

MEDICAL JUSTIFICATION FOR AN E0652 COMPRESSION PUMP

(Compression Therapy/Lymphedema Pumps)

Please Print

RVSD 8-2006

Patient Name: _____

PROVIDER NAME/ADDRESS

Medicare #: _____

Phone: _____

****ITEMS BELOW CAN ONLY BE COMPLETED BY PHYSICIAN OR HIS STAFF****

Full payment for code E0652 will only be made when there is documentation that the Individual has unique characteristics that prevent satisfactory pneumatic compression treatment using a non-segmented device (E0650) or a segmented device without manual control of the pressure in each chamber (E0651).

1. Indicate the treatment plan including the pressure in each chamber, and the frequency and duration of each treatment episode:

Pressure setting: Chambers 1 & 2: _____

Chambers 3 & 4: _____

Chambers 5 & 6: _____

Chambers 7 & 8: _____

Duration of Treatment: _____ Frequency: _____

2. Has the patient used another compression pump in the past? _____

E0650 – non-segmented compressor – **results:** _____

E0651 – segmented compressor without calibrated gradient pressure – **results:** _____

3. Why are the features of the E0652 compression pump needed for this patient?

Pain over a specific area of the limb Ulceration or wound on a specific area of the limb

neurological disorder contractures Other pumps were proven ineffective

Other: _____

4. Please indicate the exact type of pump to be provided:

Bio Compression Sequential Circulator – model 3008 (8 chamber gradient, sequential, pneumatic compression device)

Bio Compression Sequential Circulator – model 3004 (4 chamber gradient, sequential, pneumatic compression device)

Physician Name: _____

Phone: _____

Address: _____

UPIN: _____

Physician Signature: _____

Date: _____