

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 patient's 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 <sup>®</sup> , Aerobika <sup>®</sup> , Pep Valve, Pep Mask) |   |
| <input type="checkbox"/> Huff coughing             | <input type="checkbox"/> Breathing techniques   | <input type="checkbox"/> Mucomyst*  |
| <input type="checkbox"/> Hypertonic saline         | <input type="checkbox"/> Suctioning   | <small>(*Notes must document it is prescribed for secretion mobilization)</small> |

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"/> Other |
| <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             |                                |

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 HCPCS E0483)**

Start Date: \_\_\_\_\_ Check need of Length:  Lifetime (99)  Other \_\_\_\_\_

- Dispense one AffloVest by Tactile Medical/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 \_\_\_\_\_ minute treatments \_\_\_\_\_ per day
- Please check box if nebulizer therapy to be used in conjunction with HFCWO

Physician Signature: \_\_\_\_\_

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.

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

## Tactile Medical

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