

Patient Order Kit Non-Medicare



TACTILE SYSTEMS TECHNOLOGY INC.

1331 Tyler Street NE, Suite 200
Minneapolis, Minnesota 55413 USA

TEL: 866.435.3948
FAX: 866.435.3949

Hours of Operation
Monday-Friday 8 a.m. to 5 p.m. CT

www.flexitouch.com

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D/N: Packet 01-2300 Rev. F 10/2009

PATIENT INFORMATION														
LAST NAME		FIRST NAME		MI	GARMENT SET(S) REQUIRED <table border="0"> <tr> <td></td> <td>LEFT</td> <td>RIGHT</td> </tr> <tr> <td>Upper extremity</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>Lower extremity</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> </table>		LEFT	RIGHT	Upper extremity	<input type="checkbox"/>	<input type="checkbox"/>	Lower extremity	<input type="checkbox"/>	<input type="checkbox"/>
	LEFT	RIGHT												
Upper extremity	<input type="checkbox"/>	<input type="checkbox"/>												
Lower extremity	<input type="checkbox"/>	<input type="checkbox"/>												
ADDRESS														
CITY			STATE	ZIP										
PRIMARY PHONE	SECONDARY PHONE <input type="checkbox"/> CELL <input type="checkbox"/> WORK <input type="checkbox"/> OTHER		FAX	EMAIL										
DATE OF BIRTH	GENDER <input type="checkbox"/> Female <input type="checkbox"/> Male		SOCIAL SECURITY NUMBER											
EMPLOYER		EMERGENCY CONTACT NAME		EMERGENCY CONTACT PHONE										
How did you hear about the Flexitouch System? <input type="checkbox"/> Physician <input type="checkbox"/> Therapist <input type="checkbox"/> Internet <input type="checkbox"/> Friend <input type="checkbox"/> Advertisement <input type="checkbox"/> Other: _____														
INSURANCE INFORMATION														
TYPE OF INSURANCE PLEASE CHECK <input type="checkbox"/> PRIVATE HEALTH INSURANCE <input type="checkbox"/> WORKER'S COMP <input type="checkbox"/> MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> SELF-PAY														
DATE OF INJURY IF WORKER'S COMP			WORKER'S COMP CLAIM NUMBER											
PRIMARY INSURANCE COMPANY				PHONE NUMBER										
NAME OF POLICY HOLDER			PATIENT'S RELATIONSHIP TO POLICYHOLDER <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other											
DATE OF BIRTH OF POLICY HOLDER			EMPLOYER											
IDENTIFICATION NUMBER		GROUP NUMBER												
SECONDARY INSURANCE COMPANY				PHONE NUMBER										
NAME OF POLICY HOLDER		DATE OF BIRTH OF POLICY HOLDER		PATIENT'S RELATIONSHIP TO POLICYHOLDER <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other										
IDENTIFICATION NUMBER		GROUP NUMBER												
PHYSICIAN INFORMATION														
PRESCRIBING PHYSICIAN'S NAME				NPI (NATIONAL PROVIDER IDENTIFIER)										
CLINIC NAME		PHONE		FAX										
ADDRESS		CITY		STATE	ZIP									
THERAPIST INFORMATION														
THERAPIST'S NAME			FACILITY/CLINIC NAME											
WORK EMAIL	APPROVED TO EMAIL DOCUMENTS <input type="checkbox"/> YES <input type="checkbox"/> NO		PHONE		FAX									
ADDRESS		CITY		STATE	ZIP									



Medical Necessity Form and Prescription for the Flexitouch® System

Place copy in patient's medical chart.

PATIENT INFORMATION		SUPPLIER INFORMATION
NAME	DOB	TACTILE SYSTEMS TECHNOLOGY, INC. 1331 Tyler Street NE, Suite 200 Minneapolis, MN 55413 Phone: 866.435.3948 FAX: 866.435.3949 NPI: 1427131424
ADDRESS		
CITY/STATE/ZIP	PHONE	

