


MEDICAL POLICY	Non-Contact Wound Therapy (Medicare Only)	
Effective Date: 6/1/2020  <div style="text-align: right;">6/1/2020</div>	Section: MED	Policy No: 433
	Medical Policy Committee Approved Date: 5/2020	
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
<i>Non-contact wound therapy</i>	<ul style="list-style-type: none"> National Coverage Determination (NCD) for Noncontact Normothermic Wound Therapy (270.2)¹ Local Coverage Determination (LCD) for Low Frequency, Non-contact, Non-thermal Ultrasound (MIST Therapy) (L37228)² Local Coverage Article (LCA) for Billing and Coding Wound Care (A55909)³

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CPT/HCPCS CODES

Medicare Only	
Prior Authorization Required	
97610	Low frequency, non-contact, non-thermal ultrasound, including topical application(s), when performed, wound assessment, and instruction(s) for ongoing care, per day
Not Covered	
A6000	Non-contact wound warming wound cover for use with the non-contact wound warming device and warming card
E0231	Non-contact wound warming device (temperature control unit, ac adapter and power cord) for use with warming card and wound cover.
E0232	Warming card for use with the non contact wound warming device and non contact wound warming wound cover

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

- Centers for Medicare & Medicaid National Coverage Determination (NCD) for Noncontact Normothermic Wound Therapy (NNWT) (270.2). 2002; <https://www.cms.gov/medicare-coverage-database/details/ncd-details.aspx?NCDId=232>. Accessed 4/29/2020.

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2. Centers for Medicare & Medicaid Local Coverage Determination (LCD): Wound Care (L37228). 2018; <https://www.cms.gov/medicare-coverage-database/details/lcd-details.aspx?LCDId=37228>. Accessed 4/29/2020.
3. Centers for Medicare & Medicaid Services Local Coverage Article: Billing and Coding: Wound Care (A55909). 2018; <https://www.cms.gov/medicare-coverage-database/details/article-details.aspx?articleId=55909>. Accessed 4/29/2020.