Policy

Medical Management Department, acting as utilization management delegate, reviews for authorization requests for Negative Pressure Wound Therapy (NPWT) services.

This Medical Policy does not constitute medical advice. When deciding coverage, the enrollee’s specific plan document must be referenced. The terms of an enrollee’s plan document (Certificate of Coverage (COC) or Summary Plan Description (SPD)) may differ from this Medical Policy. In the event of a conflict, the enrollee’s specific benefit plan document supersedes this Medical Policy. All reviewers must first identify enrollee eligibility, any federal or state regulatory requirements, and the plan benefit coverage prior to use of this Medical Policy. Other Policies and Coverage Determination Guidelines may apply. Quartz reserves the right, in its sole discretion, to modify its Policies and Guidelines as necessary.

Procedure

I. Initial Authorization

A. Documentation Required:
In order to facilitate the initial authorization process, the referral requests must include ALL of the following:

1. Physician detailed physical exam and medical history; AND
2. Physician order for NPWT; AND
3. Physical or physiological cause of functional deficit; AND
4. Wound measurements and photographs (if applicable to the request) of the wound to be treated by appropriate licensed healthcare professional; AND
5. Expected outcomes of improvement as a result of the treatment; AND
6. Documentation outlining conservative treatment(s) that have been tried and the response (failure) to treatment (for chronic wounds); AND
7. Acute inpatient setting documentation of applicable treatment measures tried or considered and supporting evidence for selection of negative pressure wound therapy (for NPWT started in the inpatient setting).

B. Medical Necessity Criteria:

B.1 NPWT is medically necessary for initial 1-month authorization when ALL of the following criteria are met:

1. A qualifying wound meets ANY of the following:
   a. Chronic Stage III or IV pressure ulcer, neuropathic ulcer (e.g. diabetic ulcer), venous or arterial insufficiency ulcer, or a chronic ulcer of mixed etiology present for at least 30 days without improvement with conventional ulcer treatment for at least 4 weeks; OR

   b. Recent myocutaneous flap or skin graft for a pressure ulcer (surgery within the past 60 days); OR
c. Complications of surgically created wounds or traumatic wounds when there is documentation of the need for accelerated formation of granulation tissue that cannot be achieved by other topical wound treatments (e.g. surgical wound dehiscence, preoperative flap or graft, fasciotomy wounds in persons with compartment syndrome);

2. Documentation of evaluation, care and wound measurements by an appropriate licensed health professional; AND

3. Debridement of necrotic tissue if present; AND

4. Quantitative evidence of adequate nutrition. If patient’s nutritional status is compromised, action must have been taken to improve the nutritional status. e.g. protein supplements, enteral/NG feedings, parenteral nutrition, vitamin therapy or a special diet.

B.2. NPWT is medically necessary for up to 7 days immediately post-operatively at the site of a split thickness skin graft when the following criteria are met:

1. The qualifying wound meets BOTH of the following:
   a. Immediate post-op skin graft; AND
   b. Patient is considered high risk for graft loss, including, but not limited to, history of previous graft failure or suboptimal blood flow to area.

II. Continuing Authorization

A. Documentation Required
   1. Documentation that the patient is continuing to use the NPWT regularly.
   2. Documentation of wound healing

B. Medical Necessity Criteria
   NPWT is medically necessary for continued monthly authorization when ALL of the following conditions are met:
   1. Wound continues to meet the criteria for initiation of NPWT stated above; AND
   2. Documentation of measurable wound healing (improvement occurring in either surface area or depth of the wound) has occurred in the past 30 days as determined by decrease in wound dimensions; AND
   3. Continued participation in an outpatient or inpatient wound care program.
   4. After 4 months use of NPWT, continued authorization must be approved by the Medical Director.

C. Discontinuation Criteria
   For wounds described under B.1, NPWT is considered no longer medically necessary if ANY of the following exist:
   1. No measurable wound healing has occurred over the past 30 days; OR
   2. Wound depth is less than 1mm; OR
   3. Uniform granulation tissue has formed across the wound; OR
   4. Wound is infected; OR
   5. Patient is not using the NPWT equipment; OR
   6. The treating physician has discontinued therapy or is no longer providing an order for the therapy.
III. Indications Considered Experimental, Investigational, or not Medically Necessary: (Not all-inclusive)

1. Necrotic tissue with eschar present;
2. Untreated osteomyelitis;
3. Non-enteric and unexplored fistulas;
4. Malignancy/cancer in the wound;
5. Exposed vasculature, nerves, anastomotic site or organs or an open fistula to an organ or body cavity within the vicinity of the wound;
6. Open abdominal wounds with open fascia;
7. Deep sternal wound infection;
8. Partial-thickness burns;
9. Non-surgically treated pilonidal sinus disease;
10. Open fracture wounds;
11. Skin grafts over flap donor sites in non-high-risk patients;
12. Non-powered Mechanical negative pressure wound care system
13. Use of Negative Pressure Wound Therapy in combination with bioengineered skin substitutes or hyperbaric oxygen therapy;
14. Use of Negative Pressure Wound Therapy with instillation for the treatment of acute or chronic wounds;
15. Use of Negative Pressure Wound Therapy for treatment of closed wounds or incisions;
16. Use of single use Negative Pressure Wound Therapy Systems, e.g., PICO single use NPWT system.

CPT/HCPCS Codes

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<thead>
<tr>
<th>Code</th>
<th>Description</th>
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<tbody>
<tr>
<td>97605</td>
<td>Negative pressure wound therapy (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>Total wound(s) surface area greater than 50 square centimeters</td>
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<tr>
<td>A6550</td>
<td>Wound care set, for negative pressure wound therapy electrical pump, includes all supplies and accessories</td>
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<tr>
<td>E2402</td>
<td>Negative pressure wound therapy electrical pump, stationary or portable</td>
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REFERENCES:


• Negative Pressure Wound Therapy (NPWT) in the adjunct Treatment of Skin Grafts. Publication Date: June 25, 2015. Annual Review: Jun 14, 2018..


US Food and Drug Administration; Medical Devices Section.


WI Medicaid Forward Health BadgerCare Program; Nursing Home Handbook; Topic #3215 Other Covered Services Billable by Nursing Homes.
