Initiation of Negative Pressure Wound Therapy

Fax to (630) 420-0360 • Phone (630) 420-0308

PATIENT INFORMATION

Order date ____________________

Patient name ____ DOB ____________________
Last First MI

Address ____________________ City ____________________ State __________ Zip __________

Home phone ____________________ Mobile phone ____________________

REFERRAL INFORMATION

Referral name ____________________ Referral contact name ____________________

Phone ____________________ Fax ____________________

Form completed by ____________________ with information provided by ____________________ at ____________________
Name and credentials Facility

PRESCRIPTION, ATTESTATION AND TREATING PRESCRIBER INFORMATION

This form is required unless a separate detailed written order for NPWT is provided. Physician must clearly document in the patient's medical record that other modalities have been tried, or clearly document why other modalities are being ruled out.

Diagnosis Code ICD-10. Write in complete code(s): ______________________________

Equipment and Supplies Prescribed:

I prescribe a Negative Pressure Wound Therapy Pump (E2402), and up to 15 dressing kits (A6550) per wound per month and up to 10 canister sets (A7000) per month.

Supplies Needed *(Please choose ONE size and dressing type)*

Size	Dressing Kits		Other: (Channel Drains, Y Connectors or Other)
	Foam	Gauze	
Small	☐		☐ ____________________
Medium (Most Common Size)	☐	☐	☐ ____________________
Large	☐	☐	☐ ____________________

Other ______________________________

Number of months: ☐ 1 month ☐ 2 months ☐ 3 months ☐ 4 months ☐ Other ____________________

Pressure setting ____________________ Frequency of dressing changes ____________________

Wound location and measurements MUST be documented in patient's chart notes, using the format Length x Width x Depth. Wound measurement date and unit of measure also must be included.

By signing and dating, I attest that I am prescribing Negative Pressure Wound Therapy as medically necessary and all other applicable treatments have been tried or considered and ruled out. I have read and understand all safety information and other instructions for use included with therapy clinical guidelines. Additionally, I have reviewed the information provided in this form and attest to its accuracy.

Prescriber name ______________________________ **NPI #** ____________________

Address ____________________ **City** ____________________ **State** __________ **Zip** __________

Phone ____________________ **Fax** ____________________

Prescriber signature ______________________________ **Date** ____________________

Treating prescriber's original signature and date are required (no stamps).

Initiation of Negative Pressure Wound Therapy Authorization Form

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Patient name ______________________________ DOB ______________
Last First MI

PATIENT DELIVERY

Requested delivery date ______________ **Requested delivery time** ______________

☐ **Hospital Delivery** Hospital/facility name ______________________

Room number__________ Direct phone number to patient's room ______________

Address ______________________ City ______________ State ______ Zip ______

Anticipated discharge date ______________

☐ **Delivery to Patient's Home** — SAME ADDRESS AS LISTED ON THE FIRST PAGE OF THIS ORDER FORM

OR

☐ **Delivery to Alternate Address** Phone ______________

Address ______________________ City ______________ State ______ Zip ______

SECTION 3

PATIENT FOLLOW-UP CARE

Name of Home Health Agency following the patient______________________

Phone______________________ Fax ______________________

Name of Wound Care Clinic following the patient (if applicable) ______________________

Phone______________________ Fax ______________________

COMMON ICD-10 CODES FOR NEGATIVE PRESSURE WOUND THERAPY

Since NPWT is not diagnosis-driven, there is not a defined set of codes that must be used with this equipment. There are many other ICD-10 codes for which Negative Pressure Wound Therapy can be used. This is simply a short list of commonly used codes. Presence of an ICD-10 code alone does not guarantee coverage of a NPWT device.

A specific ICD-10 code ust be provided either on page 1 or in the patient's chart notes. Please list the appropriate qualifying diagnosis and write in the code. Ranges will not be accepted.

ICD-10	Description	ICD-10	Description
I83.001 – I83.229	Varicose Veins with Ulcer	L89.130 – L89.229	Pressure Ulcer of Lower Back, Hip
I87.2	Venous Insufficiency (Chronic) (Peripheral)	L89.300 – L89.319	Pressure Ulcer of Buttock
L03.90	Cellulitis, Unspecified	L89.500 – L89.629	Pressure Ulcer of Lower Limb
L03.115 – L04.3	Cellulitis of Limb	T81.30XA – T81.30XS	Disruption of Wound, Unspecified
L05.01	Pilonidal Cyst with Abscess	T81.31XA – T81.31XS	Disruption of External Operation (Surgical) Wound
L89.004 – L89.894	Pressure Ulcer, Stage IV		

CLINICAL INFORMATION BY WOUND TYPE (Complete in full OR fax applicable wound history documentation)

SECTION 4

PATIENT'S WOUND HISTORY

1. Was NPWT initiated in an inpatient facility? ☐ Yes ☐ No
   OR has the patient been on NPWT to treat this wound previously? ☐ Yes ☐ No
   Date initiated ________ Facility name ______________ Facility city, state ______________
2. Does the patient have a chronic, nonhealing ulcer with lack of improvement greater than 30 days duration despite standard wound therapy? ☐ Yes ☐ No
3. Which therapies/dressings have been previously tried and failed? ☐ Saline/gauze ☐ Collagen ☐ Hydrogel ☐ Foam ☐ Compression ☐ Alginate ☐ Hydrocolloid ☐ Absorbtive ☐ Hyperbaric Oxygen Treatment ☐ None
   ☐ Other______________________
4. Have weekly evaluations of the wound, including documentation of wound measurements (LxWxD), been conducted by a licensed medical professional? ☐ Yes ☐ No (Please include/attach these evaluations.)
5. Is Osteomyelitis present in the wound? ☐ Yes ☐ No If yes, please provide support in medical record documentation.

