Policy

Blue Cross and Blue Shield of Kansas City (Blue KC) will provide coverage for negative pressure therapy when it is determined to be medically necessary because the criteria shown below are met.

When Policy Topic is covered

Initiation of Powered Negative Pressure Wound Therapy (NPWT):
An initial therapeutic trial of not less than 2 weeks using a powered negative pressure wound therapy (NPWT) system, as part of a comprehensive wound care program that includes controlling factors such as diabetes, nutrition, relief of pressure, etc., may be considered medically necessary in the following indications:

- Chronic (> 90 days) stage III or IV pressure ulcers that have failed to heal despite optimal wound care when there is high-volume drainage that interferes with healing and/or when standard dressings cannot be maintained due to anatomic factors, or
- Traumatic or surgical wounds where there has been a failure of immediate or delayed primary closure AND there is exposed bone, cartilage, tendon, or foreign material within the wound
- Wounds in patients with underlying clinical conditions which are known to negatively impact wound healing which are non-healing (at least 30 days), despite optimal wound care. (Examples of underlying conditions include, but are not limited to diabetes, malnutrition, small vessel disease, and morbid obesity. Malnutrition, while a risk factor, must be addressed simultaneously with the negative pressure wound therapy.)

Continuation of Powered NPWT:
Continuation of the powered NPWT system, as part of a comprehensive wound care program, may be considered medically necessary following an initial 2-week therapeutic trial if the treatment trial has resulted in documented objective improvements in the wound, and if there is ongoing objective improvement during subsequent treatment. Objective improvements in the wound should include the development and presence of healthy granulation tissue, progressive wound
contracture and decreasing depth, and/or the commencement of epithelial spread from the wound margins.

**When Policy Topic is not covered**

Continuation of the powered NPWT system is considered *not medically necessary* when any of the following occurs:

- The therapeutic trial or subsequent treatment period has not resulted in documented objective improvement in the wound, OR
- The wound has developed evidence of wound complications contraindicating continued NPWT, OR
- The wound has healed to an extent that either grafting can be performed or the wound can be anticipated to heal completely with other wound care treatments.

Therapeutic trials of powered NPWT systems for the treatment of other acute or chronic wounds except as noted above is considered *not medically necessary*.

Use of non-powered NPWT systems for the treatment of acute or chronic wounds is considered *investigational*.

**Considerations**

The application of the negative pressure wound device is considered incidental to the surgical procedure when performed at the same intervention and is not separately payable.

The negative pressure wound therapy electrical pump, stationary or portable (E2402) will be reimbursed as a rental item only.

Contraindications to the use of NPWT systems include the following conditions as noted by a November 2009 FDA alert: necrotic tissue with eschar, untreated osteomyelitis, nonenteric and unexplored fistulas, malignancy in the wound, exposed nerve, exposed anastomotic site, and exposed organ.

In a 2011 update, the FDA noted additional deaths and injury reports with NPWT since 2009. Although rare, these complications can occur wherever NPWT systems are used, including hospitals, long-term care facilities, and at home. Bleeding was the cause of the most serious adverse events, including deaths. The majority of reports of wound infection were related to the retention of dressing pieces in the wounds. FDA recommendations for healthcare providers include the following: select patients for NPWT carefully knowing that NPWT systems are contraindicated for certain wound types, and patient risk factors must be thoroughly considered before use; assure that the patient is monitored frequently in an appropriate care setting by a trained practitioner; be aware of complications associated with dressing changes such as infection and bleeding; be vigilant for potentially life-threatening complications, such as bleeding, and be prepared to take prompt action if they occur. The FDA reported that the safety and effectiveness of NPWT
systems in newborns, infants and children has not been established at this time and currently, there are no NPWT systems cleared for use in these populations.

Continuation of healing during use of the NPWT system should be monitored on a frequency not less than every 14 days.

Complete healing of a wound would normally be anticipated if all bone, cartilage, tendons, and foreign material were completely covered, healthy granulation were present to within 5 mm of the surface, and the wound edges were reduced to 2 cm in width or diameter.

Powered negative pressure therapy systems should be used as part of a comprehensive wound care program that includes attention to other factors that impact wound healing such as diabetes control, nutritional status, relief of pressure, etc.

The focus of these policy statements and guidelines is for use of NPWT in the outpatient setting.

### Description of Procedure or Service

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Negative pressure wound therapy (NPWT) involves use of a negative pressure or suction device to aspirate and remove fluids, debris, and infectious materials from the wound bed to promote the formation of granulation tissue and wound healing.

For individuals who have diabetic lower-extremity ulcers or amputation wounds who receive outpatient NPWT, the evidence includes randomized controlled trials (RCTs) and a systematic review of RCTs. Relevant outcomes are symptoms, change in disease status, morbid events, quality of life, and treatment-related morbidity. There was a higher rate of wound healing and fewer amputations with NPWT, although the studies were at risk of bias due to lack of blinding. The evidence is sufficient to determine that the technology results in a meaningful improvement in the net health outcome.

For individuals who have chronic pressure ulcers who receive outpatient NPWT, the evidence includes RCTs and systematic reviews. Relevant outcomes are symptoms, change in disease status, morbid events, quality of life, and treatment-related morbidity. All trials are of low quality and at high risk of bias. In addition, most study populations were treated in inpatient settings. The evidence is insufficient to determine the effects of the technology on health outcomes.

