**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 [ ] NoComments:  |
| **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 [ ] NoComments:  |
| **For High-Frequency Chest Compression Systems:** 1.Has the patient failed standard treatments to adequately mobilize retained secretions? | [ ] Yes [ ] NoComments:  |
| 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 [ ] NoComments:  |
| 3.Does the patient have cystic fibrosis or immotile cilia syndrome? | [ ] Yes [ ] NoComments:  |
| 4.Is the patient within the first 6 months post-operatively following lung transplant and unable to tolerate standard chest physiotherapy? | [ ] Yes [ ] NoComments:  |
| 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 [ ] NoComments:   |
| **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: |  |  |