# COUGHASSIST THERAPY PRESCRIPTION
# MEDICAL NECESSITY & ASSESSMENT FORM

**VIP Phone: 866-361-2334**

**VIP Fax: 888-522-6861**

**REQUIRED ATTACHMENTS: Patient Demographics, Insurance Card, Medical Records**

## General Patient Information

First Name _____ Last Name _____ Gender _____ Date of Birth _____

Email _____ Phone _____

## Documented in Patient Progress Notes

☐ Unable to cough or clear secretions effectively due to reduced peak cough expiratory flow (less than 5-6 liters/second), resulting from high spinal cord injuries, neuromuscular deficits or severe fatigue associated with intrinsic lung diseases.

☐ Other methods of controlling secretions should have been tried but failed to provide significant response including inhalers, IPPB, incentive spirometry, PEP mask therapy, and flutter devices.

☐ Neuromuscular disease resulting in the inability to clear retained secretions caused by a significant impairment of the chest wall or diaphragmatic movement.

☐ Other:

## Diagnosis DX Codes

**Please Indicate Dx Code(s) 1. _____ 2. _____ 3. _____**

__B91 Sequelae of poliomyelitis __E74.02 Pompe disease __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 __G70.01 Myasthenia gravis with (acute) exacerbation __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 __G71.2 Congenital myopathies __G72.41 Inclusion body myositis [IBM] __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

## Rx: CoughAssist HCPCS: E0482

***Mode:*** ☐ ***manual*** ☐ ***auto*** ***Cough-Trak:*** ☐ ***on*** ☐ ***off*** ***Interface:*** ☐ ***mask A7020*** ☐ ***mouthpiece A7020*** ☐ ***trach adaptoror***

***Inspiratory pressure (range)_____cm H2O*** ***Inspiratory time _____secs.***

***Expiratory pressure (range) _____ ____cm H2O*** ***Expiratory time _____secs.***

***Frequency of treatment_____*** ***Pulse oximetry SpO2 ≤ _____% NA***

☐ ***Titrate to achieve inspiratory pressures of 35-40 cm H2O and expiratory pressures of -35-45 cm H2O or to achieve an effective cough.*** ***If not specific above setting, auto mode will be set as default settings.***

I certify that the information contained on this form is true, accurate and complete to the best of my knowledge. This prescription is for CoughAssit, which according to my professional judgment, is medically necessary for the patient listed above. The patients records contain documentation that supports use of the CoughAssist therapy. I agree to provide such documentation to Pulmonary Solutions upon request. A copy of this order will be retained as part of the patient's medical record.

## Check Length of Need: ☒ Lifetime (99)

Facility Name _____ Address _____ Phone _____ Fax _____

Ordering Physician Name (Please Print) _____ NPI (Required) _____

Pulmonary Solutions personnel may fill in physicians name and NPI prior to physicians signature and date.

Physicians Signature _____ Date _____