CARE 1ST HEALTH PLAN ARIZONA

ONECARE

NEGATIVE PRESSURE WOUND THERAPY NETWORK UPDATE

September 24, 2015

Dear Care1st and ONECare Providers:

Effective immediately, the Care1st & ONECare durable medical equipment provider for **Negative Pressure Wound Therapy (Wound Vac)** is:

MedOne – Wound Vac
Phone 480.729.6984
Fax 480.729-6999

MedOne has partnered with Care1st & ONECare to offer comprehensive Wound Vac services to Care1st & ONECare members. MedOne is the exclusive Wound Vac provider for Care1st & ONECare.

To set up your Care1st or ONECare member with Wound Vac services, complete the attached Certificate of Medical Necessity and fax it to MedOne at the number referenced above along with a patient demographic sheet and H&P. MedOne will review and submit to Care1st/ONECare for prior authorization.

The *Prior Authorization Guidelines* are also available on our website www.care1st.com/az in the following location:
Care1st > Providers > Prior Authorization Guidelines and Criteria

If you have any questions regarding this change, Provider Network Operations is available to help at the numbers below.

Thank you!

Certificate of Medical Necessity

Please contact Customer Service
888.835.9811
Please FAX completed form, patient demographic sheet, and H&P to: **888.205.2628 or**
Local Fax: Tuc-520.398.7756, Phx-480.835.9104

Patient Name: ____ DOB: __________________ Phone:___________________________

Address:____ City: ________________________ Zip: _____________

PATIENT'S WOUND HISTORY

1. Will the NPWT be used in a □ Nursing Home/ Rehab □ Private Resident □ LTAC □ ALF □ Other_________________________
   Name of Facility: ______________________________ Phone:______________________ 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 the patient's wound a direct result of an accident? □ Yes □ No Date of accident: __/__/__
   Accident Type: □ Auto □ Employment □ Trauma □ Responsible Party: ____

ADDITIONAL INFORMATION BY WOUND TYPE (*CHECK ONLY ONE*)

I. a. □ Pressure Ulcer: □ Stage III □ Stage IV
   Is moisture/incontinence being managed? □ Yes □ No □ N/A
   Was Group 2 or 3 support surface used on the posterior pelvis or trunk prior to and during NPWT? □ Yes □ No □ N/A
   Is the patient being turned and positioned? □ Yes □ No □ N/A

b. □ Diabetic and/or Neuropathic Ulcer/ Arterial Ulcer or Arterial insufficiency
   Is the patient on a comprehensive diabetic management program? _ Yes _ No _ N/A
   Is pressure over wound being relieved? □ Yes □ No □ N/A

c. □ Venous Insufficiency/ Venous Stasis
   Are compression bandages and/or garments being consistently applied? □ Yes □ No □ N/A
   Is elevation/ambulation being encouraged? □ Yes □ No □ N/A

d. □ Chronic Ulcer of Mixed or Unknown Etiology
   Thick callus surrounding wound must be debrided prior to NPWT. Was it? □ Yes □ No □ N/A
   Wound must be present for more than 30 days. Was it? □ Yes □ No

e. □ Traumatic: Describe____ Surgical: □ Dehisced □ Non-Dehisced

II. a. List previous treatments applied to maintain a moist wound environment without wound responding:
   □ Saline Soaked Gauze □ Hydrocolloid □ Alginate □ Hydrogel □ Absorptive □ Other: ______________________________

b. If other therapies were considered and ruled out, what conditions prevented you from using other therapies prior to NPWT?
   □ Presence of co-morbidities □ High risk of infection □ Need for accelerated granulation tissue
   □ Prior history of delayed wound healing □ Other, please explain ______________________________

WOUND MEASUREMENTS

Wound #1 Type: _____________Wound Age (mos): _____
Is there less than 20% slough/fibrin in the wound? □ Yes □ No
Was wound debrided recently? □ Yes □ No If yes, date: __________
Are serial debridements required? □ Yes □ No
Is muscle, tendon or bone exposed? _ Yes _ No
Does wound have MRSA? □ Yes □ No
Measurement date: __________ Wound Location: __________________
Length: ________cm Width:_________ cm Depth: ________cm
Is there undermining? □ Yes □ No
Location #1:_______________ cm, from ______ to______ o'clock
Location #2:_______________ cm, from ______ to______ o'clock
Is there tunneling/sinus? □ Yes □ No
Location #1:______________ cm, from ______ to______ o'clock
Drainage Amt: ____________________ Type:____________________

Wound #2 Type: _____________Wound Age (mos): _____
Is there less than 20% slough/fibrin in the wound? □ Yes □ No
Was wound debrided recently? □ Yes □ No If yes, date: ____________
Are serial debridements required? □ Yes □ No
Is muscle, tendon or bone exposed? _ Yes _ No
Does wound have MRSA? □ Yes □ No
Measurement date: __________ Wound Location: __________________
Length: ________cm Width:_________ cm Depth: ________cm
Is there undermining? □ Yes □ No
Location #1:_______________ cm, from _____ to______ o'clock
Location #2:_______________ cm, from ______ to______ o'clock
Is there tunneling/sinus? □ Yes □ No
Location #1:_______________ cm, from ______ to______ o'clock
Drainage Amt: ____________________ Type:____________________

ORGANIZATION PROVIDING THE PATIENTS CLINICAL CARE

Name of company:_____________________________________ Phone number: ______________________Fax:_________________
Contact:____ Phone Number: ____

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

I prescribe Genadyne (No Substitutions) NPWT system, up to 15 dressing kits □ Foam or □ Gauze, and 10 canisters kits per month for _______ months at: _______mmHg, Start of care: ____________Skilled Clinician to perform Dressing Change (frequency): _______________,
Cleanse wound with: _____________________ Dressing Kits: □ Sm □ Med □ Lg / PVA Foam: □ Rope □ Sm □ Lg/ Other____________
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: ____________________________________ **MD License** ____________________ **NPI**_______________________

Address: ____ **City:**______________________ **State:**________ **Zip:**___________

Phone: ______________________ **Fax:** _____________________________