

Review Request for Vacuum-Assisted Wound Therapy

Please fax the completed form to **1-800-823-5520**.

If you have questions, call **1-866-902-1689** during regular business hours.

Policy Last Review Date: 8/28/08	Policy Effective Date: 10/22/08	Provider Tool Effective Date: 8/10/09
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Member Name:	Date of Birth:
Insurance Identification Number:	Member Phone Number:
Ordering Provider Name and Specialty:	Provider ID Number:
Office Address:	
Office Phone Number:	Office Fax Number:
Rendering Provider Name and Specialty:	Provider ID Number:
Office Address:	
Office Phone Number:	Office Fax Number:
Facility Name:	Facility ID Number:
Facility Address:	
Date/Date Range of Service:	Place of Service: <input type="checkbox"/> Home <input type="checkbox"/> Inpatient <input type="checkbox"/> Outpatient <input type="checkbox"/> Other: _____
Service Requested (CPT if known):	
Diagnosis (ICD-9) if known:	

Please check all that apply to the member:

Initial Request

- The request is for the initiation of vacuum-assisted wound therapy in the outpatient setting
- Participation in a complete wound care program has been tried or considered and ruled out prior to the addition of vacuum-assisted wound therapy (check all that apply):
 - Documentation in member's medical record of evaluation, care and wound measurements by a licensed medical professional
 - Location of wound: _____
 - Wound measurements (cm): _____
 - Application of dressings to maintain a moist environment
 - Debridement of necrotic tissue, if present, without presence of fistula formation, macroscopic contamination or presence of malignant cells

- Evaluation of and provision for adequate nutritional status
(please list provisions, if applicable): _____
- All underlying medical conditions (i.e. diabetes, venous insufficiency, etc.) have been stabilized or are under current management (i.e., diabetes, venous insufficiency)

The member has any of the following conditions: (check all that apply)

- Pressure ulcers -Stage III or Stage IV (If checked, complete below)
 - Member has been appropriately turned and positioned
 - Member has used a group 2 or 3 support surface for pressure ulcers on the posterior trunk or pelvis (no special support is required for ulcers not located on the trunk or pelvis)
 - Member's moisture and incontinence have been appropriately managed
- Neuropathic ulcers (If checked, complete below)
 - Member has been on a comprehensive diabetic management program
 - Reduction in pressure on a foot ulcer has been accomplished with appropriate modalities
- Ulcers related to venous or arterial insufficiency (If checked, complete below)
 - Compression bandages and/or garments have been consistently applied
 - Reduction in pressure on a foot ulcer has been accomplished with appropriate modalities
 - The request is for initiation of treatment in the home setting and the ulcer has been present for at least 30 days
- Dehisced wounds or wounds with exposed hardware or bone
- Post-sternotomy wound infection or mediastinitis
- Complications of a surgically created wound where accelerated granulation therapy is necessary and cannot be achieved by other available topical wound treatment
- Other: _____

Continuation Request

- Request is for continued use of vacuum assisted wound therapy in the outpatient setting
- Documentation of the weekly assessment of the wound(s) dimensions and characteristics by a licensed health care professional:
 - Date _____ Wound measurements (cm) _____ Wound characteristics _____
 - Date _____ Wound measurements (cm) _____ Wound characteristics _____
 - Date _____ Wound measurements (cm) _____ Wound characteristics _____
 - Date _____ Wound measurements (cm) _____ Wound characteristics _____
- There is a failure of progressive wound healing without intervening complications
- In the judgment of a treating physician, adequate wound healing has occurred to the degree that vacuum assisted wound closure may be discontinued

This request is being submitted:

- Pre-Claim
- Post-Claim. If checked, please attach the claim or indicate the claim number: _____
- By checking this box, I attest the information provided is true and accurate to the best of my knowledge. I understand that BlueChoice HealthPlan Medicaid may perform a routine audit and request the medical documentation to verify the accuracy of the information reported on this form.

Name and Title of Provider or Provider Representative
Completing Form (Please Print)*

Date

***The attestation fields must be completed by a provider or provider representative in order for the tool to be accepted.**