Negative Pressure Wound Therapy Unit

Therapy Insurance Authorization Form
Rx, Letter of Medical Necessity, Detailed Written Order
Please Fax Forms, Clinical Notes, and Demographics to 480-895-2949
Support: 480-802-0202

Progressive Home Medical
10450 E Riggs Rd, Suite #107
Chandler, AZ 85248
Phone 480 802 0202
Fax 480 895 2949

Section 1 Prescriber – Patient Order Information (Complete in full or fax written prescription)

Patient Information

Patient name – Last _____ First _____ MI _____ DOB _____

Insurance/Medicare ID (HIC #) _____

Treating Prescriber Information (Complete in full or fax written prescription).

Prescription, Attestation and Treating Prescriber Information

Treating prescriber must sign and date (no stamps). This form is only to be used if you will not be providing a separate written order.

I prescribe NPWT therapy and up to 15 dressings per wound and up to 10 canisters per month for
Number of months: ○ 1 month ○ 2 months ○ 3 months ○ 4 months ○ Other _____

Diagnosis Codes (Specify ICD-9 to 4th or 5th digits) _____

Anticipated hospital/facility discharge date* _____ Start pump on* _____

Medicare allows delivery to a facility up to 48 hours prior to anticipated discharge for the purpose of fitting/training

Pressure Setting _____ Frequency of dressing changes _____

Treating prescriber only to complete. Original signature and date required (no stamps).

Treating prescriber signature _____ Date _____

By signing and dating, I attest that I am prescribing the DeRoyal System (do not substitute) 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.

Treating prescriber name (print) Last _____ First _____ MI _____

NPI# _____ **(REQUIRED)**

Supplies for Delivery

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

Kit Size	Dressing Kits		Specialty Items	
	Foam Kit	Gauze		
Small	☐	☐		☐ _____
Medium	☐	☐	☐	☐ _____
Large	☐	☐		☐ _____

Note: Foam and gauze kits do not include scissors.

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Section 2 Requester – Clinical Provider Information

Patient Information (Complete in full or fax Demographics / Patient Face Sheet / Insurance Card)

Patient name – Last _____ First _____ MI _____ DOB _____

Billing Address _____ City _____ State _____ Zip _____

Initial Delivery to: ○ Hospital Rm # _____ ○ Home Address ○ Temporary Address

Delivery Address _____ City _____ State _____ Zip

Primary Insurance _____

Secondary Insurance _____ Insurance/Medicare ID (HIC#) _____

Referral Information (Must be completed in full)

Requester's name _____ Title _____ Facility name _____

Address _____ City _____ State _____ Zip _____

Phone _____ Fax _____

What HHA will be following this patient? Facility _____ Phone _____

Will a Wound Care Clinic be following this patient? Yes (No) If yes, please identify: _____

Facility _____ Phone _____

Requested Delivery Date _____ and Time _____

Additional comments or delivery information:

Attach and fax documentation below, along with the Initiation of Therapy Form, to the fax number at the top of the page.

• Medicare requires medical records that corroborate information listed in Section 3 below, based on wound type.

Section 3 Office Order Check List

Required for All Patients

- ☐ Signed and dated written order from treating prescriber prior to product delivery (WOPD)
- ☐ Face Sheet (patient demographics, including date of birth, and insurance information)
- ☐ Medicare HIC # or insurance ID and group #
- ☐ History and Physical related to wound (e.g., physician evaluation/progress notes, wound clinic notes, etc.)
- ☐ Wound measurements = L _____ x W _____ x D _____
- ☐ Prior conservative therapies that have been tried and failed to maintain a moist wound environment (e.g., hydrogel, alginate, etc.)
  Please list conservative therapies: _____
- ☐ Documentation of debridement (if applicable)
- ☐ Dietary consult documentation on nutritional status (e.g., protein supplements, special diet, enteral/tube feeding, etc.)

Required for Traumatic or Surgical Wounds

- ☐ Date of Surgery _____Other (please describe) _____
- ☐ Pre–operative report
- ☐ Post–operative report
- ☐ Additional supporting documentation required for complications of surgically created wounds (e.g., dehiscence, flaps or grafts)

Required for Chronic Pressure Ulcer: Stage III ☐ or IV ☐

- ☐ Turning and positioning regimen employed and documented
- ☐ Moisture and incontinence management documentation history (e.g., Foley catheter, bowel and bladder program)
- ☐ If wound is located on trunk or pelvis, documentation showing a low air-loss or alternating air mattress (i.e., group 2 or group 3 support surface) was tried prior to NPWT
- ☐ Duration of pressure ulcer (_____days)

Required for Diabetic/Neuropathic Ulcers

- ☐ Documentation showing that pressure has been off–loaded from the wound area (e.g., foot ulcers)
- ☐ Documentation of comprehensive diabetic management program (e.g., endocrinologist notes, diet, education provided, glucose readings, labs, etc.)

Required for Venous Stasis Ulcers

- ☐ Documentation showing that compression bandages and/or garments have been consistently applied
- ☐ Documentation that elevation/ambulation encouraged

Common ICD-9 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-9 codes for which Negative Pressure Wound Therapy can be used. This is simply a short list of commonly used codes. Presence of an ICD-9 code alone does not guarantee coverage of a NPWT device.

ICD-9	Description
454.0	Leg Varicosity with Ulcer
459.81	Venous Insufficiency NOS
682.6	Cellulitis of Leg
682.9	Cellulitis NOS
685.0	Pilonidal Cyst with Abscess
707.03	Pressure Ulcer, Lower Back (coccyx, sacrum)
707.05	Pressure Ulcer, Buttock

ICD-9	Description
707.10	Ulcer of Lower Limb, Unspecified
707.14	Ulcer of Heel and Midfoot-Plantar Surface of Midfoot
707.24	Pressure Ulcer, Stage IV
729.99	Other Disorders of Soft Tissue
894.1	Multiple and Unspecified Open Wound of Lower Limb
998.83	Non-Healing Surgical Wound
998.32	Disruption of External Operation Surgical Wound
998.30	Disruption of Wound, Unspecified