BECN 20219012253

Prescription and Written Order
(High Frequency Chest Wall Oscillation E0483)

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PLEASE FAX COMPLETED FORM TO: 586-496-7297

First Name:_____ Last Name:_____

Address:_____

City:_____ State:_____ Zip_____

Evening Phone:_____ Daytime Phone:_____

Email:_____ Date of Birth:_____ Gender:_____

ICD10 Diagnosis Code:_____ Primary Diagnosis:_____

Chest Circumference:_____
(Measure fullest part of chest at nipple line)

Abdomen Measurement: _____
(Measure largest circumference of abdomen at belly button line)

Primary Insurance Provider:_____ Secondary Insurance Provider :_____

BELOW THIS LINE TO BE COMPLETED BY A HEALTHCARE PROVIDER ONLY

Airway Clearance Therapy Tried and Failed. This must be documented in the patients progress notes.

Reset Form

1. Have alternative airway clearance techniques been **tried and failed?** ☐ YES ☐ NO

Please indicate methods of airway clearance patient has tried and failed (check all that apply):

- ☐ CPT (manual or percussor)
- ☐ Huff Coughing
- ☐ Hypertonic Saline
- ☐ Oscillating PEP (Flutter, Acapella®, Aerobika®, Pep Valve, Pep Mask)
- ☐ Breathing Techniques
- ☐ Suctioning
- ☐ Mucomyst*
  (*Notes must document it prescribed for secretion mobilization)

2. Check all reasons why the above therapy failed, is contraindicated or inappropriate for this patient:

- ☐ Cannot tolerate positioning/hand CPT
- ☐ Physical limitations of caregiver
- ☐ Gastroesophageal reflux (GERD)
- ☐ Cognitive level
- ☐ Too fragile for hand CPT
- ☐ Caregiver unable to perform adequate CPT
- ☐ Severe arthritis, osteoporosis
- ☐ Unable to form mouth seal
- ☐ Did not mobilize secretions
- ☐ Insufficient expiratory force
- ☐ Resistance to therapy
- ☐ Artificial airway
- ☐ Other

3. For Cystic Fibrosis or Neuromuscular patients, the following must be documented in the patient's progress notes. Please attach records with RX.

- ☐ Documentation supporting diagnosis
- ☐ Tried and failed a lesser airway clearance technique indicated above

4. For Bronchiectasis patients, please check Yes or No to the following question:

Has there been a CT scan confirming Bronchiectasis diagnosis? ☐ YES ☐ NO If "Yes" please include copy of CT scan interpretation.

In addition, the following medical history in the past year must be documented in the patient's progress notes. Please attach records with RX.

- ☐ 3 or more exacerbations, i.e lung infections, requiring antibiotics, documented at least 3 separate times

OR

- ☐ Daily productive cough for at least 6 continuous months

RX: High Frequency Chest Wall Oscillation (HFCWO HCPC E0483)

Start Date: _____ Check need of Length: ☐ Lifetime (99) ☐ Other _____

- ☐ Dispense one AffloVest by International Biophysics Corporation / High Frequency Chest Wall Oscillation System / E0483
- ☐ Frequency of Use (standard): Use the AffloVest at 5Hz–20Hz for 30 minute treatments twice per day (minimum of 15 minutes per day)
- ☐ Frequency of Use (custom): Use the AffloVest at _____ Hz for _____ minutes treatments _____ per day
- ☐ Please check box if nebulizer therapy to be used in conjunction with HFCWO

Physician Signature:_____ Date: _____

Physician Printed Name:_____ NPI Number: _____

Physician Address:_____

City:_____ State:_____ Zip_____

Physician Phone:_____ Fax:_____

Alternate Contact:_____ Phone:_____ Email:_____

Preferred DME:_____

I certify the accuracy of this Rx for the AffloVest Airway Clearance System and that I am the physician identified in this form. I certify that the medical information provided above and in the supplementary documentation is true, accurate, and completed to the best of my knowledge. The patient record contains the supplementary documentation to substantiate the medical necessity of the AffloVest and physician notes will be provided to the authorized AffloVest distributor by request. By providing this form to an authorized AffloVest distributor, I acknowledge that the patient is aware that he or she may be contacted by said distributor for any additional information to process this order.

* AffloVest requires a doctor's prescription for treatment by High Frequency Chest Wall Oscillation (HFCWO). The AffloVest has received the FDA's 510k clearance for U.S. market availability, and is approved for Medicare, Medicaid, and private health insurance reimbursement under the Healthcare Common Procedure Coding System (HCPCS) code E0483 – High Frequency Chest Wall Oscillation. The AffloVest is also available through the U.S. Department of Veterans Affairs/Tricare. Patients must qualify to meet insurance eligibility requirements.

