



Please fax the attached prescription along with following documentation to (877) 535-2034 or call (800) 633-6978

For all ulcers or wounds, the wound therapy program must include a minimum of all the following general measures, which should either be addressed, applied, or considered and ruled out prior to application of NPWT. Please submit the following documentation to support medical necessity:

- \_\_\_\_ Current evaluation, care and wound measurements by a licensed medical professional, **and**
- \_\_\_\_ Past evaluation, care and wound measurements by a licensed medical professional, **and**
- \_\_\_\_ Application of dressings to maintain a moist wound environment, **and**
- \_\_\_\_ Debridement of necrotic tissue if present, **and**
- \_\_\_\_ Evaluation of and provision for adequate nutritional status, **and**
- \_\_\_\_ Other less expensive therapies tried, considered and ruled out, **and**
- \_\_\_\_ Pre- and post-operative reports, if applicable, **and**

**If the wound or ulcer is any of the following, the additional supportive documentation listed will be required:**

➤ **Chronic Stage III or IV pressure ulcer additional requirements:**

- \_\_\_\_ Patient has used a group 2 or group 3 support surface if the pressure ulcer is on the posterior trunk or pelvis, **and**
- \_\_\_\_ Turning and positioning history, **and**
- \_\_\_\_ Moisture and incontinence management history

➤ **Neuropathic (diabetic) ulcers additional requirements:**

- \_\_\_\_ Patient has been on a comprehensive diabetic management program, **and**
- \_\_\_\_ Reduction in pressure on a foot ulcer has been accomplished with appropriate modalities

➤ **Venous insufficiency ulcers additional requirements:**

- \_\_\_\_ Compression bandages and /or garments have been consistently applied, **and**
- \_\_\_\_ Leg evaluation and ambulation have been encouraged

**Medicare denies NPWT as not medically necessary when there is:**

- **The presence in the wound of necrotic tissue with eschar, if debridement was not attempted;**
- **Untreated osteomyelitis within the vicinity of the wound. If present, how treated?;**
- **Cancer is present in the wound;**
- **The presence of a fistula to an organ or body cavity within the vicinity of the wound.**

What HHA will be following this patient? \_\_\_\_\_ Phone: \_\_\_\_\_



Negative Pressure Wound Therapy Initial Documentation Form
(800) 633-6978 / (877) 535-2034 FAX

Section A Patient Information

Patient's Name: SS#: DOB:

Section B Wound History (Negative Pressure Wound Therapy)

- 1. Has patient been on NPWT in the past 30-60 days? Y N Date Initiated / /
2. NPWT initiated in inpatient facility? Y N Facility Name

Other Treatments

- 1. Has patient had a flap or graft? Y or N If yes, location Date / /
2. Is wound infected? Y or N If yes, type/treatment plan
3. Does patient have osteomyelitis? Y or N If yes, treatment

Nutrition

- 1. Does the patient have adequate nutrition? Y or N Regular Special Diet:
2. Albumin Level Date / / Height: Weight:

Previous Wound Dressings

- 1. What type of wound dressings were previously used?
Frequency of change:

Section C Wound Type (Select Appropriate Wound Type)

Pressure Ulcer NA

- 1. Has patient been on a Group 2/Group 3 Surface/Bed? Y or N From / / to / /
2. Is the patient being turned every 2 hours? Y or N
3. Is incontinence being managed/controlled? Y or N NA Specify: Bowel/Bladder

Diabetic/Neuropathic Ulcer NA

- 1. Has foot pressure been reduced? Y or N 2. Is patient on diabetic management program? Y or N

Venous Insufficiency NA

- 1. Are compression bandages being used? Y or N 2. Is elevation/ambulation of lower extremities permitted? Y or N

Chronic Ulcer NA

- 1. Has pressure been relieved? Y or N 2. Is incontinence being managed/controlled? Y or N NA Specify: Bowel/Bladder

Traumatic or Surgical or Dehisced (circle one) NA Date of occurrence: / /

Section D Current Wound Description(s)

Location #1 : Stage: Location #2 : Stage:
Size (cm) Length Width Depth Size (cm) Length Width Depth
Undermining Y or N @
Tunneling/Sinus Y or N @ Tunneling/Sinus Y or N @

Wound Bed:

- Granulation % Slough %
Other

Drainage Amount:

- Dry Minimal Serosanguinous Serous
Moderate Heavy Sanguinous Purulent

Debridement Date: / /

Within the vicinity of the wound, is there:

- Untreated osteomyelitis? Yes No
Cancer present in the wound? Yes No
A fistula to an organ or body cavity? Yes No

Drainage Amount:

- Dry Minimal Serosanguinous Serous
Moderate Heavy Sanguinous Purulent

Debridement Date: / /

Within the vicinity of the wound, is there:

- Untreated osteomyelitis? Yes No
Cancer present in the wound? Yes No
A fistula to an organ or body cavity? Yes No

Section E Ordering Physician Information

Physician's Name: NPI: Phone :

I prescribe negative pressure wound therapy pump (NPWT) E2402 as medically necessary and certify that all other treatment modalities have been utilized and evaluated. I certify that I am the treating physician identified in Section E of this form.

I hereby understand the principles of NPWT and the product information regarding the Smith & Nephew or Kalypto NPWT.

Items Ordered:

- E2402 Negative Wound Therapy Pump qty 1 Vista EZ Care Kalypto
A7000 Canister qty 10 per month Small Large
A6550 Dressing Kit qty 15 per month Gauze Dressing Small Medium Large X-Large
Flat Channel Round
Kalypto Dressing Foam Dressing Small Medium Large

Therapy initial date / / Length of Need for the ICD9 code (s)

Physician's Signature Date