Negative Pressure Wound Therapy Pumps

Guideline Number: MPG212.06
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➲ Terms and Conditions

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Overview

Negative Pressure Wound Therapy (NPWT) Pumps are defined as the application of subatmospheric pressure to a wound to remove debris and exudate from wounds. NPWT is delivered through an integrated system of a stationary or portable NPWT electrical suction pump, (E2402), separate exudate collection chamber, (A7000), and dressing sets, (A6550), to a qualified wound. The NPWT pump must be capable of being selectively switched between continuous and intermittent modes of operation and is controllable to adjust the degree of subatmospheric pressure conveyed to the wound in a range of 40-80 mm Hg subatmospheric pressure. The system must contain sensors and alarms to monitor pressure variations and exudate volume in the collection canister. In these systems, exudate is completely removed from the wound site to the collection chamber. Wound suction systems that do not contain all of the required components are not classified as NPWT.

Supplies: Code A6550 describes an allowance for a dressing set which is used in conjunction with a stationary or portable NPWT pump (E2402). A single code A6550 is used for each single, complete dressing change, and contains all necessary components, including but not limited to any separate, non-adherent porous dressing(s), drainage tubing, and an occlusive dressing(s) which creates a seal around the wound site for maintaining subatmospheric pressure at the wound.

HCPCS code A7000 describes a canister set which is used in conjunction with a stationary or portable NPWT pump and contains all necessary components, including but not limited to a container, to collect wound exudate. Canisters may be various sizes to accommodate stationary or portable NPWT pumps.

Guidelines

For these items to be covered by UnitedHealthcare a written order must be received, by the DME provider, prior to submission of the claim.

A Negative Pressure Wound Therapy pump (E2402) and supplies (A6550, A7000) are covered when either criterion are met:
Ulcers and Wounds Encountered in an Inpatient Setting:

- An ulcer or wound is encountered in the inpatient setting and, after other wound treatments have been tried or considered and ruled out, NPWT is initiated because it is considered in the judgment of the treating practitioner, the best available treatment option.
- The beneficiary has complications of a surgically created wound (for example, dehiscence) or a traumatic wound (for example, pre-operative flap or graft) where there is documentation of the medical necessity for accelerated formation of

granulation tissue which cannot be achieved by other available topical wound treatments (for example, other conditions of the beneficiary that will not allow for healing times achievable with other topical wound treatments).

NPWT will be covered when treatment is ordered to continue beyond discharge to the home setting.
Ulcers and Wounds in the Home Setting: The beneficiary has a chronic Stage III or IV pressure ulcer, neuropathic (for example, diabetic) ulcer, venous or arterial insufficiency ulcer, or a chronic (being present for at least 30 days) ulcer of mixed etiology.

NPWT pumps (E2402) must be capable of accommodating more than one wound dressing set for multiple wounds on a beneficiary. Therefore, more than one E2402 billed per beneficiary for the same time period will not be considered reasonable and necessary.

- Coverage is provided up to a maximum of 15 dressing kits (A6550) per wound per month.
- Coverage is provided up to a maximum of 10 canister sets (A7000) per month unless there is documentation evidencing a large volume of drainage (greater than 90 ml of exudate per day). For high volume exudative wounds, a stationary pump with the largest capacity canister must be used.

Regardless of utilization, a supplier must not dispense more than a one (1)-month quantity at a time.

Exclusions From Coverage

An NPWT pump and supplies will be denied at any time as not reasonable and necessary if one or more of the following are present:

- The presence in the wound of necrotic tissue with eschar, if debridement is not attempted;
- Osteomyelitis within the vicinity of the wound that is not concurrently being treated with intent to cure;
- Cancer is present in the wound;
- The presence of an open fistula to an organ or body cavity within the vicinity of the wound.

A disposable wound suction device (A9272) includes all components, accessories and dressings. Examples include, but are not limited to, SNaP (Spiracure), PICO (Smith and Nephew), and VAC Via (KCI). Disposable wound suction devices (A9272) and related supplies (A9270) will be denied as statutorily noncovered because they do not meet the DME benefit durability requirement.

Continued Coverage

On a regular basis, a licensed medical professional must directly assess the wound(s) and supervise or directly perform the NPWT dressing changes, with documentation noting changes in the ulcer's dimensions and characteristics every month. If criteria are not fulfilled, continued coverage of the NPWT pump and supplies will be denied as not reasonable and necessary.

