Clinical Policy: Negative Pressure Wound Therapy for Home Use

Reference Number: WA.CP.MP.518
Last Review Date: 06/24
Effective Date: 08/01/2024

Coding Implications
Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Description

This policy describes the medical necessity guidelines for negative pressure wound therapy (NWPT) for home use.

Policy/Criteria

I. It is the policy of Coordinated Care of Washington, Inc., in accordance with the Health Care Authority's Health Technology Assessment, that home use of negative pressure wound therapy is considered **medically necessary** for up to four months, per *InterQual* guidelines.

II. *InterQual* guidelines meet the HTA requirement that NPWT for home use is covered when either:
- A. Complete wound therapy program has been tried and failed, or
- B. Complete wound therapy programs are contraindicated.

III. Discontinuation of coverage of negative pressure wound therapy in the home will occur when either of the following has occurred:
- A. Any measurable degree of wound healing has failed to occur over the prior month. Wound healing is defined as improvement occurring in either surface are (length times width) or depth of the wound, or
- B. Four months have elapsed using an NWPT pump in the treatment of the most recent wound. This includes time NPWT was applied in an inpatient setting prior to discharge home.

Note: Disposable canisters (A7000) may only be billed with the pump (E2402) and are limited to five every 30 days.

Background

This policy is based entirely on Washington State Health Care Authority (HCA) Health Technology Assessment (HTA) and Health Care Authority Billing Guidelines.

Coding Implications

This clinical policy references Current Procedural Terminology (CPT®). CPT® is a registered trademark of the American Medical Association. All CPT codes and descriptions are copyrighted 2019, American Medical Association. All rights reserved. CPT codes and CPT descriptions are from the current manuals and those included herein are not intended to be all-inclusive and are included for informational purposes only. Codes referenced in this clinical policy are for informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

CPT® Codes	Description
A7000	Canister, disposable, used with suction pump, each
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

Reviews, Revisions, and Approvals	Date	Approval Date
Policy developed.	09/19	09/19
References reviewed and updated.	07/20	08/20
References reviewed and updated. Added A7000 and note about benefit limit. Replaced all instances of "member" with "member/enrollee".	06/21	06/21
Annual review. References updated. Added emphasis that coverage is for a maximum of four months of treatment.	05/22	06/22
Annual review. References reviewed and updated. Addition of codes to policy note following section III.	05/23	06/23
Annual review. References reviewed and updated. Section I. A. i. and ii. diagnoses of seroma and wound dehiscence removed.	06/24	06/24

References

1. Hayes, Inc. Negative Pressure Wound Therapy – Home Use. Washington Health Technology Assessment. October 14, 2016.
2. Washington State Health Care Authority. *Medical Equipment and Supplies Billing Guide*. https://www.hca.wa.gov/assets/billers-and-providers/Med-Equip-Supplies-bg-20240101.pdf. Revision effective January 1, 2024.

Important Reminder

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. "Health Plan" means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan's affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy,

contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of member/enrolleess. This clinical policy is not intended to recommend treatment for members/enrollees. Members/Enrollees should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.

This clinical policy is the property of the Health Plan. Unauthorized copying, use, and distribution of this clinical policy or any information contained herein are strictly prohibited. Providers, members/enrollees and their representatives are bound to the terms and conditions expressed herein through the terms of their contracts. Where no such contract exists, providers, members/enrollees and their representatives agree to be bound by such terms and conditions by providing services to members/enrollees and/or submitting claims for payment for such services.

Note: For Medicaid members/enrollees, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.