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| MEDICAL POLICY | Negative Pressure Wound Therapy (Medicare Only) | |
| Effective Date: 06/01/2020  <div style="text-align: right;">6/1/2020</div> | Section: DME | Policy No: 417 |
| | Medical Policy Committee Approved Date: 05/2020 | |
| Medical Officer | Date | |

See Policy CPT/HCPCS CODE section below for any prior authorization requirements

SCOPE:

Providence Health Plan, Providence Health Assurance, Providence Plan Partners, and Ayin Health Solutions as applicable (referred to individually as “Company” and collectively as “Companies”).

APPLIES TO:

Medicare only

MEDICARE POLICY CRITERIA

The following Centers for Medicare & Medicaid Service (CMS) guidelines should be utilized for medical necessity coverage determinations. Click the link provided in the table below to access applicable medical necessity criteria. All listed guidelines apply.

| Service | Medicare Guidelines |
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| <i>Negative Pressure Wound Therapy Pumps</i> | <ul style="list-style-type: none"> Local Coverage Determination (LCD): Negative Pressure Wound Therapy Pumps (L33821)¹ Local Coverage Article (LCA): Negative Pressure Wound Therapy Pumps (A52511)² LCA: Standard Documentation Requirements for All Claims Submitted to DME MACs (A55426)³ |

POLICY GUIDELINES

See guidelines above for specific documentation requirements – specifically [LCA A52511](#) and DOCUMENTATION REQUIREMENTS section of [LCA A55426](#).

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BILLING GUIDELINES

See [LCA A55426](#) for claims processing guidance.

CPT/HCPCS CODES

| Medicare Only | |
|---------------------------------|--|
| Prior Authorization Required | |
| 97605 | Negative pressure wound therapy (eg, 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 | Negative pressure wound therapy (eg, 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 greater than 50 square centimeters |
| E2402 | Negative pressure wound therapy electrical pump, stationary or portable |
| K0743 | Suction pump, home model, portable, for use on wounds |
| K0744 | Absorptive wound dressing for use with suction pump, home model, portable, pad size 16 square inches or less |
| K0745 | Absorptive wound dressing for use with suction pump, home model, portable, pad size more than 16 square inches but less than or equal to 48 square inches |
| K0746 | Absorptive wound dressing for use with suction pump, home model, portable, pad size greater than 48 square inches |
| No Prior Authorization Required | |
| A6550 | Wound care set, for negative pressure wound therapy electrical pump, includes all supplies and accessories |
| A7000 | Canister, disposable, used with suction pump, each |
| Not Covered | |
| 97607 | 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 |
| 97608 | 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 greater than 50 square centimeters |

INSTRUCTIONS FOR USE

Company Medical Policies serve as guidance for the administration of plan benefits. Medical policies do not constitute medical advice nor a guarantee of coverage. Company Medical Policies are reviewed annually and are based upon published, peer-reviewed scientific evidence and evidence-based clinical practice guidelines that are available as of the last policy update. The Companies reserve the right to determine the application of Medical Policies and make revisions to Medical Policies at any time. Providers will be given at least 60-days notice of policy changes that are restrictive in nature.

The scope and availability of all plan benefits are determined in accordance with the applicable coverage agreement. Any conflict or variance between the terms of the coverage agreement and Company Medical Policy will be resolved in favor of the coverage agreement.

REGULATORY STATUS

Mental Health Parity Statement

Coverage decisions are made on the basis of individualized determinations of medical necessity and the experimental or investigational character of the treatment in the individual case.

REFERENCES

1. Centers for Medicare & Medicaid Services. Local Coverage Determination (LCD): Negative Pressure Wound Therapy Pumps (L33821). Revision Effective Date: For services performed on or after 01/01/2020. <https://www.cms.gov/medicare-coverage-database/details/lcd-details.aspx?LCDId=33821>. Accessed 04/24/2020.
2. Centers for Medicare & Medicaid Services Local Coverage Article: Negative Pressure Wound Therapy Pumps (A52511). Revision Effective Date: 01/01/2020. <https://www.cms.gov/medicare-coverage-database/details/article-details.aspx?articleId=52511>. Accessed 04/24/2020.
3. Centers for Medicare & Medicaid Services Local Coverage Article: Standard Documentation Requirements for All Claims Submitted to DME MACs (A55426). Revision Effective Date: 04/06/2020. <https://www.cms.gov/medicare-coverage-database/details/article-details.aspx?articleId=55426>. Accessed 04/24/2020.