This form is provided by International Biophysics Corp., Manufacturer of the Afflovest. Durable Medical Equipment companies are ultimately responsible for ensuring that the reimbursement criteria for a specific insurance plan and patient situation are satisfied.

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Medicare Approved ICD-10 Codes for AffloVest HFCWO Therapy (HCPCS E0483)

Medicare Requirements for Bronchiectasis:

1. Required: CT Scan confirming diagnosis of bronchiectasis.
   AND
2. Required: Daily productive cough for at least 6 continuous months.
   OR
   Frequent (i.e. more than 2/year) exacerbations requiring antibiotic therapy.
   AND
3. Required: Documentation (chart notes) of another treatment tried to mobilize secretions and clearly indicating the other technique or device has failed.

ICD-10 CODE	DESCRIPTION
J47.0	Bronchiectasis with acute lower respiratory infection
J47.1	Bronchiectasis with (acute) exacerbation
J47.9	Bronchiectasis, uncomplicated
Q33.4	Congenital bronchiectasis

Medicare Requirements for Other Respiratory, Cystic Fibrosis and Neuromuscular Conditions*:

Physician's order that includes: AffloVest prescription, qualifying Dx, chart notes to support the Dx and well-documented failure of standard treatments to adequately mobilize retained secretions.

ICD-10 CODE/DESCRIPTION

J98.6	Disorders of diaphragm
E84.0	Cystic fibrosis with pulmonary manifestations
E84.9	Cystic fibrosis, unspecified
A15.0	Tuberculosis of lung
B91	Sequelae of poliomyelitis
D81.810	Biotinidase deficiency
D81.82	Activated phosphoinositide 3-kinase delta syndrome [APDS]
D84.1	Defects in the complement system
G12.0	Infantile spinal muscular atrophy, type I (Werdnig-Hoffman)
G12.1	Other inherited spinal muscular atrophy
G12.20	Motor neuron disease, unspecified
G12.21	Amyotrophic lateral sclerosis
G12.22	Progressive bulbar palsy
G12.23	Primary lateral sclerosis
G12.24	Familial motor neuron disease
G12.25	Progressive spinal muscle atrophy
G12.29	Other motor neuron disease
G12.8	Other spinal muscular atrophies and related syndromes
G12.9	Spinal muscular atrophy, unspecified
G14	Postpolio syndrome
G35	Multiple sclerosis
G71.00	Muscular dystrophy, unspecified
G71.01	Duchenne or Becker muscular dystrophy
G71.02	Facioscapulohumeral muscular dystrophy
G71.031	Autosomal dominant limb girdle muscular dystrophy
G71.032	Autosomal recessive limb girdle muscular dystrophy due to calpain-3 dysfunction
G71.033	Limb girdle muscular dystrophy due to dysferlin dysfunction
G71.0340	Limb girdle muscular dystrophy due to sarcoglycan dysfunction, unspecified
G71.0341	Limb girdle muscular dystrophy due to alpha sarcoglycan dysfunction
G71.0342	Limb girdle muscular dystrophy due to beta sarcoglycan dysfunction
G71.0349	Limb girdle muscular dystrophy due to other sarcoglycan dysfunction
G71.035	Limb girdle muscular dystrophy due to anoctamin-5 dysfunction
G71.038	Other limb girdle muscular dystrophy
G71.039	Limb girdle muscular dystrophy, unspecified
G71.09	Other specified muscular dystrophies
G71.11	Myotonic muscular dystrophy
G71.12	Myotonia congenita
G71.13	Myotonic chondrodystrophy
G71.14	Drug induced myotonia
G71.19	Other specified myotonic disorders
G71.20	Congenital myopathies
G71.21	Nemaline myopathy
G71.220	X-linked myotubular myopathy
G71.228	Other centronuclear myopathy
G71.29	Other congenital myopathy
G71.3	Mitochondrial myopathy, not elsewhere classified
G71.8	Other primary disorders of muscles
G72.0	Drug-induced myopathy
G72.1	Alcoholic myopathy
G72.2	Myopathy due to other toxic agents
G72.89	Other specified myopathies
G73.7	Myopathy in diseases classified elsewhere
G80.0	Spastic quadriplegic cerebral palsy
G82.50	Quadriplegia, unspecified
G82.51	Quadriplegia, C1-C4 complete
G82.52	Quadriplegia, C1-C4 incomplete
G82.53	Quadriplegia, C5-C7 complete
G82.54	Quadriplegia, C5-C7 incomplete
M33.02	Juvenile dermatomyositis with myopathy
M33.12	Other dermatomyositis with myopathy
M33.22	Polymyositis with myopathy
M33.92	Dermatopolymyositis, unspecified with myopathy
M34.82	Systemic sclerosis with myopathy
M35.03	Sicca syndrome with myopathy

*cms.gov/medicare-coverage-database/view/lcd.aspx?LCDId=33785&ContrID=140