

Date of Order: _____

Patient Name: _____ DOB: _____

Negative Pressure Wound Therapy is needed for the following wound types:

- | | | |
|--|--|---|
| <input type="checkbox"/> Arterial ulcer | <input type="checkbox"/> Pressure ulcer(s) | <input type="checkbox"/> Surgically created |
| <input type="checkbox"/> Neuropathic (diabetic) ulcer(s) | <input type="checkbox"/> Venous ulcer(s) | <input type="checkbox"/> Other _____ |

ICD10 Diagnosis code(s) and or Description of Diagnosis: _____

Wound etiology: _____ Anatomic location(s): _____

Start Date: _____ **Was NPWT started as inpatient?** ☐ No ☐ Yes **Date:** _____

Length of Need: ☐ 1 month ☐ 2 months ☐ 3 months ☐ 4 months ☐ Other (weeks) _____

Goal at completion of NPWT: ☐ Assist granulation tissue formation ☐ Delayed primary closure ☐ Flap ☐ Graft

Equipment and Supplies (please check all that apply):

☐ Invia Liberty Pump (E2402) ☐ Invia Motion Pump (E2402)

Standard Mode ☐ 40 ☐ 100 ☐ 175
Pressure mmHg: ☐ 60 ☐ 125 ☐ 200
☐ 80 ☐ 150

☐ 60 ☐ 125
☐ 80 ☐ 150
☐ 100 ☐ 175

Detailed Pressure Mode (increments of 5 mmhg):

Pressure _____ mmhg

Hours per day: _____ ☐ Continuous mode ☐ Intermittent mode

☐ Pump Canisters (A7000) 10 per month

☐ Wound Dressing Kits (A6550) 15 per month per wound

Foam
☐ Small (8x10 cm)
☐ Medium (12x20 cm)
☐ Large (15x26 cm)

Antimicrobial Gauze
☐ Regular (6x6.75 cm) ☐ Large (Kerlix roll)
☐ ESI Drain Kit ☐ Flat Drain Kit
☐ Round Channel Drain Kit

Other
☐ ESI Drain Tube
☐ Y Connector
☐ Silverlon NPWT antimicrobial wound
contact dressing quantity _____

Frequency of change: _____ Quantity per change: _____

Physician Signature: _____ **Date:** _____

Physician Name: (please print) _____ **NPI:** _____

By signing and dating, I attest that I am prescribing NPWT 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 the therapy product as well as the NPWT Clinical Guidelines. **I also understand the contraindications to NPWT:** malignancy in the wound, untreated osteomyelitis, non-enteric and unexplored fistulas, necrotic tissue with eschar present, and sensitivity to silver. Foam dressing for the therapy system should not be placed directly in contact with exposed blood vessels, anastomotic sites, organs or nerves.

Fax back to: 320-231-4941

Negative Pressure Wound Therapy

Order and Documentation Requirements

Medicare, and other insurance providers who follow Medicare guidelines, will cover NPWT pump and supplies when either criterion A or B is met. A Written Order Prior to Delivery (WOPD) is also required.

A. Ulcers and Wounds in the Home Setting:

The patient has a chronic Stage III or IV pressure ulcer, neuropathic (for example, diabetic) ulcer, venous or arterial insufficiency ulcer, or a chronic ulcer of mixed etiology present for at least 30 days. A complete wound therapy program described by criterion 1 and criteria 2, 3, or 4, as applicable depending on the type of wound, must have been tried or considered and ruled out prior to application of NPWT.

1. **FOR ALL ULCERS AND WOUNDS**, the following components of a wound therapy program must include a minimum of all of the following general measures, which should either be addressed, applied, or considered and ruled out prior to application of NPWT:
 - a. **Documentation in the patient medical record of evaluation, care, and wound measurements** by a licensed medical professional (MD or DO, PA, RN, LPN or PT), and
 - b. Application of dressings to maintain a moist wound environment, and
 - c. Debridement of necrotic tissue if present, and
 - d. Evaluation of and provision for adequate nutritional status
2. **For Stage III or IV pressure ulcers:**
 - a. The patient has been appropriately turned and positioned, and
 - b. The patient has used a group 2 or 3 support surface for pressure ulcers on the posterior trunk or pelvis, and
 - c. The patient's moisture and incontinence have been appropriately managed
3. **For neuropathic (for example, diabetic) ulcers:**
 - a. The patient has been on a comprehensive diabetic management program, and
 - b. Reduction in pressure on a foot ulcer has been accomplished with appropriate modalities
4. **For venous insufficiency ulcers:**
 - a. Compression bandages and/or garments have been consistently applied, and
 - b. Leg elevation and ambulation have been encouraged

B. Ulcers and Wounds Encountered in an Inpatient Setting:

1. An ulcer or wound (described under A above) is encountered in the inpatient setting and, after wound treatments described under A-1 through A-4 have been tried or considered and ruled out, NPWT is initiated because it is considered in the judgment of the treating physician, the best available treatment option.
2. The patient has complications of a surgically created wound (for example, dehiscence) or a traumatic wound (for example, pre-operative flap or graft) where there is documentation of the medical necessity for accelerated formation of granulation tissue which cannot be achieved by other available topical wound treatments (for example, other conditions of the patient that will not allow for healing times achievable with other topical wound treatments).

In either situation B1 or B2, NPWT will be covered when treatment is ordered to continue beyond discharge to the home setting.

THE PATIENT MEDICAL RECORD MUST INCLUDE a statement from the treating physician describing the initial condition of the wound (including measurements) and the efforts to address all aspects of wound care (listed in A1 through A4). **For each subsequent month**, the record must include updated wound measurements and what changes are being used to effect wound healing. In order for coverage to continue, a licensed medical professional must do the following on a regular basis:

1. Directly assess the wound(s) being treated with the NPWT pump, and
2. Supervise or directly perform the NPWT dressing changes, and
3. On at least a monthly basis, document changes in the ulcer's dimensions and characteristics.

Thank you for making Rice Home Medical part of your healthcare team. Please call 800-637-7795 with questions.