



PRIOR AUTHORIZATION CRITERIA GUIDELINE	
Criteria Guideline Name: DDD - High Frequency Chest Wall Oscillation Vests	PA Number: PAGL DD 1019 DDD P&P 1019
Effective Date: June 19, 2009	Page 1 of 2

PURPOSE:

To establish the process for decision making and prior authorization of the high frequency chest wall oscillation vests for those members not effectively treated using conventional physiotherapy, flutter valve, or other medically accepted therapies, and there are clearly documented medical contraindications to use such therapies.

POLICY:

The high frequency chest wall oscillation vests must be prescribed by a pulmonologist (pediatric or adult), who provides written documentation which includes the criteria for medical necessity.

PROCEDURE:

Criteria for assessment of medical necessity include:

- A. Appropriately documented diagnosis of a condition with the inability to adequately mobilize pulmonary secretions, such as cystic fibrosis, bronchiectasis, or primary ciliary dyskinesia. Other diagnosis will be considered on a case-by-case basis.

- B. Provide documentation of intolerance of or presence of a contraindication to placement of the individual in the proper positions for chest percussion therapy. (Documentation must be provided for review)

- C. Documentation must be provided showing other methods of treatment, such as Flutter device, a cappella PEP valve, hand held mechanical percussor, and other medically acceptable therapies have been tried unsuccessfully

