



Date of Order: _____

Patient Name: _____ DOB: _____

Number of wounds: _____ Complete below for each wound Length of Need: _____ months

Wound #1

| | Dressings Ordered | Size | Frequency Changed (no prn) | Qty per Change |
|------------------------------------|-------------------|------|---|----------------|
| Type of wound (DX): _____ 1) _____ | | | <input type="checkbox"/> Primary <input type="checkbox"/> Second | _____ |
| Location: _____ 2) _____ | | | <input type="checkbox"/> Primary <input type="checkbox"/> Second | _____ |
| Size in cm (LxWxD): _____ 3) _____ | | | <input type="checkbox"/> Primary <input type="checkbox"/> Second | _____ |
| Amount of Drainage: _____ 4) _____ | | | <input type="checkbox"/> Primary <input type="checkbox"/> Second | _____ |
| | | | <input type="checkbox"/> Primary <input type="checkbox"/> Second | _____ |

Debrided: No Yes Date: _____

Wound #2

| | Dressings Ordered | Size | Frequency Changed (no prn) | Qty per Change |
|------------------------------------|-------------------|------|---|----------------|
| Type of wound (DX): _____ 1) _____ | | | <input type="checkbox"/> Primary <input type="checkbox"/> Second | _____ |
| Location: _____ 2) _____ | | | <input type="checkbox"/> Primary <input type="checkbox"/> Second | _____ |
| Size in cm (LxWxD): _____ 3) _____ | | | <input type="checkbox"/> Primary <input type="checkbox"/> Second | _____ |
| Amount of Drainage: _____ 4) _____ | | | <input type="checkbox"/> Primary <input type="checkbox"/> Second | _____ |
| | | | <input type="checkbox"/> Primary <input type="checkbox"/> Second | _____ |

Debrided: No Yes Date: _____

Wound #3

| | Dressings Ordered | Size | Frequency Changed (no prn) | Qty per Change |
|------------------------------------|-------------------|------|---|----------------|
| Type of wound (DX): _____ 1) _____ | | | <input type="checkbox"/> Primary <input type="checkbox"/> Second | _____ |
| Location: _____ 2) _____ | | | <input type="checkbox"/> Primary <input type="checkbox"/> Second | _____ |
| Size in cm (LxWxD): _____ 3) _____ | | | <input type="checkbox"/> Primary <input type="checkbox"/> Second | _____ |
| Amount of Drainage: _____ 4) _____ | | | <input type="checkbox"/> Primary <input type="checkbox"/> Second | _____ |
| | | | <input type="checkbox"/> Primary <input type="checkbox"/> Second | _____ |

Debrided: No Yes Date: _____

Physician Signature: _____ Date: _____

Physician Name: (please print) _____ NPI: _____

Must attach documentation supporting medical necessity of dressing supplies

Fax back to: 320-231-4941

Surgical Dressings Order and Documentation Requirements

Surgical dressings are covered by Medicare, and other insurance providers who follow Medicare guidelines, when EITHER of the following criteria is met:

- Needed for treatment of a wound caused by, or treated by, a surgical procedure; or
- Required after debridement of a wound. The surgical procedure or debridement must be performed by a physician or other healthcare professional. Debridement of a wound may be any type of debridement (examples given are not all-inclusive):
 - a) surgical (sharp instrument or laser),
 - b) mechanical (whirlpool, irrigation or wet-to-dry dressings),
 - c) chemical (topical application of enzymes), or
 - d) autolytic (application of occlusive dressings to an open wound)

Surgical dressings include:

1. Primary dressings (therapeutic or protective coverings applied directly to wounds or lesions either on the skin or caused by an opening to the skin)
2. Secondary dressings (materials that serve a therapeutic or protective function and needed to secure a primary dressing)

Information defining the number of surgical/debrided wounds being treated with a dressing, the reason for dressing use (e.g. surgical wound, debrided wound, etc.), and whether the dressing is being used as a primary or secondary dressing or for some noncovered use (e.g. wound cleansing) should be documented in the patient medical record.

Evaluation of a patient's wound(s) must be performed at least on a monthly basis and should include:

- 1) The type of each wound (e.g. surgical wound, pressure ulcer/stage, etc.),
- 2) Location of the wound(s),
- 3) Size – length, width, and depth (clearly specify inches or cm)
- 4) Presence/amount of exudate (drainage)
- 5) Presence/extent of tunneling or undermining
- 6) Presence/extent of eschar or granulation tissue
- 7) Presence of infection or other complicating conditions

This evaluation may be performed by a physician, nurse, or other qualified health care professional. If performed by someone other than the physician, there should be notes in the patient chart indicating oversight by the physician of the treatment both initially and periodically on an ongoing basis.

A new order is required:

- If a new dressing is added or if the quantity of an existing dressing is increased.
- At least every 3 months for each dressing being used even if the quantity used has remained the same or decreased.

➤ **DRESSINGS ARE NOT COVERED for:**

- a. Drainage from a cutaneous fistula which has not been caused by or treated by a surgical procedure; or
- b. A Stage I pressure ulcer; or
- c. A first degree burn; or
- d. Wounds caused by trauma which do not require surgical closure or debridement (skin tear, abrasion); or
- e. A venipuncture or arterial puncture site other than the site of an indwelling catheter or needle.

Thank you for making Lake Region Home Medical Supply part of your healthcare team. Please call 218-332-5920 with questions.