*When NPWT therapy exceeds 4 months on the most recent wound and reimbursement ends, individual consideration for one additional month at a time may be sought using the appeals process. Information from the treating practitioner's medical record, contemporaneous with each requested one-month treatment time period extension, must be submitted with each appeal explaining the special circumstances necessitating the extended month of therapy.

When Coverage Ends

Criteria for continued coverage ceases to occur, in the judgment of the treating practitioner, adequate wound healing has occurred to the degree that NPWT may be discontinued, any measurable degree of wound healing has failed to occur over the prior month, four months (including the time NPWT was applied in an inpatient setting prior to discharge to the home) have elapsed using an NPWT pump in the treatment of the most recent wound or once equipment or supplies are no longer being used for the beneficiary, whether or not by the treating practitioner's order.

Documentation Requirements – Policy Specific

A complete wound therapy program must have been tried or considered and ruled out prior to application of NPWT pump. For all ulcers or wounds the following components of a wound therapy program must include the following:

- Documentation in the beneficiary's medical record of evaluation, care, and wound measurements by a licensed medical professional, and
- Application of dressings to maintain a moist wound environment, and

- Debridement of necrotic tissue if present, and
- Evaluation of and provision for adequate nutritional status

For Stage III or IV pressure ulcers:
- The beneficiary has been appropriately turned and positioned, and
- The beneficiary has used a group 2 or 3 support surface for pressure ulcers on the posterior trunk or pelvis and
- The beneficiary's moisture and incontinence have been appropriately managed

For neuropathic ulcers:
- The beneficiary has been on a comprehensive diabetic management program, and
- Reduction in pressure on a foot ulcer has been accomplished with appropriate modalities

For venous insufficiency ulcers:
- Compression bandages and/or garments have been consistently applied, and
- Leg elevation and ambulation have been encouraged

Documentation Requirements - General

There are numerous CMS manual requirements, reasonable and necessary requirements, benefit category, and other statutory and regulatory requirements that must be met in order for payment to be justified. In the event of a claim review, a DMEPOS supplier must provide sufficient information to demonstrate that the applicable criteria have been met thus justifying payment. Refer to the LCD, NCD or other CMS Manuals for more information on what documents may be required.
See Article A55426 Standard Documentation Requirements for All Claims Submitted to DME MACs.

Applicable Codes

The following list(s) of procedure and/or diagnosis codes is provided for reference purposes only and may not be all inclusive. Listing of a code in this guideline does not imply that the service described by the code is a covered or non-covered health service. Benefit coverage for health services is determined by the member specific benefit plan document and applicable laws that may require coverage for a specific service. The inclusion of a code does not imply any right to reimbursement or guarantee claim payment. Other Policies and Guidelines may apply.

HCPCS Code	Description
A6550	Wound care set, for negative pressure wound therapy electrical pump, includes all supplies and accessories
A7000	Canister, disposable, used with suction pump, each
A9272	Wound suction, disposable, includes dressing, all accessories and components, any type, each (Non-Covered)
E2402	Negative pressure wound therapy electrical pump, stationary or portable

Modifier	Description
KX	Requirements specified in the medical policy have been met

References

CMS Local Coverage Determinations (LCDs) and Articles

LCD	Article	Contractor	DME MAC
L33821 Negative Pressure Wound Therapy Pumps	A52511 Negative Pressure Wound Therapy Pumps - Policy Article	CGS	AL, AR, CO, FL, GA, IL, IN, KY, LA, MI, MN, NC, NM, OH, OK, PR, SC, TN, TX, VA, VI, WI, WV

LCD	Article	Contractor	DME MAC
		Noridian	AK, AS, AZ, CA, CT, DC, DW, GU, HI, IA, ID, KS, MA, MD, ME, MI, ND, NE, NH, NMI NJ, NY, NV, OR, PA, RI, SD, UT, WA, WY, VA
L33612 Suction Pumps	A52519 Suction Pumps - Policy Article	CGS	AL, AR, CO, FL, GA, IL, IN, KY, LA, MI, MN, NC, NM, OH, OK, PR, SC, TN, TX, VA, VI, WI, WV
		Noridian	AK, AS, AZ, CA, CT, DC, DW, GU, HI, IA, ID, KS, MA, MD, ME, MI, ND, NE, NH, NMI NJ, NY, NV, OR, PA, RI, SD, UT, WA, WY, VA
N/A	A55426 Standard Documentation Requirements for All Claims Submitted to DME MACs	CGS	AL, AR, CO, FL, GA, IL, IN, KY, LA, MI, MN, NC, NM, OH, OK, PR, SC, TN, TX, VA, VI, WI, WV
		Noridian	AK, AS, AZ, CA, CT, DC, DW, GU, HI, IA, ID, KS, MA, MD, ME, MI, ND, NE, NH, NMI NJ, NY, NV, OR, PA, RI, SD, UT, WA, WY, VA

CMS Claims Processing Manual

Chapter 20; § 10.1.1 Durable Medical Equipment (DME)

MLN Matters

MLN Fact Sheet, Provider Compliance Tips for Negative Pressure Wound Therapy, ICN 909484 February 2018

Guideline History/Revision Information

Revisions to this summary document do not in any way modify the requirement that services be provided and documented in accordance with the Medicare guidelines in effect on the date of service in question.

