**REQUEST FOR AIRWAY CLEARANCE DEVICES**

**PLEASE COMPLETE BOTH EVALUATION SEGMENTS DURING THE TRIAL**

***PLEASE SUBMIT COMPLETED FORM TO DME PROVIDER***

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Member ID#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth: \_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_\_

Physician Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ­­Medicaid Provider Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Physician Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City, State, Zip code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­­\_\_\_\_\_\_

Physician Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Physician Fax#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| **Durable Medical Equipment (DME) Requested:**  DME Description: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ HCPCS code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  DME Description: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ HCPCS code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  DME Description: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ HCPCS code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

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| **For Airway Oscillating Devices and Mechanical Percussors:**  1.Does the patient have cystic fibrosis/CF, chronic bronchitis, bronchiectasis, immotile cilia syndrome, or asthma? | Yes No  Comments: |
| **For Positive Expiratory Pressure/PEP Masks:**  1.Does the patient have CF, chronic bronchitis, immotile cilia syndrome, asthma, or chronic obstructive pulmonary disease/COPD? | Yes No  Comments: |
| **For High-Frequency Chest Compression Systems:**  1.Has the patient failed standard treatments to adequately mobilize retained secretions? | Yes No  Comments: |
| 2.Does the patient have bronchiectasis confirmed by CT scan characterized by daily productive cough for at least 6 months or by frequent (more than 2 times per year) exacerbations requiring antibiotic therapy? | Yes No  Comments: |
| 3.Does the patient have cystic fibrosis or immotile cilia syndrome? | Yes No  Comments: |
| 4.Is the patient within the first 6 months post-operatively following lung transplant and unable to tolerate standard chest physiotherapy? | Yes No  Comments: |
| 5.Does the patient have one of the following neuromuscular diseases? | Acid maltase deficiency Hereditary muscular dystrophy Anterior horn cell disease, including amyotrophic lateral sclerosis Multiple Sclerosis Myotonic disorder Paralysis of the diaphragm Post-polio  Quadriplegia Other myopathies |
| **For Mechanical In-Exsufflation Devices:**  1.Does the patient have a neuromuscular disease that is causing a significant impairment of chest wall and/or diaphragmatic movement and for whom standard treatments have not been successful in adequately mobilizing retained secretions? | Yes No  Comments: |
| **There must be well-documented failure of standard treatments to adequately mobilize retained secretions:**  Document trial/consideration of each applicable device/technique trialed listed below, AND why it was not successful for the beneficiary.  CPT (Manual or Percussor) PEP Flutter/Acapella Cough Assist Breathing/Drainage Techniques  No Caregiver Available Physical Limitations of Caregiver GERD Physical Limitations of Patient Did not Mobilize Secretions Young Age Too Fragile for Percussion Resistance to Therapy Aspiration Risk Can’t Tolerate Positioning Insufficient Expiratory Force Artificial Airway Severe Arthritis/Osteoporosis Kyphosis/Scoliosis Cognitive Level Spasticity/Contractures Inability to Form Mouth Seal Other­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Reason for failure: | |

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| Trial Period - item requested must have a 3-month trial period. | First Evaluation: Baseline    \_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ | Final Evaluation (at least 3 months from first): final determination of device efficacy    \_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ |
| Prescription for device use (include minutes/day): |  |  |
| Hospitalizations including dates and reason for admission or IV antibiotic therapy including dates and reason: |  |  |
| Requires assistance to mobilize secretions: | Yes No  N/A | Yes No N/A |
| Adequate physiological cough reflex: | Yes No N/A | Yes No  N/A |
| Pulmonary Functions:  (please attach results) | Pre use of device: | With device use: |
| Daily productive cough:  Duration in months: | Yes No  ­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_ | Yes  No  \_\_\_\_\_\_\_\_\_\_\_ |
| Is member ventilator dependent: | Yes No | Yes No |
| Is there assistance of a caregiver in the home: | Yes No | Yes No |
| Documented adherence to therapy is required:  (please attach data chart) | Yes No | Yes No |
| Education provided to member and family if applicable: | Yes No | Yes No |
| Specify brands trialed: |  |  |
| Other Pertinent Information: |  |  |