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Patient name ______________________________ (Last / First / MI) DOB ______________

CLINICAL INFORMATION BY WOUND TYPE (Complete in full OR fax applicable wound history documentation) Cont.

SECTION 4

PATIENT'S WOUND TYPE

☐ **TRAUMATIC:** ☐ Flap (post-op) ☐ Graft (post-op) ☐ Soft tissue/open wound ☐ Traumatic amputation ☐ Exposed bones and tendons ☐ Other (please describe) ______________

Is accelerated formation of granulation tissue not achievable by other topical wound treatments needed? ☐ Yes ☐ No

☐ **SURGICAL:** ☐ Dehisced ☐ Wound with exposed hardware/bone ☐ Poststernotomy mediastinitis ☐ Postoperative disunion of abdominal wall ☐ Other (please describe) ______________

Date of surgery __________ Description of surgical procedure involving wound ______________

☐ **PRESSURE ULCER:** ☐ **Stage III** ☐ **Stage IV**

1. Has the patient been on an appropriate turning/positioning regimen? ☐ Yes ☐ No
2. Has the patient used appropriate pressure relief modalities for ulcer(s) located on the posterior trunk or pelvis? ☐ Yes ☐ No
3. Has the patient's moisture and/or incontinence been appropriately managed? ☐ Yes ☐ No

☐ **DIABETIC ULCER OF NEUROPATHIC ULCER**

1. Has reduction of pressure on the foot ulcer been accomplished with appropriate modalities? ☐ Yes ☐ No

☐ **VENOUS STASIS ULCER/VENOUS INSUFFICIENCY**

1. Have compression dressings and/or garments been consistently applied? ☐ Yes ☐ No
2. Has leg elevation/ambulation been encouraged? ☐ Yes ☐ No

WOUND DESCRIPTION — Please submit supporting documentation

SECTION 5

Wound #1 Type ______________

Wound age in months ______

Is there necrotic tissue with eschar present in the wound? ☐ Yes ☐ No

Has debridement been attempted in the last 10 days? ☐ Yes ☐ No

If yes, debridement date __________

Debridement type ______________

Are serial debridements required? ☐ Yes ☐ No

Measurement date __________

Wound location ______________

Length ______ cm Width ______ cm Depth ______ cm

Appearance of wound bed and odor ______________

Exudate (amount and color) ______________

Is the wound full thickness? ☐ Yes ☐ No

Is muscle, tendon, or bone exposed? ☐ Yes ☐ No

Is there undermining? ☐ Yes ☐ No

Location #1: ______ cm, from ______ to ______ o'clock

Location #2: ______ cm, from ______ to ______ o'clock

Is there tunneling/sinus? ☐ Yes ☐ No

Location #1: ______ cm, from ______ to ______ o'clock

Location #2: ______ cm, from ______ to ______ o'clock

Within the vicinity of the wound, is there:

- Cancer present in the wound? ☐ Yes ☐ No
- A fistula to an organ or body cavity? ☐ Yes ☐ No
- Active bleeding/difficult wound hemostasis? ☐ Yes ☐ No
- Exposed vital organs, nerves, arteries/veins, or anastomotic sites? ☐ Yes ☐ No

Wound #2 Type ______________

Wound age in months ______

Is there necrotic tissue with eschar present in the wound? ☐ Yes ☐ No

Has debridement been attempted in the last 10 days? ☐ Yes ☐ No

If yes, debridement date __________

Debridement type ______________

Are serial debridements required? ☐ Yes ☐ No

Measurement date __________

Wound location ______________

Length ______ cm Width ______ cm Depth ______ cm

Appearance of wound bed and odor ______________

Exudate (amount and color) ______________

Is the wound full thickness? ☐ Yes ☐ No

Is muscle, tendon, or bone exposed? ☐ Yes ☐ No

Is there undermining? ☐ Yes ☐ No

Location #1: ______ cm, from ______ to ______ o'clock

Location #2: ______ cm, from ______ to ______ o'clock

Is there tunneling/sinus? ☐ Yes ☐ No

Location #1: ______ cm, from ______ to ______ o'clock

Location #2: ______ cm, from ______ to ______ o'clock

Within the vicinity of the wound, is there:

- Cancer present in the wound? ☐ Yes ☐ No
- A fistula to an organ or body cavity? ☐ Yes ☐ No
- Active bleeding/difficult wound hemostasis? ☐ Yes ☐ No
- Exposed vital organs, nerves, arteries/veins, or anastomotic sites? ☐ Yes ☐ No