

# Initiation of Negative Pressure Wound Therapy

Fax to (847) 904-6804 • Phone (847) 904-6803



## PATIENT INFORMATION

Order date \_\_\_\_\_  
Patient name \_\_\_\_\_ Last First MI DOB \_\_\_\_\_  
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 \_\_\_\_\_ Facility  
Name and credentials

## 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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> _____
<b>Medium</b> (Most Common Size)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> _____
Large	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> _____

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 \_\_\_\_\_ Last \_\_\_\_\_ First \_\_\_\_\_ MI \_\_\_\_\_ DOB \_\_\_\_\_

## 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 \_\_\_\_\_

## 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 must 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)

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

### 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:**  Dehiscenced  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

**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

SECTION 4

SECTION 5