Negative Pressure Wound Therapy (NPWT)

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. Policy Criteria
A. Negative pressure wound therapy (NPWT) is covered (subject to Limitations 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.

B. Continuation of NPWT on a monthly basis is covered for up to a total of four months, including the time NPWT was applied in an inpatient setting prior to discharge home (subject to Limitations and Administrative Guidelines) when all the following criteria are met:
   1. A licensed medical professional has directly assessed the wound(s) being treated and on at least a monthly basis, documents the changes in the ulcer’s dimensions and characteristics, progress of healing and, if applicable, concurrent measures being addressed relevant to wound therapy (e.g., debridement, nutrition, positioning).
   2. There is a significant, measurable degree of wound healing over the prior month. Wound healing is defined as improvement in either surface area (length × width) or depth of wound.
   3. The depth of the wound is at least 1mm.
   4. A switch to alternative treatment, e.g., moist topical dressings, is not feasible or is contraindicated.

C. Continuation of NPWT beyond four months may be covered on a case-by-case basis when all the following criteria are met:
   1. There is reasonable expectation that the wound will continue to heal with the use of NPWT.
   2. There is specific and detailed documentation of all of the following:
      a. Continuing problems affecting healing of the wound.
      b. Additional measures being undertaken to address these problems and promote healing.
      c. Why a switch to alternative treatment is not possible.

III. Limitations
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 significant, measurable degree of wound healing over the prior month. Wound healing is defined as improvement in either surface area (length × 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.

4. Four months (including the time NPWT was applied in an inpatient setting prior to discharge to home) have elapsed and documentation does not support continued treatment (see criteria II.C.1 and 2.a to c above).

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 not 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. HMSA reserves the right to perform retrospective review using the above criteria to validate if services rendered met payment determination criteria. The following documentation supporting medical necessity should be legible, maintained in the patient’s medical record and made available to HMSA upon request:

1. Initial use of NPWT 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 of NPWT requests must include documentation from the medical record supporting the following:
   a. The wound has been assessed by licensed medical personnel.
   b. Accurate wound measurements by licensed medical personnel supporting a measurable degree of wound healing over the prior month and that depth of the wound is at least 1mm,
   c. Alternative treatment, e.g., moist topical dressings, is not feasible or is contraindicated.

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 Codes</th>
<th>Description</th>
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<tr>
<td>97605</td>
<td>Negative pressure wound therapy (e.g., vacuum-assisted drainage collection), utilizing durable medical equipment (DME), including topical application(s), wound assessment, and instruction(s) 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>97606</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 wound(s) surface area less than or equal to 50 square centimeters</td>
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<tr>
<th>HCPCS Code</th>
<th>Description</th>
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<tbody>
<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 January 2017.


