Biphasic Cuirass Ventilation Home Care Ordering Information

FAX: 866-667-6740

EMAIL: homecare@breasymedical.com

Documentation and Information to Fax or Email

- ☐ **Patient Demographics and Insurance Information**
- ☐ **Prescription Form (NEXT PAGE – Complete all required areas)**
- ☐ **Letter of Medical Necessity (LMN)**

A letter of medical necessity (LMN) is required to support the order. We have several examples based on the patient's diagnosis.

The contents of the LMN can be copied and incorporated into the medical record OR placed on ordering Clinician letterhead with a signature.

You can review the LMN templates at http://www.breasymedical.com/lmn/

- ☐ **Medical Records**

Required Documentation to include in the Medical Records as required by the Payor.

- ☐ Document in the medical record the need for biphasic cuirass ventilation (BCV) and WHY.
- ☐ Document in the medical record the need for airway clearance therapy and WHY.

Does the patient have Positive Pressure Ventilation (PPV)?

- ☐ YES → Will PPV be discontinued?
  - ☐ YES → Document in the Medical Record the discontinuation of PPV and WHY.
  - ☐ NO → Document in the Medical Record the need of PPV and BCV (in conjunction, or separately)
    - For example, is PPV needed for one part of the day and BCV needed for the other part of the day, OR is PPV needed while using BCV? Document WHY.
- ☐ NO → PPV related documentation is NOT required.

Document in the Medical Record if the patient has tried and failed therapies, contraindicated, or inappropriate and WHY. (Check all that apply):

- ☐ Positive Pressure Ventilation (mask or trach)
- ☐ CPT (manual or percussor)
- ☐ Cannot use other methods
- ☐ Other: _____

Document in the Medical Record why therapies failed, or are contraindicated, or inappropriate for this patient. (Check all that apply):

- ☐ Poor Secretion Mobilization
- ☐ Resistance to therapy
- ☐ Insufficient Expiratory Force
- ☐ Poor lung expansion
- ☐ Physical limitations of patient
- ☐ Recurrent Atelectasis
- ☐ Limitation of caregiver
- ☐ Artificial airway
- ☐ Aspiration Risk
- ☐ Other: _____

Please include Patient Demographic/Face Sheet, Copy of Insurance Card(s), Prescription Form and Medical Records. **FAX all documents to 866-667-6740**.

Prescription Form - The Hayek

Patient Name: _____ Date of Birth: _____

Patient Height: _____ Patient Weight: _____

PROTOCOL - The Standard Settings to be used by patient group / age as selected below. CNEP is required for cuirass Sealing and Recruitment, as needed.

The Hayek, HCPCS: E1399

℞

REQUIRED - Length of Need ☐ 99 months or ☐ other: _____
(1-99 months, 99 months = lifetime)

☐ **INFANT** ☐ **PEDIATRIC** ☐ **ADULT**

Settings adjusted per patient comfort and therapeutic benefit. Use settings best tolerated by patient group selected. Include all necessary supplies. Notify physician of changes. No substitution products permitted.

MODES **Selection of 1, 2 and/or 3 are Required**	**STANDARD SETTINGS**	**STANDARD TIME** **Check frequency of use.**
☐ **1. CNEP** **Negative Pressure Ventilation (NPV)**	**INFANT: - 8 cm** **PEDIATRIC: -10 cm** **ADULT: -15 cm**	☐ **6 – 12 hours daily** ☐ **Nocturnal** ☐ **24 hours daily**
☐ **2. CONTROL** **Biphasic Cuirass Ventilation (BCV)**	**INFANT: -12/+4 cm Rate: 30, I:E 1:1** **PEDIATRIC: -18/+6 cm, Rate: 20, I:E 1:1** **ADULT: -21/+7 cm, Rate: 16, I:E 1:1**	☐ **6 – 12 hours daily** ☐ **Nocturnal** ☐ **24 hours daily**
☐ **3. RESP SYNC** **Biphasic Cuirass Ventilation (BCV) with SYNC**	**INFANT: -12/+4 cm, Backup Rate: 15, I:E 1:1, airway sync** **PEDIATRIC: -18/+6 cm, Backup Rate: 10, I:E 1:1, airway sync** **ADULT: -21/+7 cm, Backup Rate: 8, I:E 1:1, airway sync**	☐ **6 – 12 hours daily** ☐ **Nocturnal** ☐ **24 hours daily**
SECRETION CLEARANCE Repeat cycle 4-5 times	**INFANT: 1000 cpm, -10 cm, 3 mins|36 cpm, -20/+15 cm, 2 mins** **PEDIATRIC: 900 cpm, -20 cm, 3 mins|24 cpm, -25/+20 cm, 2 mins** **ADULT: 800 cpm, -25 cm, 4 mins|24 cpm, -30/+25 cm, 2 mins**	**3 x Daily,** **and as needed**

Other Notes / Custom Settings:

Primary Diagnosis - REQUIRED

Primary Diagnosis ICD10 Code - REQUIRED

Secondary Diagnosis – REQUIRED (if applicable)

Secondary Diagnosis ICD10 Code - REQUIRED (if applicable)

I certify that this standard Rx is for the Hayek System(s). I certify that I am the physician identified in this form. I have reviewed all sections of the physician's written order. Any statement on my letterhead attached hereto has been reviewed and signed by me. I certify that the medical necessity information is true, accurate, and complete to the best of my knowledge. I certify that the patient/caregiver is capable and has or will complete training in utilizing the products prescribed in this Written Order. The patient's record contains supporting documentation which substantiates the utilization and medical necessity of the products listed and physician notes will be provided to an authorized distributor/DME upon request. I understand any falsification, omission or concealment of material fact may subject me to civil or criminal liability. By faxing this form, I am acknowledging that the patient is aware that an authorized distributor/DME may be contacting them for any additional information to process this order. A copy of this order will be retained as part of the patient's medical record.

Physician Signature (Stamp signature not accepted) - REQUIRED

NPI - REQUIRED

Physician Name (PRINT) - REQUIRED

Date - REQUIRED