Indiana Health Coverage Programs

Medical Clearance Form

Negative Pressure Wound Therapy

Section A	**Certification Date**	**Initial:** _____	**Revised:** _____

Patient name Address		Supplier name Address	
Phone number _____	RID number _____	Phone number _____	Provider number _____
Place of service _____ Name and address of facility (if applicable)	HCPCS Code	PT DOB_____; Sex___(M/F) HT_____(IN); WT_____(LBS) 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) _____

Answers	Select 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○	Have 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 out this section for the primary wound and fill out a supplemental form for each additional wound.

Type of wound (select 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 _____

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. Select the appropriate response.**

D1 Complete these questions for pressure ulcers

Has the patient been on a turning schedule?	Yes	○	No	○
Is the patient using a group 2 or group 3 support surface?	Yes	○	No	○
Have moisture and incontinence been appropriately managed?	Yes	○	No	○

If any of the previous answers are 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	○	No	○
Has reduction in pressure on a foot ulcer been accomplished with appropriate modalities?	Yes	○	No	○

If either of the previous answers is 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	○	No	○
Does the patient have a traumatic wound?	Yes	○	No	○

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	○	No	○
Have leg elevation and ambulation been encouraged?	Yes	○	No	○

If either of the previous answers is 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	○	No	○
Have moisture and incontinence been controlled?	Yes	○	No	○

If either of the previous answers is 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 Sections B through 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 (select 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. Select the appropriate response.**

Supplemental D1 Complete these questions for pressure ulcers

Has the patient been on a turning schedule?	Yes	○	No	○
Is the patient using a group 2 or group 3 support surface?	Yes	○	No	○
Have moisture and incontinence been appropriately managed?	Yes	○	No	○

If any of the previous answers 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	○	No	○
Has reduction in pressure on a foot ulcer been accomplished with appropriate modalities?	Yes	○	No	○

If either of the previous answers is 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	○	No	○
Does the patient have a traumatic wound?	Yes	○	No	○

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	○	No	○
Has leg elevation and ambulation been encouraged?	Yes	○	No	○

If either of the previous answers is 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	○	No	○
Have moisture and incontinence been controlled?	Yes	○	No	○
If either of the previous answers is No, and these treatment measures have been considered and ruled out, please explain.				
Physician Signature:				**Date:**