LIBERTY MEDICAL SPECIALTIES

# Certificate of Medical Necessity

612-10 Jefferson Street
Whiteville, NC 28472
Phone: 1-800-297-7567
Fax: 1-866-982-0109

Date of Order: _____
Patient Name: _____ Social Security #: _____
Address: _____ Phone: _____

## PATIENT'S WOUND HISTORY

1. Was NPWT initiated in an inpatient facility? ☐ Yes ☐ No
   If Yes, Name of Facility: _____ Date NPWT was initiated: ____/____/____
2. Is there anything compromising the patient's nutritional status? ☐ Yes ☐ No
   If Yes, what measures have been taken?
   ☐ Protein Supplements ☐ Enteral/NG Feeding ☐ TPN
   ☐ Vitamin Therapy ☐ Special Diet ☐ Other _____
3. Is NPWT being ordered for any type of chronic wound (more than 30 days)? ☐ Yes ☐ No
   If Yes, which previous therapies have been applied to maintain a moist wound environment?
   ☐ Saline Soaked Gauze ☐ Hydrocolloid ☐ Alginate
   ☐ Hydrogel ☐ Absorptive ☐ Other _____
4. Is the patient on a comprehensive diabetic management program? ☐ Yes ☐ No ☐ N/A
5. Is the patient's wound a direct result of an accident? ☐ Yes ☐ No
   Accident Type: ☐ Auto ☐ Employment ☐ Trauma ☐ Responsible Party: _____
6. Is there muscle, bone, tendons exposed? ☐ Yes ☐ No

## ADDITIONAL INFORMATION BY WOUND TYPE

a. ☐ Pressure Ulcer: ☐ Stage III ☐ Stage IV
   Is moisture/incontinence being managed? ☐ Yes ☐ No ☐ N/A
   Is a specialized support surface being used for ulcers on the posterior pelvis or trunk? ☐ Yes ☐ No ☐ N/A
   Is the patient being turned and positioned? ☐ Yes ☐ No ☐ N/A
b. ☐ Diabetic and/or Neuropathic Ulcer
   Is foot pressure being reduced? ☐ Yes ☐ No ☐ N/A
c. ☐ Wound: ☐ Traumatic ☐ Surgically Created ☐ Dehisced
d. ☐ Venous Insufficiency
   Are compression bandages and/or garments being consistently applied? ☐ Yes ☐ No ☐ N/A
e. ☐ Chronic ulcer of Mixed or Unknown Etiology, Including Arterial Insufficiency
   Is pressure over the wound being relieved? ☐ Yes ☐ No ☐ N/A
   Is moisture/incontinence being managed? ☐ Yes ☐ No ☐ N/A

## WOUND MEASUREMENTS

Wound #1 Type: _____ Wound Age (mos): _____
Is there less than 20% slough/fibrin in the wound? ☐ Yes ☐ No
Are serial debridements required? ☐ Yes ☐ No
Measurement date: _____ Wound Location: _____
Length: _____ cm Width: _____ cm Depth: _____ cm
Is there undermining? ☐ Yes ☐ No
Location #1: _____ cm, at _____ o'clock
Location #2: _____ cm, at _____ o'clock
Is there tunneling/sinus? ☐ Yes ☐ No
Location #1: _____ cm, at _____ o'clock
Location #2: _____ cm, at _____ o'clock
Does wound have MRSA? ☐ Yes ☐ No

Wound #2 Type: _____ Wound Age (mos): _____
Is there less than 20% slough/fibrin in the wound? ☐ Yes ☐ No
Are serial debridements required? ☐ Yes ☐ No
Measurement date: _____ Wound Location: _____
Length: _____ cm Width: _____ cm Depth: _____ cm
Is there undermining? ☐ Yes ☐ No
Location #1: _____ cm, at _____ o'clock
Location #2: _____ cm, at _____ o'clock
Is there tunneling/sinus? ☐ Yes ☐ No
Location #1: _____ cm, at _____ o'clock
Location #2: _____ cm, at _____ o'clock

## PRESCRIPTION, ATTESTATION AND PHYSICIAN INFORMATION (Physician must sign & date)

**I prescribe NPWT pump (E2402) and up to 15 dressing kits (A7000), and 10 canister kits (A6550) per month for _____ months, starting therapy on _____ for the following diagnosis _____ ICD-9 Code_____**
Cleanse wound with _____ Change dressing (how often) _____ Setting to be placed at _____ MMMHG, ☐ Foam ☐ Gauze
Goal at completion of NPWT: ☐ Assist granulation tissue formation ☐ Flap ☐ Graft ☐ Delayed primary closure

Physician Signature: _____ Date: _____
*By my signature, I attest that I am prescribing NPWT as medically necessary and all other applicable treatments have been tried or considered and ruled out. I have read and understood all safety information and other instructions for NPWT as well as NPWT clinical guidelines.*
Physician Name: _____
Address: _____ City: _____ State: _____ Zip: _____
Phone: _____ Fax: _____ NPI: _____