ACTitouch™
Adaptive Compression Therapy

flexitouch®

Medicare Coverage Criteria for Chronic Venous Ulcers

Pneumatic Compression Devices E0651 (ACTitouch) and E0652 (Flexitouch)

How to initiate a Medicare order:

Fax a copy of the patient's medical record face sheet to 866.435.3949. After we have verified Medicare is the patient's primary insurance, a Medicare Specialist will contact you to discuss which pneumatic compression device is appropriate for the patient based upon Medicare's coverage criteria outlined below, and will then work with you to complete the necessary forms and documentation.

Patient's medical records must include the following to meet criteria for either an E0651 or an E0652 device:

☐ **Documented diagnosis of chronic venous insufficiency with nonhealing venous ulcer(s)**	Documentation must include 6 months **continuous** treatment of a nonhealing venous stasis ulcer.
☐ **Objective findings that establish the severity of the condition**	Medical record must include: • Location of venous stasis ulcer(s) • How long each ulcer has been present • Ulcer(s) measurements • Other findings that demonstrate severity including levels of edema and exudate
☐ **Record of conservative therapies used for at least the previous 6 months**	Use of all conservative therapies must be documented for a minimum of 6 months, including: • Compression bandage system or compression garment • Appropriate wound dressing • Exercise • Elevation
☐ **Physician oversight**	Evidence in medical record of regular physician visits for treatment of venous ulcer(s) during the last 6 months.
☐ **Significant symptoms remain following conservative therapies**	Medical record shows ulcer(s) remain nonhealing despite 6 months continuous treatment with conservative therapies.

Medicare denies coverage when all questions on the Certificate of Medical Necessity (CMN) are answered "no". Tactile Medical offers self-pay options for patients that do not meet Medicare criteria.

CONTINUES ON REVERSE

Patient's medical records must additionally include the following to meet Medicare criteria for an E0652 device:

☐ **Trial of a basic* pump** **A "basic" pump (E0650 or E0651) is defined for these purposes as a noncalibrated pressure pump with no appliances to treat the trunk or chest.*	Medicare says that before paying for an advanced (E0652) pump, a less costly basic pump must be used to determine if it meets the patient's medical need. Documentation of a basic pump trial should include: • Dates and/or timeframe the pump was used • Treatment plan including pressure settings • Measurements before and during trial to show outcomes on ulcer healing and swelling • Patient's ability to tolerate the pump • Type/make/model of pump
☐ **Unique characteristics that prevented satisfactory treatment with basic pump**	The following are examples of possible "unique characteristics" that may prevent satisfactory pneumatic compression with the basic pump: • Pain or clear intolerance to the pump's pressures – Location and severity of pain – Modification made to attempt to alleviate pain – Comorbidities that may contribute to pain • Venous ulcer(s) not responding, increasing in size, or presentation of additional ulcers • Development of significant objective swelling/fibrotic cuff proximal to pump sleeve – Modifications made to attempt to alleviate proximal symptoms
☐ **Justification for medical necessity of advanced (E0652) pump**	Record should discuss what clinical symptoms remain that require the features of an advanced (E0652) pump and why the advanced pump should produce better results than previously tried pump.

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