AffloVest® BY TACTILE MEDICAL

PRESCRIPTION AND WRITTEN ORDER

(High Frequency Chest Wall Oscillation E0483)

FAX: 866.569.1912

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.

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

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

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

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afflovest.com

Tactile MEDICAL®

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:

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
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
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
G71.09	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
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

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