



High Frequency Chest Wall Oscillation Devices

I. Policy

University Health Alliance (UHA) will reimburse for intrapulmonary percussive ventilation or high-frequency chest wall compression with the Vest Airway Clearance System when it is determined to be medically necessary and when it meets the medical criteria guidelines (subject to limitations and exclusions) indicated below.

II. Criteria/Guidelines

- A. The Vest™ is covered when all of the following criteria are met (subject to the Limitations/Exclusions and Administrative Guidelines):
1. The device must be recommended by a pulmonologist; and
 2. The patient has a diagnosis of cystic fibrosis or chronic diffuse bronchiectasis. Chronic bronchiectasis is defined as daily productive cough for at least six continuous months or more than two exacerbations per year requiring antibiotic therapy and confirmed by high resolution or spiral chest computed tomography scan; and
 3. The patient has been hospitalized more than once for pulmonary-related conditions within the past two years; and
 4. Recent pulmonary function studies demonstrate forced expiratory volume (FEV-1) less than 80 percent of predicted and forced vital capacity (FVC) less than 50 percent of predicted; and
 5. The caregiver is unable to provide effective chest percussion and postural drainage; and
 6. Alternative therapy (e.g., daily percussion and postural drainage, autologous drainage or positive end expiratory pressure, flutter link device) is ineffective, not tolerated, or contraindicated.
- B. The use of a high frequency chest wall oscillation device beyond the first two months of therapy is covered when documentation supports that the patient is compliant with therapy and benefiting from therapy.

NOTE:

This UHA payment policy is a guide to coverage, the need for prior authorization and other administrative directives. It is not meant to provide instruction in the practice of medicine and it should not deter a provider from expressing his/her judgment.

Even though this payment policy may indicate that a particular service or supply is considered covered, specific provider contract terms and/or member's individual benefit plans may apply, and this policy is not a guarantee of payment. UHA reserves the right to apply this payment policy to all UHA companies and subsidiaries.

UHA understands that opinions about and approaches to clinical problems may vary. Questions concerning medical necessity (see Hawaii Revised Statutes §432E-1.4) are welcome. A provider may request that UHA reconsider the application of the medical necessity criteria in light of any supporting documentation.

III. Limitations/Exclusions

- A. Individuals with a contraindication for external manipulation of the thorax as defined by the American Association of Respiratory Care (AARC) are excluded from use of the bronchial drainage system vest. These contraindications include:
 - 1. Bronchospasms
 - 2. Complaint of chest wall pain
 - 3. Unstable head and/or neck injury
 - 4. Subcutaneous emphysema
 - 5. Recent epidural spinal infusion or spinal anesthesia
 - 6. Recent skin grafts, or flaps, on the thorax
 - 7. Burns, open wounds and skin infections of the thorax
 - 8. Recently placed transvenous pacemaker or subcutaneous pacemaker
 - 9. Osteomyelitis of the ribs
 - 10. Active hemorrhage with hemodynamic instability
 - 11. Suspected pulmonary tuberculosis
 - 12. Lung contusion
 - 13. Respiratory conditions associated with neuromuscular disorders
- B. The use of high-frequency chest wall compression and intrapulmonary percussive ventilation devices in chronic pulmonary diseases other than CF or chronic diffuse bronchiectasis (such as COPD), does not meet criteria for medical necessity due to insufficient evidence on the impact of treatment on health outcomes

IV. Administrative Guidelines

- A. Prior authorization is required. To request prior authorization, please submit via UHA's online portal. If a login has not been established, you may contact UHA at 808-532-4000 to establish one.
- B. Requests must include the following documentation from the medical record:
 - 1. For chronic diffuse bronchiectasis, high resolution or spiral CT confirming diagnosis and documentation supporting that patient has daily productive cough for at least six continuous months or more than two exacerbations per year requiring antibiotic therapy.
 - 2. More than one hospitalization in the past two years.
 - 3. Recent pulmonary function study results.
 - 4. Alternative therapy is ineffective, not tolerated or contraindicated, or the caregiver is unable to provide effective chest therapy.
- C. Authorizations will be given for a rental period of two months. After the two month rental period, the device may be considered for purchase. The physician must submit documentation from the medical record that the patient is compliant with and benefiting from the use of The Vest.

HCPCS Code	Description
E0483	High frequency chest wall oscillation air-pulse generator system, (includes hoses and vest), each
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

V. Policy History

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