MEDICAL NECESSITY INFORMATION (Information in this section may not be completed by the supplier of the item)		
DIAGNOSIS (ICD-9 CODE) [Check all that apply] <input type="checkbox"/> Primary (Congenital) Lymphedema (757.0) <input type="checkbox"/> Postmastectomy Lymphedema (457.0) <input type="checkbox"/> Secondary/Other Lymphedema (457.1) <input type="checkbox"/> Venous Insufficiency (459.81) <input type="checkbox"/> Other: _____	LYMPHEDEMA IS SECONDARY TO: Cancer <input type="checkbox"/> Breast <input type="checkbox"/> Other/Type: _____ Relevant Medical History <input type="checkbox"/> Lymph Node Dissection <input type="checkbox"/> Chemotherapy <input type="checkbox"/> Radiation	
		Non-Cancer (Please describe) <input type="checkbox"/> Trauma: _____ <input type="checkbox"/> Infection: _____ <input type="checkbox"/> Surgery: _____ <input type="checkbox"/> Other: _____

PRIOR LYMPHEDEMA TREATMENT	
① Has patient tried and failed* a minimum of 4 weeks of home conservative therapy, defined as bandaging and/or compression garments, exercise and elevation? *Failure defined as significant symptoms remain or no significant improvement. <input type="checkbox"/> YES <input type="checkbox"/> NO	② Has patient used a "pneumatic device" other than Flexitouch system? <input type="checkbox"/> YES <input type="checkbox"/> NO Why was it discontinued? (Check all that apply) <input type="checkbox"/> Not effective <input type="checkbox"/> Unable to tolerate pressures <input type="checkbox"/> Exacerbated symptoms <input type="checkbox"/> Developed Fibrotic Cuff <input type="checkbox"/> Other: _____
Why hasn't another device been tried? (Check all that apply) <input type="checkbox"/> Inability to treat trunk <input type="checkbox"/> Unable to tolerate pressures <input type="checkbox"/> Likelihood of tissue damage <input type="checkbox"/> Likelihood of genital edema <input type="checkbox"/> Other: _____	

PRESCRIPTION FOR THE FLEXITOUCH SYSTEM														
PROGRAM FREQUENCY (Select one) UNILATERAL <input type="checkbox"/> 1 treatment daily. <input type="checkbox"/> 2 treatments daily. <input type="checkbox"/> ___ treatment(s) daily for ___ weeks, then 1 treatment daily thereafter. BILATERAL <input type="checkbox"/> 1 treatment every A.M. for left extremity; 1 treatment every P.M. for right extremity. <input type="checkbox"/> 1 treatment one day for left extremity followed by 1 treatment next day for right extremity; continue alternating daily.	PROGRAM SELECTION AND DURATION (Check all that apply) <table border="1"> <thead> <tr> <th>REGION</th> <th>PROGRAM</th> <th>APPROX. TIME</th> </tr> </thead> <tbody> <tr> <td><input type="checkbox"/> Upper Extremity: Full treatment</td> <td>U1</td> <td>60 minutes</td> </tr> <tr> <td><input type="checkbox"/> Lower Extremity: Full treatment</td> <td>L1</td> <td>60 minutes</td> </tr> <tr> <td colspan="3"><input type="checkbox"/> Other: _____</td> </tr> </tbody> </table>		REGION	PROGRAM	APPROX. TIME	<input type="checkbox"/> Upper Extremity: Full treatment	U1	60 minutes	<input type="checkbox"/> Lower Extremity: Full treatment	L1	60 minutes	<input type="checkbox"/> Other: _____		
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ANATOMIC REGIONS WITH EDEMA (Check all that apply) <table border="1"> <thead> <tr> <th>LEFT</th> <th>RIGHT</th> <th></th> <th></th> </tr> </thead> <tbody> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/> Chest</td> <td><input type="checkbox"/> Trunk</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/> Back</td> <td><input type="checkbox"/> Genital/Perineum</td> </tr> </tbody> </table>	LEFT	RIGHT			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Chest	<input type="checkbox"/> Trunk	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Back	<input type="checkbox"/> Genital/Perineum	DISTAL PRESSURE (Select one) <input type="checkbox"/> Normal <input type="checkbox"/> Increased	LENGTH OF NEED (Select one) <input type="checkbox"/> Lifetime (over 13 months) <input type="checkbox"/> Other: _____
LEFT	RIGHT													
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Chest	<input type="checkbox"/> Trunk											
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Back	<input type="checkbox"/> Genital/Perineum											

COMPLICATIONS AND FUNCTIONAL IMPAIRMENT (Check all that apply) <input type="checkbox"/> Infection(s) <input type="checkbox"/> Fibrosis <input type="checkbox"/> Compromised skin integrity <input type="checkbox"/> Psychosocial issues <input type="checkbox"/> Required hospitalization(s) <input type="checkbox"/> Pain <input type="checkbox"/> Impaired ROM <input type="checkbox"/> Isolation <input type="checkbox"/> Depression <input type="checkbox"/> Required IV antibiotic(s) <input type="checkbox"/> Impaired ADLs <input type="checkbox"/> Impaired body image			
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NAME OF PERSON COMPLETING FORM IF OTHER THAN PHYSICIAN	
NAME	PHONE
SIGNATURE	FACILITY/CLINIC

