Negative Pressure Wound Therapy (NPWT)

Policy Number: MM.01.005
Original Effective Date: 11/19/1999
Line(s) of Business: HMO; PPO; QUEST
Current Effective Date: 01/01/2015
Section: DME
Place(s) of Service: Home

I. Description

Negative pressure wound therapy (NPWT) also referred to as vacuum-assisted wound closure is a non-invasive device designed to promote healing in acute and chronic wounds by localized controlled negative pressure. The goal of NPWT is to achieve a closed wound in the shortest possible period of time with the least trauma to the patient. For this technique, sterile, open cell foam dressing with tubing is placed into the wound bed after obtaining hemostasis. The wound is covered with a clear adhesive drape to achieve a sealed environment and an evacuation tube is connected to the tubing of the foam dressing. Negative pressure is then applied by a computerized vacuum pump programmed to deliver the appropriate amount of pressure intermittently or continuously, depending on the characteristics of the specific wound. Wound fluid is evacuated and collected in a canister attached to the pump. Dressing changes are performed every 48 hours for the majority of patients.

II. Criteria/Guidelines

A. Negative pressure wound therapy (NPWT) is covered (subject to Limitations/Exclusions and Administrative Guidelines) when criterion 1 or 2 and criteria 3 and, if applicable, 4 are met:

1. There is a chronic ulcer with lack of improvement for at least the previous 30 days despite consistent application of moist topical dressings.
2. There is a complex wound (usually a surgical or traumatic wound) where size, depth, location, complications, etiology and/or other patient specific factors support that application of moist topical dressings is not feasible.
3. The following standard wound treatment measures have been accomplished for all chronic ulcers and complex wounds:
   a. Evaluation of wound with documentation of measurements (length, width and depth) at baseline and at least weekly by a licensed medical professional.
   b. Debridement of necrotic tissue, if present
c. Treatment of infection, if present

d. Evaluation and provision of adequate nutrition

e. Management of diabetes mellitus, if applicable

f. Evaluation and management of peripheral artery disease, if applicable

4. The following standard wound treatment measures have been accomplished for chronic ulcers:

a. For stage III or IV pressure ulcer:
   i. The patient has been appropriately turned and positioned; and
   ii. The patient has used a support surface for pressure ulcers on the posterior trunk or pelvis (pressure reducing mattress or pad), (a support surface is not required if the ulcer is not on the trunk or pelvis); and
   iii. Moisture and incontinence have been appropriately managed.

b. For neuropathic ulcer (e.g., diabetic ulcer)
   i. The patient has been on a comprehensive diabetic management program; and
   ii. Reduction in pressure on a foot ulcer has been accomplished with appropriate modalities.

c. For venous insufficiency ulcer:
   i. Compression bandages and/or garments have been consistently applied, and
   ii. Leg elevation and ambulation have been encouraged.

III. Limitations/Exclusions

A. NPWT is contraindicated for patients with any of the following conditions:
   1. Rapidly fatal condition
   2. Poor nutritional status
   3. Fragile skin surrounding wound
   4. Presence of necrotic tissue with eschar
   5. Fistula to an organ or body cavity within the vicinity of the wound
   6. Untreated or advanced osteomyelitis
   7. Malignancy in the wound
   8. Untreated wound infections
   9. Exposed vasculature
   10. Exposed nerves
   11. Exposed anastomotic site
   12. Exposed organs
   13. Noncompliance with therapy

B. Continuation of NPWT is not covered when:
   1. There is no measurable degree of wound healing over the prior month. Wound healing is defined as improvement in either surface area (length x width) or depth of wound.
   2. Wound healing has occurred to the extent that NPWT is no longer medically necessary.
   3. The depth of the wound is less than 1 millimeter, as wounds of this depth cannot accommodate the sponge.

