

**Mountain State Blue Cross Blue Shield
(Otherwise referred to as the Plan)**

CORPORATE POLICY AND PROCEDURES

TITLE: USE OF HIGH FREQUENCY CHEST WALL OSCILLATORY VEST

No: MP 02	Supersedes No.: N/A	Original Effective Date: 08/31/01
Standards:		Date of Last Review: 09/17/04
Related Policies: N/A		Date of Last Revision: 09/17/04

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DRAFT ()	INTERIM ()	FINAL (X)
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Lines of Business:

Applies To: **FEP (X) PPO (X) POS (X) INDEMNITY (X)**

Variation for: (N/A)

Intended Distribution: **Standard List (X)** **Secondary Review List ()** **Secondary Distribution List:()**

DESCRIPTION

The use of a high frequency chest wall oscillatory vest is a device designed to facilitate the clearance of mucus secretions from the respiratory systems of patients. It operates on the principle of chest percussion, but allows the patient to self-administer the required treatments.

POLICY

Benefits are provided for a high frequency chest wall oscillatory vest device only when all of the following criteria are met:

1. A diagnosis of moderate to severe cystic fibrosis.
2. Prescribed by a pulmonary specialist.
3. Recent pulmonary function studies demonstrating:
 - FEV1 less than 80% of predicted,
 - FVC less than 50% of predicted, and
 - 25% decrease on small airway score over one (1) year

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4. Multiple admissions with a diagnosis of respiratory distress involving inability to clear mucus effectively from the respiratory tract.
 5. Documentation exhibiting a lack of success in using chest physiotherapy or respiratory therapy using a flutter link, or documentation that family members or other caregivers are unavailable or unable to provide effective chest therapy.

CODES

<u>Code</u>	<u>Number</u>	<u>Description</u>
HCPCS	E1399	Durable Medical Equipment, Miscellaneous

REFERENCES

1. CareFirst BlueCross BlueShield, Policy 1.011.12A
2. BlueCross BlueShield of Minnesota, Policy VII-35
3. Nordin BlueCross BlueShield
4. Wellmark (BlueCross BlueShield of Iowa)
5. BlueCross BlueShield of Alabama
6. BlueCross BlueShield of Minnesota
7. Highmark Medical Policy #E-1

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This policy is designed to address medical guidelines that are appropriate for the majority of individuals with a particular disease, illness, or condition. Each person's unique clinical circumstances may warrant individual consideration, based on review of applicable medical records.

Medical policies are designed to supplement the terms of a member's contract. The member's contract defines the benefits available; therefore, medical policies should not be construed as overriding specific contract language. In the event of conflict, the contract shall govern.

Medical policies do not constitute medical advice, nor the practice of medicine. Rather, such policies are intended only to establish general guidelines for coverage and reimbursement under Mountain State Blue Cross Blue Shield plans. Application of a medical policy to determine coverage in an individual instance is not intended and shall not be construed to supercede the professional judgment of a treating provider. In all situations, the treating provider must use his/her professional judgment to provide care he/she believes to be in the best interest of the patient, and the provider and patient remain responsible for all treatment decisions.

Mountain State Blue Cross Blue Shield (MSBCBS) retains the right to review and update its medical policy guidelines at its sole discretion. These guidelines are the proprietary information of MSBCBS. Any sale, copying or dissemination of the medical policies is prohibited; however, limited copying of medical policies is permitted for individual use.

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SIGNATURE PAGE

Approval: _____

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Date: _____

Date: _____