Performance Care

Certificate of Medical Necessity

NEGATIVE PRESSURE WOUND THERAPY (NPWT)

PATIENT NAME: **DOB:** **HEIGHT/WEIGHT:**	**SUPPLIER**: PERFORMANCE CARE **Address**: 121 Fairway Dr. Nashville, TN 37214 **Phone**: 615-647-7828 – Fax: 615-953-7946

PHYSICIAN (FULL) NAME: **NPI:**

PHONE: **FAX:**

PRODUCTS:

❒ Negative Pressure Wound Therapy System with 15 kits (A6550) & 10 Canisters (A7000)

Length of Need in Months: 1 2 3 4 Other_____

THERAPY SETTINGS:

❒ Continuous Mode: _____ mmHG (40 mmHg-200 mmHG)

❒ Variable Intermittent Mode:

Low Pressure (40-200) _____ mmHg Cycle Time (1 minute increments) _____

High Pressure (40-200) _____ mmHg Cycle Time (1 minute increments) _____

DIAGNOSIS:

Wound Type: _____ Stage (if applicable): _____ Diagnosis Code(s): _____

Other Contributing Diagnoses:

Previous Treatments to Wound:

CLINICAL INFORMATION:

Y	N	n/a	1. Is the patient being seen regularly by a nurse, physician, or other licensed practitioner?
Y	N	n/a	2. Has a care plan been established including ongoing nutritional assessments and consistent interventions?
Y	N	n/a	3. Has the patient been involved in a comprehensive ulcer treatment program?
Y	N	n/a	4. Is the wound full thickness?
Y	N	n/a	5. Is the moisture/incontinence being appropriately managed?
Y	N	n/a	6. Has the wound environment remained moist?
Y	N	n/a	7. Is there 20% or less eschar in the wound?
Y	N	n/a	8. Has the patient been on a Group 2 or 3 surface relieving the pressure on the trunk or pelvis?
			If yes, what type of mattress: _____
Y	N	n/a	9. Has NPWT ever been utilized prior? If yes, date: _____

Order Date: _____

Physician Signature: _____ **Signature Date: _____**

By signing above, I am authorizing the order of a Negative Pressure Wound Therapy (NPWT) System as a medically necessary for the patient listed above. I am also proclaiming that all other applicable healing treatments have been attempted or considered and ruled out. I have read and understand all safety information and instructions for use included with this specific product as well as the systems it is contraindicated for: patients with malignancy of the wound, untreated osteomyelitis, non-enteric or unexplored fistulas, or necrotic tissue with the presence of eschar. Dressings for the NPWT System should never be directly placed in contact with exposed blood vessels, anastomotic sites, organs, or nerves. I prescribe the NPWT system and up to 15 dressings per wound and 10 canisters per month. PHYSICIAN SIGNATURE COVERS ALL SECTIONS ON NPWT CERTIFICATE OF MEDICAL NECESSITY AND STATEMENT OF ORDERING PHYSICIAN.

FAX TO PERFORMANCE CARE AT 615-953-7946