PHYSICIAN CERTIFICATION AND SIGNATURE. I certify that this patient is under my care, the equipment is medically necessary, and there are currently no contraindications* that prohibit use of the prescribed equipment. I also certify that the medical information above is true and accurate to the best of my knowledge. (*Infections/inflammation, deep vein thrombosis [DVT], increased lymphatic return is undesirable, acute cancer, thrombophlebitis, episodes of pulmonary embolism, congestive heart failure [CHF] and pulmonary edema.)			
PRESCRIBER'S NAME	DATE (Required)	PRESCRIBER'S SIGNATURE	NPI

Guidelines for Completion of the Medical Necessity Form for the Flexitouch® System

Patient Information: Enter all pertinent patient information, including mailing address, phone number, and date of birth.

Medical Necessity Information

Diagnosis (ICD-9 Code): Check 757.0 for congenital or primary lymphedema. For secondary lymphedema, check 457.0 for postmastectomy lymphedema or 457.1 for other lymphedema. For Venous Insufficiency check 459.81. Check other and indicate the applicable ICD-9 code for all other diagnoses.

Lymphedema is Secondary to: Complete this section for all secondary lymphedema conditions. Please be sure to provide detail on the lines provided as this information is required by third party payers to determine payment authorization.

Prior Treatment Questions:

Question 1: Indicate whether patient has undergone a minimum of 4 weeks of home conservative therapy (bandaging/garments, exercise, elevation) prior to the prescription for the Flexitouch system. Payers require patients to have tried and failed more conservative therapies before they will consider the Flexitouch system.

Question 2: Indicate whether patient has used a pneumatic device other than the Flexitouch system. This refers to any *traditional* compression pump the patient may have tried in the past. If YES, please indicate the reason(s) the *traditional* pump was discontinued –OR– if NO previous pump has been tried, indicate the reason(s) why a pump has not been used or recommended.

Prescription for the Flexitouch System

Program Frequency (Select one): Indicate applicable therapy treatment plan. The recommended unilateral treatment plan is *1 treatment daily or 2 treatments daily depending on the severity and desired outcomes*. The recommended bilateral treatment plan is *1 treatment in A.M. for left extremity and 1 treatment in P.M. for right extremity*. If the clinician feels that another specified treatment plan is more appropriate, indicate the desired treatment plan in the space provided.

Program Duration (check all that apply; must select at least one): Please complete this section to indicate the prescribed treatment specific to your patient.

To prescribe the Upper Extremity Treatment Program, please check the “Upper Extremity: Full Treatment” box. To prescribe the Lower Extremity Treatment Program, please check the “Lower Extremity: Full Treatment” box. If the patient requires additional focused treatment for the upper extremity or lower extremity, please select the appropriate program from the table below and write the corresponding anatomic region and program number in the space provided. Additional programs offer focused treatment on specific anatomic regions, and are not recommended as a stand alone treatment. For the treatment of bi-lateral lower extremity, it is recommended that the program of “Trunk only” (L2) be done in addition to the “Lower Extremity: Full Treatment” (L1) program.

Upper Extremity Additional Programs	Anatomic Region Treated	Approximate Time (minutes)
U2	Trunk only	12
U3	Trunk, chest only	24
U4	Bicep, forearm, hand only	36
U5	Forearm, hand only	24
U6	Hand only	12

Lower Extremity Additional Programs	Anatomic Region Treated	Approximate Time (minutes)
L2	Trunk only	15
L3	Trunk, thigh only	30
L4	Thigh, calf, foot only	45
L5	Calf, foot only	30
L6	Foot only	15
L7	Calf, foot <i>Drainage</i> only	30

Anatomic Regions with Edema: Please accurately indicate all anatomic regions that have edema and require treatment. Oftentimes patients have edema in the trunk, chest or perineal areas that has not been previously noted. It is especially pertinent for justification for the Flexitouch system, as this system is unique in that it treats the trunk/pelvic areas in addition to the affected extremities.

Complications and Functional Impairment: Indicate any and all complications and functional impairment the patient has experienced as a result of lymphedema.

