APRIA HEALTHCARE®

Initiation of Negative Pressure Wound Therapy Authorization Form for Commercial Payors

Fax to (800) 323-1882 • Phone (800) 780-1228

PATIENT INFORMATION

Order date _____

Patient name _____ DOB _____
Last First MI

Address _____ City _____ State _____ Zip _____

Home phone _____ Mobile phone _____

Patient's HIC/ID number: _____

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): _____

I prescribe a Negative Pressure Wound Therapy Pump, and up to 15 wound care sets/dressing kits per wound per month and 10 canister sets per month

OR alternatively, I prescribe the Negative Pressure Wound Therapy Pump and up to _____ dressing kits (quantity) per wound per month, and _____ canister sets (quantity) per month.

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.

SUPPLIES FOR DELIVERY

For proper processing, please choose ONE row/size and check one box.

Kit Size	Dressing Kits		
	Foam	Gauze	**Other:** (Channel Drains, Y Connectors or Other)
Small	☐		☐ _____
Medium/Regular	☐	☐	☐ _____
Large	☐	☐	☐ _____

Note: Foam and gauze kits do not include scissors.

Other Specifications: _____

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).

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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 hospital/facility discharge date (if applicable) _____

☐ **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.

Description	ICD-10 Codes
Varicose Veins with Ulcer	I83.001 – I83.029
Varicose Veins with Ulcer, Lower Extremity	I83.202 – I83.229
Venous Insufficiency (Chronic) (Peripheral)	I87.2
Cellulitis of Limb	L03.113 – L03.116
Cellulitis, Unspecified	L03.90
Pilonidal Cyst with Abscess	L05.01
Pressure Ulcer, Various	Various L89 Codes
Disruption of Wound, Unspecified	T81.30XA – T81.30XS
Disruption of External Operation (Surgical) Wound	T81.31XA – T81.31XS
Non-Pressure Chronic Ulcer of Unspecified Heel and Midfoot with Unspecified Severity	L97.409
Non-Pressure Chronic Ulcer of Unspecified Part of Unspecified Lower Leg with Unspecified Severity	L97.909
Other Complications of Procedures, Not Elsewhere Classified, Initial Encounter	T81.89XA

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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. Is the patient's nutritional status compromised? ☐ Yes ☐ No If yes, check the action taken:
   ☐ Protein Supplements ☐ Enteral/NG feeding ☐ TPN ☐ Vitamin therapy ☐ Special diet
   Albumin: _____ Date: _____ Pre-albumin: _____ Date: _____ Protein levels: _____ Date: _____
3. Does the patient have a chronic, nonhealing ulcer with lack of improvement greater than 30 days duration despite standard wound therapy? ☐ Yes ☐ No
4. Which therapies/dressings have been previously tried and failed? ☐ Saline/gauze ☐ Collagen ☐ Hydrogel ☐ Foam
   ☐ Electrical Stimulation ☐ Compression ☐ Alginate ☐ Hydrocolloid ☐ Absorptive ☐ Hyperbaric Oxygen Treatment
   ☐ None ☐ Other: _____
5. If other therapies were considered and ruled out, what conditions prevented you from using other therapies prior to applying NPWT?
   ☐ Presence of co-morbidities ☐ High risk of infections ☐ Need for accelerated granulation tissue
   ☐ Prior history of delayed wound healing ☐ Other, please describe: _____
6. 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.)
7. Which of the following co-morbidities apply? ☐ Diabetes ☐ Immobility ☐ Immunocompromised ☐ ESRD
   ☐ PVD ☐ PAD ☐ Obesity ☐ Smoking ☐ Depression ☐ N/A
8. If above diabetes box checked, is the patient on a comprehensive diabetic management program? ☐ Yes ☐ No ☐ N/A
9. Is Osteomyelitis present in the wound? ☐ Yes ☐ No If yes, please indicate the following:
   ☐ Antibiotic (list name) _____ ☐ IV Antibiotics (list name) _____
   ☐ Hyperbaric Oxygen
   Is the above treatment administered to the patient with the intention to completely resolve the underlying bone infection? ☐ Yes ☐ No
10. Please provide a short narrative of possible consequences if NPWT is not used. (Please include/attach any clinical data such as H&P, OP report, and other medical documentation supporting treatments tried and describing factors impacting wound healing): _____
    _____

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 wound a direct result of an accident? ☐ Yes ☐ No If yes, please complete the following: Date of accident _____
Description of accident involving wound _____
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 _____

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☐ **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 OR 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, at _____ o'clock

Location #2: _____ cm, at _____ 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, at _____ o'clock

Location #2: _____ cm, at _____ 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