



PLEASE FAX COMPLETED FORM TO: 586-496-7297

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



First Name: _____ Last Name: _____
 Address: _____
 City: _____ State: _____ Zip: _____
 Evening Phone: _____ Daytime Phone: _____
 Email: _____ Date of Birth: _____ Gender: _____
 ICD10 Diagnosis Code: _____ Primary Diagnosis: _____
 Chest Circumference: _____ Abdomen Measurement: _____
(Measure fullest part of chest at nipple line) (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.

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):

- | | |
|----------------------------------------------------|----------------------------------------------------------------------------------------------------------------------|
| <input type="checkbox"/> CPT (manual or percussor) | <input type="checkbox"/> Oscillating PEP (Flutter, Acapella®, Aerobika®, Pep Valve, Pep Mask) |
| <input type="checkbox"/> Huff Coughing | <input type="checkbox"/> Breathing Techniques |
| <input type="checkbox"/> Hypertonic Saline | <input type="checkbox"/> Mucomyst*
<small>(*Notes must document it prescribed for secretion mobilization)</small> |
| <input type="checkbox"/> Suctioning | |

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

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

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 Cystic Fibrosis and Neuromuscular Conditions:

Physicians 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		
A15.0	Tuberculosis of lung	G71.12	Myotonia congenita
B91	Sequelae of poliomyelitis	G71.13	Myotonic chondrodystrophy
D81.810	Biotinidase deficiency	G71.14	Drug induced myotonia
D84.1	Defects in the complement system	G71.19	Other specified myotonic disorders
E84.0	Cystic fibrosis with pulmonary manifestations	G71.2	Congenital myopathies
E84.9	Cystic fibrosis, unspecified	G71.3	Mitochondrial myopathy, not elsewhere classified
G12.0	Infantile spinal muscular atrophy, type I [Werdnig-Hoffman]	G71.8	Other primary disorders of muscles
G12.1	Other inherited spinal muscular atrophy	G72.0	Drug-induced myopathy
G12.20	Motor neuron disease, unspecified	G72.1	Alcoholic myopathy
G12.21	Amyotrophic lateral sclerosis	G72.2	Myopathy due to other toxic agents
G12.22	Progressive bulbar palsy	G72.89	Other specified myopathies
G12.23	Primary lateral sclerosis	G73.7	Myopathy in diseases classified elsewhere
G12.24	Familial motor neuron disease	G82.50	Quadriplegia, unspecified
G12.25	Progressive spinal muscle atrophy	G82.51	Quadriplegia, C1-C4 complete
G12.29	Other motor neuron disease	G82.52	Quadriplegia, C1-C4 incomplete
G12.8	Other spinal muscular atrophies and related syndromes	G82.53	Quadriplegia, C5-C7 complete
G12.9	Spinal muscular atrophy, unspecified	G82.54	Quadriplegia, C5-C7 incomplete
G14	Postpolio syndrome	M33.02	Juvenile dermatomyositis with myopathy
G35	Multiple sclerosis	M33.12	Other dermatomyositis with myopathy
G71.00	Muscular dystrophy, unspecified	M33.22	Polymyositis with myopathy
G71.01	Duchenne or Becker muscular dystrophy	M33.92	Dermatopolymyositis, unspecified with myopathy
G71.02	Facioscapulohumeral muscular dystrophy	M34.82	Systemic sclerosis with myopathy
G71.09	Other specified muscular dystrophies	M35.03	Sicca syndrome with myopathy
G71.11	Myotonic muscular dystrophy	J98.6	Disorders of diaphragm

<https://www.cms.gov/medicare-coverage-database/details/lcd-details.aspx?LCDId=33785&ver=29&CoverageSelection=Local&ArticleType=All&PolicyType=Final&s=Texas&CptHcpcsCode=E0483>