Name of person completing form: If other than the physician, this section needs to be completed and signed.

Physician Certification and Signature: The information on this form **MUST** be certified and signed by a physician or other health care professional (i.e. CRNP) licensed to prescribe durable medical equipment in the state where the equipment was prescribed. This certification must also verify that none of the contraindications listed prohibit use of the prescribed equipment.

Treatment Information E0652 Pneumatic Compression Device Flexitouch System

**Place Copy
in Patient's
Medical Chart**

PATIENT INFORMATION				GARMENT SET(S) REQUIRED	
NAME			DOB	LEFT	RIGHT
				Upper extremity	<input type="checkbox"/> <input type="checkbox"/>
				Lower extremity	<input type="checkbox"/> <input type="checkbox"/>
ADDRESS	CITY	STATE	ZIP	HEIGHT	WEIGHT

CONTRAINDICATIONS

Does the patient **currently** have any of the contraindications listed? **No** **Yes** (Please indicate below, check all that apply)

Infections/Inflammation
 Deep Vein Thrombosis (DVT)
 Increased Lymphatic Return is undesirable
 Acute Cancer
 Thrombophlebitis
 Episodes of Pulmonary Embolism
 Congestive Heart Failure (CHF)
 Pulmonary Edema

Did the patient receive a treatment demonstration with the Flexitouch system?

YES, complete only the **Demonstration Results** section below.
 NO, complete only the **Ordering Information** section below.

DEMONSTRATION RESULTS

Date of Demonstration: _____

UPPER EXTREMITY MEASUREMENTS (cm)			LOWER EXTREMITY MEASUREMENTS (cm)		
Arm Inseam			Leg Inseam		
Place the arm close to the side. Measure from the tip of the longest finger to the axilla. Record the measurements.					
	PRE	POST		PRE	POST
Waist			Hips		
Chest			Thigh		
Bicep			Knee		
Forearm			Calf		
Wrist			Ankle		

ORDERING INFORMATION

UPPER EXTREMITY REQUIRED MEASUREMENTS (cm)

Arm Inseam		
Place the arm close to the side. Measure from the tip of the longest finger to the axilla. Record the measurements.		
	MAX*	PATIENT
Waist	190 cm	
Chest	160 cm	
Bicep	60 cm	

LOWER EXTREMITY REQUIRED MEASUREMENTS (cm)

Leg Inseam		
While standing, place the heel on the floor. Measure from the bottom of heel to the groin. Record the measurements.		
	MAX*	PATIENT
Hips	228 cm	
Thigh	89 cm	
Calf	66 cm	

CLINICAL RESPONSE TO TREATMENT DEMONSTRATION

Patient is capable of donning/doffing the garments or they have a caregiver capable of assisting them to don/doff the garments? Yes No

Patient is able to tolerate the treatment session? Yes No

Clinician's Comments:

*If measurements exceed the listed maximum (MAX), please contact Patient Services at 866.435.3948 prior to ordering.

CLINICIAN CERTIFICATION AND SIGNATURE

I attest that the clinical information and measurements set forth above are true and accurate based on my personal participation in and observation of the demonstration.

CLINICIAN'S NAME (Please print)

CLINICIAN'S SIGNATURE DATE

Check box if a Spanish User Guide is needed.

Special Instructions

IR



Patient Consent

Consent for the Use and Disclosure of Protected Health Information

I understand that Tactile Systems Technology, Inc. (Tactile) originates, collects and maintains paper and/or electronic records describing my Protected Health Information (PHI) such as health history, diagnosis, symptoms, test results, etc. I consent to the use and disclosure of my PHI by Tactile, its staff, and its business associates for treatment, payment and health care operations.

I understand I have a right to request restrictions or revoke any use and/or disclosure of my PHI by Tactile. A detailed description of my rights was provided to me in the Notice of Privacy Practices.

I consent to the release of PHI by Tactile to my health care providers and insurance company(ies). I authorize and consent to the release by my health care providers to Tactile and any insurance company(ies), all PHI necessary to secure payment for the Flexitouch® system (Flexitouch).

I understand Tactile may desire to review de-identified health information for the purposes of clinical research, evaluation of patient outcomes, clinical protocol development or other commercial purposes. I consent to the release and use of my de-identified information so long as Tactile ensures that I cannot be identified through release and use of that information.

