Date: _____

FAX

TO:

FAX:

PHONE:

Patient: **DOB:**

RE—Negative Pressure Wound Therapy

★Wound Notes/Assessments Needed

Pages: 3

Quality Team Inc QT Team HomeCare

3740 N. Sillect Ave., Ste. 1B
Bakersfield, CA 93308
Qualityteamhomecare.com
PH: 661.327.5500
FX: 661.327.5503
Or FX: 559.570.0185

COMMENTS:

In order for your patient to qualify for Negative Pressure Wound Therapy coverage under Medicare guidelines, the following documentation is required:

- *Patient Demographics,* including accurate insurance information
- *Clinical Documentation pertaining to wound, including:*
  - Current **Wound Assessment**
  - **Wound Notes** outlining previous treatments that have been tried, wound etiology, etc.
- *Initial Wound Assessment* Questionnaire (attached)
- *Detailed Written Order* (attached)

While any medical professional licensed to administer wound care can assess the wounds being treated, a PECOS Physician is ultimately responsible for prescribing NPWT and must SIGN the attached documents.

The above documentation should be reviewed by the prescribing physician and returned to us via fax (661)327-5503

Thank you for all of your help!

Initial NPWT Assessment

Documentation Requirements

3740 N. Sillect Ave., Ste. 1B
Bakersfield, CA 93308
661.327.5500/661.327.5503fx

Patient Information

Name:_____ DOB:_____

Diagnoses: _____

Initiating Wound Therapy

DOCUMENTATION REQUIRED

- ☐ Attach **patient demographics**
- ☐ Attach **clinical documentation** pertaining to the wound, addressing its etiology and what other treatments have been tried and deemed clinically ineffective
- ☐ Attach a current **wound assessment**
- ☐ Complete attached **Detailed Written Order**

*Medicare considers Negative Pressure Wound Therapy to be the **last resort** when your patient has a chronic ulcer. In order for Medicare to cover NPWT, it is quintessential that the medical record reflects which other treatments have been tried and considered and ruled out, and that your patient is on a comprehensive wound therapy program. To establish medical necessity, the following questions must be addressed:*

1. Has the patient previously utilized NPWT in the last 60 days? **Y N** If yes, when?_____
2. Has NPWT being initiated in an inpatient setting? **Y N** If yes, when is the initial start date? _____
3. Is the patient's nutritional status adequate to promote healing? **Y N** If no, what measures are being taken to achieve adequate nutrition? ☐ Enteral/NG Feeding ☐ Vitamins/Supplements ☐ Special Diet ☐ TPN
4. What therapies have been applied to maintain a moist wound environment?:
   ☐ Saline gauze ☐ Hydrogel ☐ Alginate ☐ Hydrocolloid ☐ Absorptive ☐ Other_____
5. Has debridement been attempted? **Y N** Date of debridement_____ ☐ Debridement unnecessary
6. Check which of the following are present in the wound:
   ☐ Fistula to organ/body cavity ☐ Osteomyelitis (How is Osteomyelitis being treated?_____)
   ☐ Cancer ☐ Necrotic tissue (Is necrotic tissue ☐ eschar or ☐ slough?)
7. According to wound type, answer appropriate questions below:
   (Circle applicable responses)

Pressure Ulcer	**Neuropathic Ulcer**	**Venous Stasis Ulcer**	**Surgical/Traumatic Ulcer**
-Stage: **III IV** -Has pressure ulcer persisted more than 30 days? **Y N** -Is moisture and incontinence being properly managed? **Y N** -Is the patient being turned and positioned regularly? **Y N** -If ulcer is on patients posterior trunk or pelvis: Has the patient been on a grp 2 or grp 3 support surface? **Y N**	-Is the patient on a comprehensive diabetes management program? **Y N n/a** -What prior pressure relieving techniques have been attempted and failed? _____ _____ _____	-Is compression being consistently applied? **Y N** -Is elevation and ambulation being encouraged? **Y N**	-Was wound surgically created? **Y N** -Date of surgery: _____ - Is it medically necessary for there to be accelerated formation of granulation tissue? **Y N** -If the wound is a result of a traumatic injury, specify date of trauma:_____ -Description: _____ _____

8. Wound Measurements
   a. Wound #1 Location: _____ Age of wound: _____
      i. Length: _____ Width: _____ Depth: _____
      ii. Any Tunneling or Undermining? **Y N** If yes, specify: ____cm at ____o'clock
      iii. Exudate: ☐ None ☐ Minimal ☐ Moderate ☐ Heavy Specify: _____cc's per day
   b. Wound #2 Location: _____ Age of wound: _____
      i. Length: _____ Width: _____ Depth: _____
      ii. Any Tunneling or Undermining? **Y N** If yes, specify: ____cm at ____o'clock
      iii. Exudate: ☐ None ☐ Minimal ☐ Moderate ☐ Heavy Specify: _____cc's per day

By signing below, I agree with the information recorded above. This patient is on a comprehensive wound therapy program, and despite previous efforts, a NPWT pump is medically necessary to facilitate wound healing.

Physician Signature:_____ Date of Signature:_____

Return with Detailed Written Order, Patient Demographics, and pertinent wound documentation to Quality Team FAX: (661)327-5503

Detailed Written Order
(Negative Pressure Wound Therapy)

3740 N. Sillect Ave., Ste. 1B
Bakersfield, CA 93308
661.327.5500/661.327.5503fx

Patient Information

Name:_____ DOB:_____

ICD-10 Diagnoses: _____ *must be specific to the 5th digit*

Equipment Ordered

I prescribe a Negative Pressure Wound Therapy Pump (E2402), and up to 15 black foam dressing kits (A6550) per wound per month and 10 canisters (A7000) per month, for the above named patient.

Therapy Settings (select only one)

___ Continuous Mode pressure _____mmHg

___ Intermittent Mode

Low pressure _____ mmHg cycle time _____ minutes

High pressure _____ mmHg cycle time _____ minutes

Frequency of Dressing Changes_____

Length of need (in months) ONE TWO THREE FOUR Other (in weeks)_____

Therapy Start Date _____ (If this date is left unfilled, then use my signature at the therapy start date)

Licensed Medical Professional responsible for administering NPWT

_____ (include credentials)

Agency _____ Phone Number _____

Prescribing Physician Signature Required

Name:_____ NPI Number:_____

Address:_____ City:_____ State:____ Zip:_____

Fax Number:_____ Phone Number_____

By signing and dating below, I verify that I am prescribing this patient Negative Pressure Wound Therapy as medically necessary to promote wound healing. All other applicable treatments have been tried or considered and deemed clinically ineffective. I understand that negative pressure wound therapy will be denied and deemed unreasonable and unnecessary in any of the following instances: necrotic tissue with eschar is present in the wound and debridement has not been attempted, osteomyelitis is present in the vicinity of the wound and is not concurrently being treated, cancer is present in the wound, or the wound has an open fistula to an organ or body cavity.

Signature:_____ Date:_____

Return with NPWT Assessment, Patient Demographics, and pertinent wound documentation to Quality Team FAX: (661)327-5503