Kansas Medical Assistance Program

Negative Pressure Wound Therapy Prior Authorization Request

FORM INSTRUCTIONS

1. This form must be completed by the MEDICAL STAFF who are currently caring for the beneficiary.
2. **The durable medical equipment (DME) provider MAY NOT fill out any part of this form.**
3. This form must be submitted to the Kansas Medical Assistance Program (KMAP) by the DME provider.
4. The DME provider must attach a completed General Prior Authorization Request Form prior to submitting to KMAP.
5. All spaces must be filled out completely. (Incomplete requests will be returned unprocessed.)
6. All information must be within 30 days prior to the dates being requested.
7. The DME provider must maintain supporting documentation in the beneficiary's file at all times.
8. Prior authorization (PA) requests will be considered for up to 30 days at a time. (Backdating is not allowed.)
9. The request must include a copy of the physician's prescription, current labs, and one page office/hospital notes showing onset date of the wound.

PLEASE PRINT ALL INFORMATION LEGIBLY.

BENEFICIARY NAME	BENEFICIARY ID NUMBER	
NAME OF HOME HEALTH AGENCY	PHONE NUMBER	FAX NUMBER
PHYSICIAN NAME	PHONE NUMBER	FAX NUMBER
SERVICE DATES	ESTIMATED LENGTH OF NEED	

BENEFICIARY IS CURRENTLY IN (CHECK ONLY ONE): ☐ SKILLED NURSING FACILITY ☐ HOSPITAL ☐ SPECIALTY HOSPITAL ☐ HOME

UPCOMING DISCHARGE DATE (IF APPLICABLE): ☐ GROUP HOME ☐ ASSISTED LIVING ☐ OTHER FACILITY:

BENEFICIARY SPECIFIC INFORMATION

HEIGHT	WEIGHT	LIFE EXPECTANCY	TURNING SCHEDULE	AMBULATORY STATUS	CAREGIVER

CURRENT SUPPORT SURFACE	BENEFICIARY COMPLIANCE OF WOUND HEALING PROMOTION (PLEASE DESCRIBE):

LIFESTYLE CHANGES MADE TO PROMOTE HEALING AND PREVENT REOCCURRENCE:

WHAT IS THE GOAL OF THERAPY?	☐ MAINTAIN FLAP	☐ GRAFT ISSUES	☐ AID IN GRANULATION

BENEFICIARY DIAGNOSES

DESCRIBE IN DETAIL ALL OF THE BENEFICIARY'S MEDICAL CONDITIONS/DIAGNOSES:

ARE THESE CONDITIONS CONTROLLED/STABLE? ☐ YES ☐ NO

IF NO, PLEASE SPECIFY REASONS:

MENTAL/BEHAVIOR

RATE THE FOLLOWING AS **A**LWAYS, **S**OMETIMES OR **N**EVER:

ALERT ☐ A ☐ S ☐ N ORIENTED ☐ A ☐ S ☐ N

COMPLIANCE WITH CARE ☐ A ☐ S ☐ N

COMMENTS

NUTRITIONAL/DIETARY STATUS

TUBE FED	SELF FED			TOTAL DAILY CALORIES
☐ YES	WITH ASSIST	☐ YES	☐ NO	
☐ NO		☐ YES	☐ NO	

LIST ALL NUTRITIONAL SUPPLEMENTS GIVEN:

LABS

PLEASE INCLUDE DATE DRAWN FOR EACH LAB.

ALBUMIN	PREALBUMIN	HgbA1C (IF APPLICABLE)	HEMATOCRIT

HEMOGLOBIN

WOUND INFORMATION

ALL WOUND INFORMATION MUST BE CURRENT STAGE NOT HEALING STAGE.

