

# Medicare Checklist for AffloVest (High Frequency Chest Wall Oscillation)

## 1 MEDICAL RECORD

The following must all be well documented in the Medical Record itself

### Reason(s) for ordering AffloVest, such as:

#### Signs & Symptoms



Daily productive (mucus) cough for at least 6 continuous months — or —



Frequent (i.e. more than 2/year) exacerbations/ chest infections requiring antibiotic therapy

### Diagnosis



BRONCHIECTASIS confirmed by a high resolution, spiral or standard CT scan — or —

- Cystic fibrosis
- MS
- MD
- ALS
- Other neuromuscular diseases

### Airway Clearance Therapy TRIED AND FAILED

**Required:** Documentation (chart notes) of another treatment (flutter valve, percussion, postural drainage, breathing techniques, suctioning) tried to mobilize secretions and clearly indicating that the other device has failed.



- Which of the following treatment methods have been tried and failed?\*

- ☐ CPT (Manual or Percussor)
- ☐ PEP (Flutter/Acapella/Aerobika, etc.)
- ☐ Breathing/Drainage Techniques
- ☐ Other

\*Must be well documented in patient chart notes

### Treatment plan

- Recommendation for AffloVest or HFCWO

### Practitioner signature

- Signature must be legible or verified by signature log.
- Medical records must be dated within 12 months prior to order.

## 2 WRITTEN ORDER

Prior to dispensing.

See Reverse for Order Form

## 3 FAX

Medical record and written order to:



289 Foster City Blvd, Suite A  
Foster City, CA 94404  
Main: (650) 357-8550  
Fax: (650) 931-8928  
Email: [orders@chme.org](mailto:orders@chme.org)  
Website: [www.chme.org](http://www.chme.org)

### Medicare approved diagnoses for AffloVest or HFCWO equipment

DESCRIPTION	ICD-10 CODE
CYSTIC FIBROSIS, UNSPECIFIED	E84.9
CYSTIC FIBROSIS WITH PULMONARY MANIFESTATIONS	E84.0
BRONCHIECTASIS WITH ACUTE LOWER RESPIRATORY INFECTION	J47.0
BRONCHIECTASIS WITH (ACUTE) EXACERBATION	J47.1
CONGENITAL BRONCHIECTASIS	Q33.4
BRONCHIECTASIS, UNCOMPLICATED	J47.9

### NEUROMUSCULAR DISEASES

POST-POLIO SYNDROME	G14
GLYCOGEN STORAGE DISEASE DUE TO ACID MALTASE DEFICIENCY	E74.0
SPINAL MUSCULAR ATROPHY, UNSPECIFIED	G12.9
MULTIPLE SCLEROSIS	G35
QUADRIPLEGIA, UNSPECIFIED	G82.50
MUSCULAR DYSTROPHY	G71.0
OTHER SPECIFIED MYOTONIC DISORDERS	G71.19
MYOPATHY, UNSPECIFIED	G72.89
AMYOTROPHIC LATERAL SCLEROSIS	G12.21
DISORDERS OF DIAPHRAGM	J98.6



Distributed By:

## Patient Information

Patient First Name

Patient Last Name

Gender

Date of Birth

Patient Phone Number

Patient Primary Insurance

Policy Number

Height / Weight

Narrative Diagnosis Descriptions &amp; ICD-10 Codes

Patient Chest Circumference (nipple line) &amp; Abdomen Circumference (navel line)

## Prescription / Written Order Prior to Delivery

Start Date: \_\_\_\_\_ Length of Need: ☐ 30 Day Rx ☐ 99 (Lifetime) ☐ 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 10 minutes per day)☐ Frequency of Use (custom): Use the AffloVest at \_\_\_\_\_ Hz for \_\_\_\_\_ minutes treatments \_\_\_\_\_ per day.

Physician Signature (stamped signature not accepted)

Date

Physician Printed Name

NPI Number

Physician Address

City

State

Zip

Physician Phone

Physician Fax

Alternate Contact Name

Phone

Email

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.



International Biophysics Corporation | 2101 E. St. Elmo Road, Building 2, Suite 275, Austin, TX 78744 | 888-711-1145 | AffloVest.com