Use for Experience Health Medicare Advantage SM (HMO)

Negative Pressure Wound Therapy (NPWT) Pump Rental
Prior Authorization (PA) Request Form

(Incomplete Form May Delay Processing)

I doProvider Information		Member Information
Ordering Physician Name:	NPI #:	Member Name:
Office Phone#: Office Fax#:	Contact Name:	Member ID #:
Vendor Name:	NPI #:	Member's Date of Birth:
Vendor Phone #: Vendor Fax #:	Contact Name:	Member's Phone #:
ICD-10 Code(s):		

Please answer questions below

HCPCS code(s) (REQUIRED): _____

If this is the initial rental from an outpatient setting, please provide the following information:

1. What is the start date of the rental? _ _/_ _/_ _ _ _
2. Do any of the following conditions exist in the area of the wound?..... ☐ Yes ☐ No
   - ☐ Osteomyelitis within the area of the wound that is not at the same time being treated with intent to cure
   - ☐ Cancer present in the wound
   - ☐ An open fistula to an organ or body cavity within the area of the wound
3. What type of wound does the member have?
   - ☐ Chronic Stage III pressure ulcer
   - ☐ Chronic Stage IV pressure ulcer
   - ☐ Neuropathic ulcer
   - ☐ Venous or arterial insufficiency ulcer
   - ☐ Chronic ulcer of mixed etiology
4. Please list all wound care measures tried and failed. _____
   _____
   _____
5. What are the current wound measurements (determined by a licensed medical professional) to include length, width, and depth (l x w x d)? _____
6. If present, was necrotic tissue debrided?..... ☐ Yes ☐ No ☐ N/A
7. Has the member been evaluated for adequate nutritional status? ..... ☐ Yes ☐ No

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8. Were any identified nutritional conditions addressed? ..... ☐ Yes ☐ No ☐ N/A

9. For Stage III and IV pressure ulcers:
   a. Has the member been appropriately turned and positioned? ..... ☐ Yes ☐ No
   b. Has the member used a Group 2 or 3 support surface for pressure ulcers on the posterior trunk or pelvis? ..... ☐ Yes ☐ No
   c. Has the member's moisture and incontinence been appropriately managed?..... ☐ Yes ☐ No ☐ N/A

10. For neuropathic ulcers:
   a. Has the member been on a comprehensive diabetic management program?..... ☐ Yes ☐ No
   b. Has reduction in pressure on a foot ulcer been accomplished with appropriate modalities?..... ☐ Yes ☐ No

11. For venous insufficiency ulcers:
   a. Have compression bandages and/or garments been consistently applied? ..... ☐ Yes ☐ No
   b. Has leg elevation and ambulation been encouraged? ..... ☐ Yes ☐ No

Was the pump placed on an ulcer/wound encountered during an inpatient setting? ..... ☐ Yes ☐ No ☐ N/A

1. If yes, please submit inpatient medical records relevant to the wound and wound treatments.
2. What date was the pump placed? _ _/_ _/_ _ _ _

If this request is for continued coverage/rental, please provide the following information:

1. Which month's rental is being requested?..... ☐ 2nd ☐ 3rd ☐ 4th ☐ Beyond 4th

2. On a regular basis:
   a. Has a medical professional directly assessed the wound(s) being treated with the pump? ..... ☐ Yes ☐ No
   b. Has a medical professional supervised or directly performed the pump dressing changes? ..... ☐ Yes ☐ No

3. On at least a monthly basis, has a medical professional documented changes in the ulcer's dimensions and characteristics? ..... ☐ Yes ☐ No

4. What are the current wound measurements (l x w x d)?_____

I certify that I have appropriate authority to request an organization determination for the item(s) indicated on this request. I further certify that the patient's medical records accurately reflect the information provided. I understand that Experience Health Medicare Advantage SM (HMO) may request medical records for this patient at any time in order to verify this information.

Signature:_____ Date: _____

Please Return Completed Form to:
Fax 1-919-765-7805
For questions, please call Care Management at 1-833-941-0107.

Experience Health Medicare Advantage SM is a HMO plan. This plan has a Medicare contract. Enrollment in the plan depends on contract renewal.