Additional Medical History Form – Lymphedema

Place copy in patient's medical chart.

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Patient Information

_____ _____
Name *DOB*

Medical Necessity Information

1. Diagnosis: ☐ Primary Lymphedema (Congenital) Q82.0 ☐ Post-mastectomy Lymphedema I97.2
☐ Acquired Lymphedema I89.0 ☐ Secondary due to surgery I97.89

2. Location of Lymphedema:

	Swelling	Fibrosis	Pain		Swelling	Fibrosis	Pain		Swelling	Fibrosis	Pain
Feet	☐	☐	☐	Right Upper Leg	☐	☐	☐	Left Arm	☐	☐	☐
Left Upper Leg	☐	☐	☐	Right Lower Leg	☐	☐	☐	Right Arm	☐	☐	☐
Left Lower Leg	☐	☐	☐	Underarm/Axilla	☐	☐	☐	Hand(s)	☐	☐	☐

3. Patient is currently experiencing the following related complications/impairments:

☐ Unable to control swelling ☐ Fibrosis ☐ Pain ☐ Impaired ROM ☐ Compromised skin integrity
☐ Impaired mobility ☐ Contractures ☐ Scarring ☐ Infections

4. What home treatments has patient been performing for the past 4 weeks?

	Yes	No		Yes	No
Compression garments and bandaging	☐	☐	Exercise	☐	☐
Manual Lymph Drainage	☐	☐	Elevation	☐	☐

Comments: _____
_____
_____

Patient has the following barriers to using compression garments:
☐ None ☐ Adverse reaction ☐ Unable to don/doff ☐ Unable to afford ☐ Unable to accommodate size

Patient tried and failed* home treatments for at least 4 weeks? Yes No **Failure defined as significant symptoms remain or no significant improvement.*

5. Patient tried and failed a basic pump? *Basic pump defined as uncalibrated segmental pressure pump (E0651)* Yes No

If yes, after trials with the basic pump, the patient was unable to tolerate due to:
☐ Exacerbated symptoms ☐ Compromised skin integrity ☐ Pain ☐ Unable to accommodate size ☐ No clinical improvement

Name/Signature of Person Answering Questions *(if other than physician)*

_____ _____ _____
Name *Signature* *Date*

Physician Certification and Signature

I certify that this patient is under my care and the above medical necessity information is true and accurate to the best of my knowledge.

_____ _____ _____
Physician Name *Signature* *Date*

11/2017

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*Please refer to this guide when completing the **Additional Medical History Form — Lymphedema**. The requirements listed below are necessary to obtain coverage by most insurers.*

Lymphedema

1. **Diagnosis**
   The patient must have a diagnosis of Lymphedema which has failed* to resolve after a 4-week trial of conservative therapy. The types of Lymphedema approved for coverage by most commercial insurers are Congenital Lymphedema, Post-mastectomy Lymphedema, and Acquired Lymphedema Secondary to Surgery or Cancer.
   **Failure is defined as significant symptoms remain or no significant improvement.*

2. **Location of Lymphedema**
   At least one part of lower extremity (ie: upper/lower/foot) **OR** upper extremity (ie: upper/lower/hand/underarm/axilla), needs to have swelling, fibrosis, and/or pain documented.

3. **Complications/Impairments**
   Document any of the complications that your patient is experiencing due to Lymphedema.

4. **Home Treatments**
   Patients must have tried and failed* conservative therapy** for a minimum of 4 weeks.
   **Failure is defined as significant symptoms remain or no significant improvement.*
   ***Conservative therapies must include: either compression garments or compression bandaging, exercise, elevation, and if appropriate, MLD.*
   - Exercise includes ambulation and does not have to be a formal exercise program.

5. **Basic pump**
   Some insurers require a treatment trial with a “basic pump” (an E0651) before they will cover an E0652 device. If your patient has tried and failed* a basic pump, please document that here.
   **Failure is defined as significant symptoms remain or no significant improvement.*

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