Medical Management & Policy
Fax Number 412-544-2921

Certificate of Medical Necessity (CMN) for Lymphedema Pump

Date: ____/_____/_____ **Requesting Provider: _____**

Pt. Name: _____ **I.D. Number: _____**

1. What diagnosis/condition does the patient have to warrant the use of a Lymphedema Pump?

   What are the clinical findings?

   What is the expected frequency of use?

   What is the expected duration of use?

   What are the pump pressures to be used?

2. For the Lymphedema, has the patient undergone a four-week trial of conservative therapy, including use of an appropriate compression bandage system or compression garment, exercise, and elevation of the limb, with no significant improvement? Y N D

3. If the diagnosis is chronic venous insufficiency (CVI):
   a. Are there 1 or more non-healing venous stasis ulcers? Y N D
   b. For CVI, have 6 months of conservative therapy been tried and failed? Y N D

Additional Clinical Rationale (Print):

Contact Name: _____ **Phone :_____**

_____ _____

Physician Signature (Stamps are not acceptable) **Date**

Key - **(Y)**es, **(N)**o, **(D)**oes not apply

Requested Information:
1. Typed office note with pertinent information.

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