Utilization Management
Phone: 1-877-284-0102 Fax: 1-800-510-2162

Durable Medical Equipment - Wound Vac Precertification Review

Date: _____ Reference #: _____(provided after initial review)
A Utilization Management representative will fax you a notification number by the next business day after receiving this completed form. This notification number does not indicate an approval or denial of benefits, but only proof that the Plan has been notified. This information will be forwarded to the Plan's Managed Care Department. If you have any questions, please call HealthLink at 1-877-284-0102.

Provider Information

Provider Name: _____

Address: _____

Phone: _____

Fax: _____

Patient Information

Patient Name: _____

ID Number: _____

Address: _____

Patient's DOB: _____

Phone: _____

Ordering Physician Information

Ordering Physician Name: _____

Address: _____

Phone: _____

Fax: _____

TIN: _____

Treatment Information

Pertinent Medical History (submit history, physical and include previous treatments and dates): _____

_____

_____

Procedure (ICD-10) Code(s): _____

Anticipated Treatment Date(s): _____

Has the patient participated in a complete wound care program? ☐ YES ☐ NO

If the patient has not participated in a wound care program has it been tried or considered and ruled out prior to the addition of vacuum assisted wound therapy? ☐ YES ☐ NO

If no, please explain _____

If yes, did the wound care program include the following? (Check all that apply)

☐ Documentation in the individual's medical record of evaluation, care, and wound measurements by a licensed medical professional

☐ Application of dressings to maintain a moist environment

☐ Debridement of necrotic tissue if present

☐ Evaluation of and provision for adequate nutritional status

☐ All underlying conditions have been stabilized or are under current management (i.e., diabetes, venous insufficiency

Does the patient's condition meet any of the following:

☐ Stage III or IV pressure ulcers at initiation of vacuum assisted wound therapy

☐ Has the individual been appropriately turned and positioned

If no, please explain: _____

☐ None of the above

Does the individual have a pressure ulcer on the posterior trunk or pelvis? ☐ YES ☐ NO

If yes, is a group 2 or 3 support surface (mattress) being used? ☐ YES ☐ NO

Has the individual's moisture and incontinence been appropriately managed? ☐ YES ☐ NO ☐ N/A

Does the patient have a neuropathic ulcer? ☐ YES ☐ NO

If yes, has the individual been on a comprehensive diabetic management program? ☐ YES ☐ NO

Has reduction of pressure of a foot ulcer been accomplished with appropriate modalities? ☐ YES ☐ NO ☐ N/A

Is the ulcer(s) related to venous or arterial insufficiency? ☐ YES ☐ NO

If yes, have compression bandages and/or garments been consistently applied? ☐ YES ☐ NO

Has reduction in pressure of a foot ulcer been accomplished with appropriate modalities? ☐ YES ☐ NO ☐ N/A

If care is in the home setting has the ulcer been present for at least 30 days? ☐ YES ☐ NO

Is the wound dehisced or with exposed hardware or bone? ☐ YES ☐ NO

Is the wound:

☐ Post sternotomy infection

☐ Mediastinitis

☐ None of the above

Are there complications of a surgically created wound where accelerated granulation therapy is necessary and cannot be achieved by other available topical wound treatment? ☐ YES ☐ NO

Do any of the following apply?

☐ Necrotic tissue with eschar present

☐ Untreated osteomyelitis

☐ Non-enteric and unexplored fistulas

☐ Malignancy in the wound

☐ Exposed vasculature

☐ Exposed nerves

☐ Exposed anastomotic site

☐ Exposed organs

☐ None of the above

Please provide any additional clinical information

_____

_____

_____

Provider Contact Information

Contact Person: _____

Title: _____

Phone: _____

Fax: _____