schedules](#) (login required).

E0483 is an all-inclusive code and billing of A7025 and/or A7026 in combination of E0483 is not allowed

Billing details

Include a narrative in the NTE segment of the electronic claim indicating the number of months you are billing. For example, if billing a three-month supply of PAP accessories (i.e., mask, tubing, cushions), you must add "90-day supply" or "three-month supply".

Documentation Requirements

Complete and thorough documentation to substantiate the procedure performed is the responsibility of the Provider. In addition, the Provider should consult any specific documentation requirements that are necessary of any applicable defined guidelines.

Modifiers

Priority Health follows standard billing and coding guidelines which include CMS NCCI. Modifiers should be applied when applicable based on this guidance and only when supported by documentation.

Incorrect application of modifiers will result in denials. Please see our provider manual page for modifier use [here](#).

Place of Service

Coverage will be considered for services furnished in the appropriate setting to the patient's medical needs and condition. Authorization may be required. Click [here](#) for additional information.

REFERENCES

DISCLAIMER

CMS and/or MDHHS guidelines apply unless otherwise specified in this policy or provider manual. Where such guidance is absent, this policy applies. Priority Health's billing policies outline our guidelines to assist providers in accurate claim submissions and define reimbursement or coding requirements if the service is covered by a Priority Health member's benefit plan. The determination of visits, procedures, DME, supplies and other services or items for coverage under a member's benefit plan or authorization isn't being determined for reimbursement. Authorization requirements and medical necessity requirements appropriate to procedure, diagnosis and frequency are still required. We use Current Procedural Terminology (CPT), Centers for Medicare and Medicaid Services (CMS), Michigan Department of Health and Human Services (MDHHS), and other defined medical coding guidelines for coding accuracy.

An authorization isn't a guarantee of payment when proper billing and coding requirements or adherence to our policies aren't followed. Proper billing and submission guidelines must be followed. We require industry standard, compliant codes defined by CPT, HCPCS, and revenue codes for all claim submissions. CPT, HCPCS, revenue codes, etc., can be reported only when the service has been performed and fully documented in the medical record to the highest level of specificity. Failure to document services rendered or items supplied will result in a denial. To validate billing and coding accuracy, payment integrity pre- or post-claim reviews may be performed to prevent fraud, waste and abuse. Unless otherwise detailed in the policy, our billing policies apply to both participating and non-participating providers and facilities.

If guidelines detailed in government program regulations, defined in policies and contractual requirements aren't followed, Priority Health may:

- Reject or deny the claim
- Recover or recoup claim payment

An authorization on file for an item or services doesn't supersede coding, billing or reimbursement requirements.

These policies may be superseded by mandates defined in provider contracts or state, federal or CMS contracts or requirements. We make every effort to update our policies in a timely manner to align to these requirements or contracts. If there's a delay in implementation of a policy or requirement defined by state or federal law, as well as contract language, we reserve the right to recoup and/or recover claim payments to the effective dates per our policy. We reserve the right to update policies when necessary. Our most current policy will be made available [in our Provider Manual](#).

CHANGE / REVIEW HISTORY

Date	Revisions made
Dec 2025	New Policy
March 18, 2026	Added- E0483 is an all-inclusive code and billing of A7025 and/or A7026 in combination of E0483 is not allowed