C. Non-powered NPWT devices, e.g., Smart Negative Pressure (SNaP) Wound Care System, are not covered as they are not known to improve health outcomes.
IV. Administrative Guidelines

A. Precertification is required for initiation and continuation of NPWT. Requests will be authorized for a duration of one month at a time. To precertify, please complete HMSA's Precertification Request and mail or fax the form as indicated.

1. Initial precertification requests must include documentation from the medical record supporting the following:
   a. Patient has a chronic ulcer with lack of improvement for at least 30 days despite consistent application of moist topical dressing; or
   b. Patient has a complex wound and application of moist topical dressings is not feasible AND
   c. Wound evaluation and accurate wound measurements at baseline and repeated at least weekly by a licensed medical professional;
   d. Debridement of necrotic tissue and treatment of infection, if applicable;
   e. Other applicable wound measures have been accomplished as outlined in criteria II.A.4.

2. Continuation requests must include documentation of accurate wound measurements by a licensed medical personnel supporting a measurable degree of wound healing over the prior month.

B. NPWT pumps (E2402) must be capable of accommodating more than one wound dressing set for multiple wounds on a patient. Therefore, more than one E2402 billed per patient for the same time period will be denied as not meeting payment determination.

C. Coverage is provided up to a maximum of 15 dressing kits (A6550) per wound per month unless there is documentation that the wound size requires more than one dressing kit for each dressing change.

D. Coverage is provided up to a maximum of 10 canister sets (A7000) per month unless there is documentation indicating a large volume of drainage (greater than 90 ml of exudate per day). For high volume exudative wounds, a stationary pump with the largest capacity canister must be used. Excess utilization of canisters related to equipment failure (as opposed to excessive volume drainage) will be denied as not medically necessary.

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<tr>
<th>CPT Code</th>
<th>Description</th>
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<tr>
<td>97607</td>
<td>Negative pressure wound therapy, (eg. vacuum assisted drainage collection), utilizing disposable, non-durable medical equipment including provision of exudate management collection system, topical application(s), wound assessment, and instructions for ongoing care, per session; total wound(s) surface area less than or equal to 50 square centimeters</td>
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<tr>
<td>97608</td>
<td>Negative pressure wound therapy, (e.g. vacuum assisted drainage collection), utilizing disposable, non-durable medical equipment including provision of exudate management collection system, topical application(s), wound assessment, and instructions for ongoing care, per session; total wounds(s) surface area greater than 50 square centimeters</td>
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<td>HCPCS Code</td>
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<tr>
<td>A6550</td>
<td>Dressing set for negative pressure wound therapy electrical pump, stationary or portable, each</td>
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<tr>
<td>A7000</td>
<td>Canister, disposable, used with suction pump, each</td>
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<tr>
<td>E2402</td>
<td>Negative pressure wound therapy electrical pump, stationary or portable</td>
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V. Important Reminder

The purpose of this Medical Policy is to provide a guide to coverage. This Medical Policy is not intended to dictate to providers how to practice medicine. Nothing in this Medical Policy is intended to discourage or prohibit providing other medical advice or treatment deemed appropriate by the treating physician.

Benefit determinations are subject to applicable member contract language. To the extent there are any conflicts between these guidelines and the contract language, the contract language will control.

This Medical Policy has been developed through consideration of the medical necessity criteria under Hawaii’s Patients’ Bill of Rights and Responsibilities Act (Hawaii Revised Statutes §432E-1.4), generally accepted standards of medical practice and review of medical literature and government approval status. HMSA has determined that services not covered under this Medical Policy will not be medically necessary under Hawaii law in most cases. If a treating physician disagrees with HMSA’s determination as to medical necessity in a given case, the physician may request that HMSA reconsider the application of the medical necessity criteria to the case at issue in light of any supporting documentation.

VI. References

1. Blue Cross Blue Shield Association. Negative Pressure Wound Therapy in the Outpatient Setting. 1.01.16; Last revised Jan 2014.
4. Local Coverage Determination (LCD) for Negative Pressure Wound Therapy Pumps (L11489). Effective 11/01/2013.