Oscillatory Device for Bronchial Drainage (The Vest™)

I. Policy

University Health Alliance (UHA) will reimburse for oscillatory device for bronchial drainage (The Vest™) 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.
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.
3. The patient has been hospitalized more than once for pulmonary related conditions within the past two years.
4. Recent pulmonary function studies demonstrate all of the following:

<table>
<thead>
<tr>
<th>Forced expiratory volume (FEV-1)</th>
<th>&lt; 80 percent of predicted</th>
</tr>
</thead>
<tbody>
<tr>
<td>Forced vital capacity (FVC)</td>
<td>&lt; 50 percent of predicted</td>
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<tr>
<td>Forced expiratory flow (FEF) (25 to 75%)</td>
<td>Has decreased by 25 percent in the past year</td>
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</tbody>
</table>

5. Caregiver is unable to provide effective chest percussion and postural drainage.
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. 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

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

IV. Administrative Guidelines

A. Prior authorization is required. To request prior authorization, please go to UHA’s website:
   http://www.uhahealth.com/forms/form_request_auth.pdf and submit it:

   Via Fax: 1-866-572-4384

   Via Mail:
   UHA Health Care Services
   700 Bishop Street, Suite 300
   Honolulu, HI 96813

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 that 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.

B. 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 the use of The Vest.
<table>
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<tr>
<th>HCPCS</th>
<th>Description</th>
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<tr>
<td>E0483</td>
<td>High-frequency chest wall oscillation air-pulse generator system, (includes hoses and vest), each</td>
</tr>
</tbody>
</table>

V. **Policy History**

**Policy Number:** M.DME.06.120301  
**Current Effective Date:** 03/01/2012  
**Original Document Effective Date:** 03/01/2012  
**Previous Revision Dates:** N/A