STATE OF IOWA DEPARTMENT OF
Health AND Human
SERVICES

Percussors
DME-012

Iowa Medicaid Program:	Claims Pre-Pay	**Effective Date:**	1/21/2011
Revision Number:	5	**Last Rev Date:**	10/20/2023
Reviewed By:	Medicaid Medical Director	**Next Rev Date:**	10/18/2024
Approved By:	Medicaid Clinical Advisory Committee	**Approved Date:**	8/23/2019

Criteria

A home model, electric or pneumatic percussor is covered (for purchase only) when:

1. Member is not using a vibratory airway clearance device such as a high frequency chest wall oscillation device; **AND**
2. Prescribed for mobilizing respiratory tract secretions in members with chronic obstructive lung disease, chronic bronchitis, or emphysema, cystic fibrosis, neuromuscular conditions with impaired cough, bronchiectasis, or ciliary dyskinesia; **AND**
3. The member or operator of a powered percussor has received appropriate training by a physician or therapist; **AND**
4. No one competent and physically able to administer manual therapy is available due to the length and intensity of the treatment; **AND**
5. Long-term chest therapy is medically necessary.

Coding

NA

Compliance

1. Should conflict exist between this policy and applicable statute, the applicable statute shall supersede.
2. Federal and State law, as well as contract language, including definitions and specific contract provisions or exclusions, take precedence over medical policy and must be considered first in determining eligibility for coverage.
3. Medical technology is constantly evolving and Iowa Medicaid reserves the right to review and update medical policy on an annual or as-needed basis.

Medical necessity guidelines have been developed for determining coverage for member benefits and are published to provide a better understanding of the basis upon which coverage decisions are made. Medical necessity guidelines are developed for selected physician administered medications found to be safe and proven to be effective in a limited, defined

population or clinical circumstances. They include concise clinical coverage criteria based on current literature review, consultation with practicing physicians in the service area who are medical experts in the particular field, FDA and other government agency policies, and standards adopted by national accreditation organizations. Criteria are revised and updated annually, or more frequently if new evidence becomes available that suggests needed revisions.

References

Development of utilization management criteria may also involve research into other state Medicaid programs, other payer policies, consultation with experts and review by the Medicaid Clinical Advisory Committee (CAC). These sources may not be referenced individually unless they are specifically published and are otherwise applicable to the criteria at issue.

Criteria Change History

Change Date	Changed By	Description of Change	Version
Signature			

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Signature			

Change Date	Changed By	Description of Change	Version
10/20/2023	CAC	Annual review.	5
Signature William (Bill) Jagiello, DO			

Change Date	Changed By	Description of Change	Version
7/16/2021	CAC	Annual review. Formatting changes.	4
Signature William (Bill) Jagiello, DO			

Change Date	Changed By	Description of Change	Version
7/17/2020	Medical Director	Prior authorization requirement removed.	3
Signature William (Bill) Jagiello, DO			

Change Date	Changed By	Description of Change	Version
7/17/2015	CAC	Added paragraph in References Used.	2
Signature Mark E. Randleman, DO			

Change Date	Changed By	Description of Change	Version
7/14/2015	Medical Director	Criterion #1 replaced "The vest" with "HFCWO device".	1
Signature			