

**Indiana Health Coverage Programs
Medical Clearance Form**

Negative Pressure Wound Therapy

Section A				Certification Date		Initial: __/__/__		Revised: __/__/__			
Patient name				Supplier name		Address					
Address				Address							
Phone number (____) _____			RID number _____			Phone number (____) _____			Provider number _____		
Place of service _____				HCPCS Code		PT DOB __/__/__/; Sex__(M/F) HT____(IN); WT____(LBS)					
Name and address of facility (if applicable)						Physician name					
						Address					
						Physician UPIN number _____					
						Physician telephone () _____					
Section B		Information in this Section May Not Be Completed by the Supplier of the Items/Supplies									
Estimated length of need (Number of months _____)						Dx codes (ICD-9) _____					
Answers		Circle Y for Yes, N for No, or NA for Not applicable									
Y N NA		Is the patient's nutritional status adequate for wound healing? Describe the diet.									
Y N NA		Has a moist wound environment dressings been tried and failed? If yes, please describe what type of dressing was used.									
Y N NA		If necrotic tissue is present, has debridement been attempted?									
Y N NA		Does the patient have osteomyelitis? If yes, what is the treatment regimen?									
Y N NA		Is there a fistula within the vicinity of the wound or cancer in the wound?									
Y N NA		Is there a documented history of previous wound management regimen, including wound measurements available for review on request by the IHCP?									
Section C		Wound Description									
		Fill this section out for the primary wound and fill out a supplemental form for each additional wound.									
Type of wound (check one)				Wound site: _____							
Arterial insufficiency ulcer _____											
Stage 3 or 4 pressure ulcer _____				Approximate age of wound _____							
Chronic ulcer of mixed etiology _____											
Venous stasis ulcer _____				<u>Wound measurements</u>							
Neuropathic ulcer (such as diabetic) _____				<u>Current</u>		<u>One month ago</u>					
Traumatic (such as pre-op graft or flap) _____				Length ___cm		Length ___cm					
Surgically created (such as dehisced) _____				Width ___cm		Width ___cm					
				Depth ___cm		Depth ___cm					
				<u>Exudate</u>							
				<u>Current</u>		<u>One month ago</u>					
				Slight _____		Slight _____					
				Moderate _____		Moderate _____					
				Heavy _____		Heavy _____					

**Indiana Health Coverage Programs
Medical Clearance Form (continued)**

Negative Pressure Wound Therapy

Section D Complete this section in addition to the previous sections according to the type of wound the patient has. Place an X in the appropriate box.

D1 Complete these questions for Pressure ulcers

Has the patient been on a turning schedule?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Is the patient using a group 2 or group 3 support surface?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Have moisture and incontinence been appropriately managed?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>

If any of the answers above are answered no and these treatment measures have been considered and ruled out, please explain.

D2 Complete these questions for Neuropathic ulcers

Has the patient been on a comprehensive diabetic management program?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Has reduction in pressure on a foot ulcer been accomplished with appropriate modalities?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>

If either of the answers above are No, and these treatment measures have been considered and ruled out, please explain.

D3 Complete these questions for Surgical or Traumatic wounds

Does the patient have complications of a surgically created wound?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Does the patient have a traumatic wound?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>

Is there documentation for the medical necessity for accelerated formation of granulation tissue that cannot be achieved by other available topical wound treatments? If yes, please explain.

D4 Complete these questions for Venous Insufficiency ulcers

Have compression bandages or garments been consistently applied?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Has leg elevation and ambulation been encouraged?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>

If either of the answers above are No, and these treatment measures have been considered and ruled out, please explain.

D5 Complete these questions for Arterial or Chronic ulcers

Has relief of pressure over the wound been achieved?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Have moisture and incontinence been controlled?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>

If either of the answers above are No, and these treatment measures have been considered and ruled out, please explain.

Section E

Physician Signature, Attestation, and Date

I certify that I am the physician listed in section A of this form. I have received sections A through E of the certificate of medical necessity. All supplemental attachments and any statement on my letterhead, attached hereto, have been reviewed and signed by me. I certify that the medical necessity information in Section B thru D is true, accurate, and complete to the best of my knowledge, and I understand falsification, omission, or concealment of material fact in that section may subject me to civil or criminal liability.

Physician Signature:

Date:

Patient Name		RID Number			
Negative Pressure wound Therapy Supplemental Form					
Supplemental Section C (A supplement for each additional wound must be completed)		Wound number # _____			
Type of wound (check one)		Wound site: _____			
Arterial insufficiency ulcer _____					
Stage 3 or 4 pressure ulcer _____		Approximate age of wound _____			
Chronic ulcer of mixed etiology _____					
Venous stasis ulcer _____		Wound measurements			
Neuropathic ulcer (such as diabetic) _____		Current	One month ago		
Traumatic (such as pre-op graft or flap) _____		Length ___ cm	Length ___ cm		
Surgically created (such as dehisced) _____		Width ___ cm	Width ___ cm		
		Depth ___ cm	Depth ___ cm		
		Exudate			
		Current	One month ago		
		Slight _____	Slight _____		
		Moderate _____	Moderate _____		
		Heavy _____	Heavy _____		
Supplemental Section D	Complete this section according to the type of wound in addition to the previous sections. Place an X in the appropriate box				
Supplemental D1 Complete these questions for Pressure ulcers					
Has the patient been on a turning schedule?		Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Is the patient using a group 2 or group 3 support surface?		Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Have moisture and incontinence been appropriately managed?		Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
If any of the answers above are No, and these treatment measures have been considered and ruled out, please explain.					
Supplemental D2 Complete these questions for Neuropathic ulcers					
Has the patient been on a comprehensive diabetic management program?		Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Has reduction in pressure on a foot ulcer been accomplished with appropriate modalities?		Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
If either of the answers above are No, and these treatment measures have been considered and ruled out, please explain.					
Supplemental D3 Complete these questions for Surgical or Traumatic wounds					
Does the patient have complications of a surgically created wound?		Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Does the patient have a traumatic wound?		Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Is there documentation for the medical necessity for accelerated formation of granulation tissue that cannot be achieved by other available topical wound treatments? If yes, please explain.					
Supplemental D4 Complete these questions for Venous Insufficiency ulcers					
Have compression bandages or garments been consistently applied?		Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Has leg elevation and ambulation been encouraged?		Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
If either of the answers above are No, and these treatment measures have been considered and ruled out, please explain.					

Patient Name			RID Number	
Negative Pressure wound Therapy Supplemental Form (continued)				
Supplemental D5 Complete these questions for Arterial or Chronic ulcers				
Has relief of pressure over the wound been achieved?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Have moisture and incontinence been controlled?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
If either of the answers above are No, and these treatment measures have been considered and ruled out, please explain.				
Physician Signature:			Date:	