1. WHAT IS THE ONSET DATE (ORIGINAL DATE) OF THE WOUND? _____
2. IS THERE A FISTULA TO AN ORGAN OR BODY CAVITY WITHIN THE VICINTY OF THE WOUND? ☐ YES ☐ NO
3. IS UNTREATED OSTEOMYELITIS PRESENT WITHIN THE VICINTY OF THE WOUND? ☐ YES ☐ NO
4. IS CANCER PRESENT IN THE WOUND? ☐ YES ☐ NO
5. DID THE WOUND BEGIN AS AN ABSCESS OR CYST? ☐ YES ☐ NO

IF YES, PLEASE EXPLAIN INCLUDING ALL SURGERY DATES:

6. WHAT IS THE TYPE OF WOUND? (CHOOSE ONE.)

SURGICAL	☐ YES	☐ NO	**PRESSURE**	☐ YES	☐ NO
IF YES,			IF YES,		
A. TYPE OF SURGERY			A. SUPPORT SURFACE IN USE?	☐ YES	☐ NO
			1. IF YES, KIND?		
B. DATE OF SURGERY			B. MOISTURE/INCONTINENCE MANAGED?	☐ YES	☐ NO
C. DATE DEHISCED			1. IF YES, HOW?		
D. DEBRIDEMENT DATES			C. DEBRIDEMENT DATES		
NEUROPATHIC	☐ YES	☐ NO	**VENOUS STASIS ULCER**	☐ YES	☐ NO
IF YES,			IF YES,		
A. ON A COMP. DIABETIC MANAGEMENT PROGRAM?	☐ YES	☐ NO	A. COMPRESSION GARMENTS CONSISTENTLY APPLIED?	☐ YES	☐ NO
B. ARE BLOOD SUGARS WITHIN NORMAL LIMITS?	☐ YES	☐ NO	B. LEGS ELEVATED CONSISTENTLY?	☐ YES	☐ NO
C. DEBRIDEMENT DATES			C. IS BENEFICIARY AMBULATING?	☐ YES	☐ NO
			D. DEBRIDEMENT DATES		

7. IS THE BENEFICIARY DIABETIC?	☐ YES	☐ NO	IF THIS IS A DIABETIC WOUND, INDICATE THE WAGNER GRADE:

8. HAS THE BENEFICIARY BEEN HOSPITALIZED IN THE LAST TWO YEARS? ☐ YES ☐ NO
IF YES, GIVE DATES AND REASONS:

9. LIST ALL TREATMENTS/DRESSINGS (INCLUDING START DATE OF EACH TREATMENT) TRIED PRIOR TO NPWT (SUCH AS WET/DRY, POWDERS, DRESSINGS, AND BANDAGES):

10. WHY WERE PREVIOUS TREATMENTS DISCONTINUED OR CONSIDERED INEFFECTIVE?

13. DOES BENEFICIARY HAVE HOME NURSING CARE? ☐ YES ☐ NO

IF NO, WHY NOT?

14. PLEASE DESCRIBE IN DETAIL THE PLAN OF CARE (AT HOME) INCLUDING WHO THE CAREGIVERS ARE, TRAINING DONE, TURNING, DRESSING CHANGES, AND INCONTINENCE ISSUES:

WOUND EVALUATION

	WOUND A	WOUND B	WOUND C	WOUND D
LOCATION				
SIZE (W X L X D)				
FREE OF NECTROTIC TISSUE/ESCHAR (yes/no)				
STAGE/GRADE				
DRAINAGE-color, odor, amount				
TUNNELING-amount, location				
UNDERMINING-amount, location				

PLEASE LIST ANY OTHER CONDITIONS THE BENEFICIARY HAS THAT MAY RESULT IN DECREASED HEALING:
HOW IS IT BEING MANAGED?

LIST ALL MEDICATIONS CURRENTLY BEING TAKEN:

ADDITIONAL COMMENTS	
ALL INFORMATION ON THIS FORM IS TRUTHFUL AND CORRECT. I AM NOT EMPLOYED BY THE DME PROVIDER. I HAVE PERSONALLY SEEN AND CURRENTLY PROVIDE MEDICAL CARE FOR THIS BENEFICIARY IN HIS OR HER HOME OR ON AN OUTPATIENT BASIS.	
MEDICAL STAFF NAME (PLEASE PRINT LEGIBLY.)	
MEDICAL STAFF SIGNATURE	TELEPHONE NUMBER
TITLE	DATE