Date	Summary of Changes
04/01/2021	**Template Update** • Reformatted policy; transferred content to new template

02/10/2021	**Policy Summary**
	• Replaced references to "treating *physician*" with "treating *practitioner*"
	Documentation Requirements – General
	• Added language to indicate:
	  ○ There are numerous CMS manual requirements, reasonable and necessary requirements, benefit category, and other statutory and regulatory requirements that must be met in order for payment to be justified
	  ▪ In the event of a claim review, a DMEPOS supplier must provide sufficient information to demonstrate that the applicable criteria have been met thus justifying payment
	  ▪ Refer to the Local Coverage Determination (LCD), National Coverage Determination (NCD) or other CMS Manuals for more information on what documents may be required
	  ○ See the Local Coverage Article (LCA) titled *Standard Documentation Requirements for All Claims Submitted to DME MACs (A55426)*
	Applicable Codes
	• Revised notation pertaining to HCPCS code A9272 to indicate this code is "non-covered"
	Supporting Information
	• Updated *References* section to reflect the most current information

Date	Summary of Changes
	• Archived previous policy version MPG212.05

Purpose

The Medicare Advantage Policy Guideline documents are generally used to support UnitedHealthcare Medicare Advantage claims processing activities and facilitate providers' submission of accurate claims for the specified services. The document can be used as a guide to help determine applicable:

- Medicare coding or billing requirements, and/or
- Medical necessity coverage guidelines; including documentation requirements.

UnitedHealthcare follows Medicare guidelines such as NCDs, LCDs, LCAs, and other Medicare manuals for the purposes of determining coverage. It is expected providers retain or have access to appropriate documentation when requested to support coverage. Please utilize the links in the References section below to view the Medicare source materials used to develop this resource document. This document is not a replacement for the Medicare source materials that outline Medicare coverage requirements. Where there is a conflict between this document and Medicare source materials, the Medicare source materials will apply.

Terms and Conditions

The Medicare Advantage Policy Guidelines are applicable to UnitedHealthcare Medicare Advantage Plans offered by UnitedHealthcare and its affiliates.

These Policy Guidelines are provided for informational purposes, and do not constitute medical advice. Treating physicians and healthcare providers are solely responsible for determining what care to provide to their patients. Members should always consult their physician before making any decisions about medical care.

Benefit coverage for health services is determined by the member specific benefit plan document* and applicable laws that may require coverage for a specific service. The member specific benefit plan document identifies which services are covered, which are excluded, and which are subject to limitations. In the event of a conflict, the member specific benefit plan document supersedes the Medicare Advantage Policy Guidelines.

Medicare Advantage Policy Guidelines are developed as needed, are regularly reviewed and updated, and are subject to change. They represent a portion of the resources used to support UnitedHealthcare coverage decision making. UnitedHealthcare may modify these Policy Guidelines at any time by publishing a new version of the policy on this website. Medicare source materials used to develop these guidelines include, but are not limited to, CMS National Coverage Determinations (NCDs), Local Coverage Determinations (LCDs), Medicare Benefit Policy Manual, Medicare Claims Processing Manual, Medicare Program Integrity Manual, Medicare Managed Care Manual, etc. The information presented in the Medicare Advantage Policy Guidelines is believed to be accurate and current as of the date of publication and is provided on an "AS IS" basis. Where there is a conflict between this document and Medicare source materials, the Medicare source materials will apply.

You are responsible for submission of accurate claims. Medicare Advantage Policy Guidelines are intended to ensure that coverage decisions are made accurately based on the code or codes that correctly describe the health care services provided. UnitedHealthcare Medicare Advantage Policy Guidelines use Current Procedural Terminology (CPT®), Centers for Medicare and Medicaid Services (CMS), or other coding guidelines. References to CPT® or other sources are for definitional purposes only and do not imply any right to reimbursement or guarantee claims payment.

*For more information on a specific member's benefit coverage, please call the customer service number on the back of the member ID card or refer to the Administrative Guide.