Quartz

Negative Pressure Wound Therapy for Adults

Last Revision/Review Date: November 14, 2018 **P&P # C.6.14**

I. Initial Authorization

A. Documentation Required:

To facilitate the initial authorization process, the referral requests must include **ALL** 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 because 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:

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

1. The patient is twelve years of age or older; **AND**

2. 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); **AND**

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

4. Debridement of necrotic tissue if present; **AND**

5. 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.

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

1. The patient is twelve years of age or older; **AND**

2. 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** the following conditions are met:

1. Wound continues to meet the criteria for initiation of NPWT stated above; **AND**
2. Documentation of measureable 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. Children under 12 years of age;
13. Non-powered Mechanical negative pressure wound care system
14. Use of Negative Pressure Wound Therapy in combination with bioengineered skin substitutes or hyperbaric oxygen therapy;
15. Use of Negative Pressure Wound Therapy with instillation for the treatment of acute or chronic wounds;
16. Use of Negative Pressure Wound Therapy for treatment of closed wounds or incisions;
17. Use of single use Negative Pressure Wound Therapy Systems, e.g., PICO single use NPWT system).

CPT/HCPCS CODES

97605	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
97606	Total wound(s) surface area greater than 50 square centimeters
A6550	Wound care set, for negative pressure wound therapy electrical pump, includes all supplies and accessories
E2402	Negative pressure wound therapy electrical pump, stationary or portable

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WI Medicaid Forward Health BadgerCare Program; Durable Medical Equipment Handbook; Topic #11157 Negative Pressure Wound Therapy Pumps.