APRIA®

Initiation of Negative Pressure Wound Therapy Form

Fax completed form to: _____

Apria Representative _____ **Branch Location** _____ **Phone** _____

To expedite the processing of your Negative Pressure Wound Therapy (NPWT) order and to minimize call backs and follow-up requests, please provide all required documentation up front. Please utilize this checklist to ensure all necessary documentation is included so your order can be processed quickly.

PATIENT INFORMATION

Patient name _____ DOB _____
Last First

Home phone _____ Mobile phone _____ Email _____

Negative Pressure Wound Therapy Documentation Requirements

Documentation Needed for NPWT Orders

- ☐ Detailed written order/prescription signed and dated by the treating authorized prescriber
- ☐ Copy of patient demographics and insurance information
- ☐ Copy of discharge summary (if applicable)
- ☐ Copy of history and physical
- ☐ Documentation of wound measurements (Length x Width x Depth), including the unit of measure and date measurement was taken
- ☐ Amount of exudate (if available)
- ☐ Documentation of patient's nutritional status
- ☐ Documentation to support debridement of necrotic tissue (if applicable)

If other therapies were considered and ruled out, what conditions prevented you from using other therapies prior to applying Negative Pressure Wound Therapy?:

☐ Presence of co-morbidities ☐ High risk of infections ☐ Need for accelerated granulation tissue
☐ Prior history of delayed wound healing ☐ Other, please describe: _____

Required for Traumatic or Surgical Wounds

- ☐ Date of surgery or other (include description in chart notes)
- ☐ Copy of pre-operative report
- ☐ Copy of 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 Stage 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 (for Medicare must be group 2 or group 3 support surface) was tried, or considered and ruled out prior to ordering NPWT
- ☐ Duration of pressure ulcer (Include number of days in chart notes)

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

Please note: This list represents a condensed listing of common documentation requirements that are needed in order to process NPWT orders for patients with Medicare and other payors. Documentation requirements vary by payor and additional documentation may be requested based on individual payor guidelines.

Referral contact name _____ **Date** _____

Fax _____ **Phone** _____

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REFERRAL SOURCE

Facility name _____ Contact name _____

Order date _____ Phone _____ Fax _____

PLEASE SEND PATIENT DEMOGRAPHICS, CHART NOTES AND INSURANCE INFORMATION

PATIENT INFORMATION

Patient name _____ DOB _____
Last First

Address _____ City _____ State _____ Zip _____

Home phone _____ Mobile phone _____ Email _____

Insurance Provider _____ Insurance ID # _____

SECTION 1 — PATIENT ORDER INFORMATION (Complete in full or fax copy of written prescription)

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. Unit of measure and date measurement was taken.

SUPPLIES FOR DELIVERY **For proper processing, please choose ONE row/size and check one box.**

Kit Size	Foam Dressing Kits	**Other:** (White Foam, Gauze Rolls or Other)
Small	☐	☐ _____
Medium/Regular	☐	☐ _____
Large	☐	☐ _____

Note: Foam kits do not include scissors.

Type of pump or equivalent: ☐ Medela Invia® Liberty™ ☐ Medela Invia® Motion™-Endure ☐ Other _____

No substitutions allowed _____ 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** _____ **Email** _____

Prescriber signature _____ **Date** _____

Treating prescriber's original signature and date are required (no stamps).

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SECTION 2 — PATIENT DELIVERY AND FOLLOW-UP CARE

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)* _____

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

☐ **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

Negative pressure wound therapy is not diagnosis-driven. Therefore, Medicare does not provide a defined set of codes that must be used with this equipment.

Please note that the patient's condition and diagnosis must be documented. A code alone will not support medical necessity.

The following is a short list of diagnosis codes commonly used with negative pressure wound therapy.

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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