Consent to Assist

I understand that Tactile will take the necessary steps to secure authorization and payment for the Flexitouch on my behalf. I agree to cooperate with that process, including using the Flexitouch as prescribed. In the event that Tactile is unable to obtain authorization and payment for the Flexitouch, I understand Tactile will contact me regarding options for obtaining the Flexitouch.

Assignment of Benefits

I assign payment of medical benefits for the Flexitouch to Tactile and direct any payer to make payment on my behalf directly to Tactile. I understand that all costs of the Flexitouch not covered by my insurance are my responsibility.

Consent to Leave Messages

I authorize Tactile to leave voice mail messages for me regarding medical and/or billing information at the following number(s):

(_____) _____ (_____) _____

I authorize Tactile to leave messages with or respond to inquiries from the following individual(s):

_____	_____	_____
Name	Relationship	Phone
_____	_____	_____
Name	Relationship	Phone

I do not authorize Tactile to leave voice mail messages containing medical or billing information.

I authorize Tactile to contact me by email regarding the Flexitouch: _____
Email Address

By signing this, I agree to all the terms and conditions listed above.

_____	_____	_____
Patient Name (Please print)	Patient Signature	Date
_____	_____	_____
Guardian Name (If applicable, please print)	Guardian Signature	Date

Please return completed form to Tactile Systems Technology, Inc.
Mail: 1331 Tyler Street NE, Suite 200, Minneapolis, MN 55413 **Fax:** 866.435.3949
To speak with a Patient Services representative, call toll-free: 866.435.3948



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Tactile Systems Technology, Inc.

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

Uses and Disclosures

Treatment. Your health information may be used by staff members or disclosed to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment.

Payment. Your health information may be used to seek payment from your health plan, from other sources of coverage such as an automobile insurer, or from credit card companies that you may use to pay for services.

Health care operations. Your health information may be used as necessary to support the day-to-day activities and management of Tactile Systems Technology. For example, information on the services you received may be used to support budgeting and financial reporting, and activities to evaluate and promote quality.

Law enforcement. Your health information may be disclosed to law enforcement agencies to support government audits and inspections, to facilitate law enforcement investigations, and to comply with government mandated reporting.

Public health reporting. Your health information may be disclosed to public health agencies as required by law.

Other uses and disclosures require your authorization. Disclosure of your health information or its use for any purpose other than those listed above requires your specific written authorization. If you change your mind after authorizing a use or disclosure of your information you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision to revoke your authorization.

Additional Uses of Information

Information about treatments. Your health information may be used to send you information that you may find interesting on the treatment and management of your medical condition. We may also send you information describing other health related products and services that we believe may interest you.

Individual Rights

You have certain rights under the federal privacy standards. These include:

- the right to request restrictions on the use and disclosure of your protected health information
- the right to receive confidential communications

- concerning your medical condition and treatment
- the right to inspect and copy your protected health information
- the right to amend or submit corrections to your protected health information
- the right to receive an accounting of how and to whom your protected health information has been disclosed
- the right to receive a printed copy of this notice

Tactile Systems Technology's Duties

We are required by law to maintain the privacy of your protected health information and to provide you with this notice of privacy practices. We also are required to abide by the privacy policies and practices that are outlined in this notice.

Right to Revise Privacy Practices

As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required by changes in federal and state laws and regulations. Upon request, we will provide you with the most recently revised notice on any office visit. The revised policies and practices will be applied to all protected health information we maintain.

Requests to Inspect Protected Health Information

You may generally inspect or copy the protected health information that we maintain. As permitted by federal regulation, we require that requests to inspect or copy protected health information be submitted in writing. You may obtain a form to request access to your records by contacting the privacy officer. Your request will be reviewed and will generally be approved unless there are legal or medical reasons to deny the request.

Complaints

If you would like to submit a comment or complaint about our privacy practices, you can do so by sending a letter outlining your concerns to:

Privacy Officer
Tactile Systems Technology, Inc.
1331 Tyler Street NE, Suite 200
Minneapolis, MN 55413

If you believe that your privacy rights have been violated, you should call the matter to our attention by sending a letter describing the cause of your concern to the same address. You will not be penalized or otherwise retaliated against for filing a complaint.

Contact Person

The name and address of the person you can contact for further information concerning our privacy practices is:

Privacy Officer
Tactile Systems Technology, Inc.
1331 Tyler Street NE, Suite 200
Minneapolis, MN 55413
612-355-5100

Effective Date

This Notice is effective on or after April 14, 2003.

D/N: 01-2125 Rev C 12/2009

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(PATIENT COPY)