For individuals who have lower-extremity ulcers due to venous insufficiency who receive outpatient NPWT, the evidence includes 1 RCT and a systematic review. Relevant outcomes are symptoms, change in disease status, morbid events, quality of life, and treatment-related morbidity. A single RCT in patients with nonhealing leg ulcers who were treated with skin grafts found a faster rate of healing with NPWT when used in the inpatient setting. No studies were identified on the effectiveness of NPWT as a primary treatment for leg ulcers or for use of NPWT in the outpatient setting. The evidence is insufficient to determine the effects of the technology on health outcomes.

For individuals who have burn wounds who receive outpatient NPWT, the evidence includes RCTs and systematic reviews. Relevant outcomes are symptoms, change in disease status, morbid events, quality of life, and treatment-related morbidity. An interim report of an RCT evaluating NPWT in partial-thickness burns, summarized in a Cochrane review, did not permit conclusions on the efficacy of NPWT in partial-thickness burns. A separate RCT comparing NPWT with split-skin grafts in patients with full-thickness burns did not show differences in graft take and wound epithelialization. The evidence is insufficient to determine the effects of the technology on health outcomes.

For individuals who have traumatic or surgical wounds who receive outpatient NPWT, the evidence includes RCTs and systematic reviews. Relevant outcomes are symptoms, change in disease status, morbid events, quality of life, and treatment-related morbidity.
related morbidity. There are limited data on NPWT as a primary treatment of partial-thickness burns. One RCT found no benefit of NPWT on graft take and wound epithelialization in patients with full-thickness burns. NPWT showed no benefit in the treatment of patients with surgical wounds or skin grafts healing by primary intention, and a systematic review of NPWT for traumatic and surgical wounds found no differences between standard dressing and NPWT for any wound outcome measure. However, 1 small RCT has suggested that prophylactic NPWT may reduce the number of dressing changes and pain when used in an outpatient setting. Additional study in larger samples is needed to evaluate this outcome measure. The evidence is insufficient to determine the effects of the technology on health outcomes.

For individuals who have any wound type (acute or nonhealing) who receive portable single-use outpatient NPWT, the evidence includes RCTs. Relevant outcomes are symptoms, change in disease status, morbid events, quality of life, and treatment-related morbidity. The evidence includes an RCT of the PICO Single Use Negative Pressure Wound Therapy System, an RCT of the nonpowered Smart Negative Pressure (SNaP) Wound Care System, and a pseudorandomized study of the Prevena Incision Management System. The PICO device was studied in an adequately powered but unblinded RCT of combined in- and outpatient use following total joint arthroplasty. Results showed some benefits that approached statistical significance. Further study in an outpatient setting is needed. One study with the SNaP nonpowered Wound Care System showed noninferiority to a vacuum-assisted closure device. However, interpretation of this trial is limited by a high loss to follow-up and lack of a control group treated with dressings. These studies are insufficient to draw conclusions about its efficacy. Well-designed comparative studies with larger numbers of patients are needed to determine the effects of the technology with greater certainty. The evidence is insufficient to determine the effects of the technology on health outcomes.

Overall, the evidence from comparative clinical trials has demonstrated that there is a subset of problematic wounds for which the use of NPWT may provide a significant clinical benefit. However, due to clinical variability and limited data, it is not possible to determine prospectively which wounds are most likely to respond favorably to NPWT. In addition, clinical input supports a therapeutic trial of NPWT for chronic pressure ulcers that have failed to heal, for traumatic or surgical wounds that have failed to close when there is exposed bone, cartilage, tendon, or foreign material within the wound, and for nonhealing wounds in patients with underlying clinical conditions known to negatively impact wound healing. Therefore, a therapeutic trial of NPWT of not less than 14 days may be considered medically necessary for chronic wounds that have failed to heal, despite intense conventional wound therapy for at least 90 days, or for wounds of at least 30 days that have a high probability of failure to heal due to compounding factors involving the wound and the patient. For continued use of NPWT beyond 14 days to meet criteria for medical necessity, there must be objective evidence of wound healing, such as the development of healthy granulation tissue and progressive wound contracture.
Background
The management and treatment of chronic wounds, including decubitus ulcers, is challenging. Most chronic wounds will heal only if the underlying cause (ie, venous stasis, pressure, infection) is addressed. In addition, cleaning the wound to remove nonviable tissue, microorganisms, and foreign bodies is essential to create the optimal conditions for either re-epithelialization (ie, healing by secondary intention) or preparation for wound closure with skin grafts or flaps (ie, healing by primary intention). Therefore, débridement, irrigation, whirlpool treatments, and wet-to-dry dressings are common components of chronic wound care.

Negative pressure wound therapy (NPWT) involves use of a negative pressure therapy or suction device to aspirate and remove fluids, debris, and infectious materials from the wound bed to promote the formation of granulation tissue. The devices may also be used as an adjunct to surgical therapy or as an alternative to surgery in a debilitated patient. Although the exact mechanism has not been elucidated, it is hypothesized that negative pressure contributes to wound healing by removing excess interstitial fluid, increasing the vascularity of the wound, reducing edema, and/or creating beneficial mechanical forces that lead to cell growth and expansion.

A nonpowered (mechanical) NPWT system has also been developed; the Smart Negative Pressure (SNaP) Wound Care System. This device is portable and lightweight (3 oz) and can be worn underneath clothing. This system consists of a cartridge, dressing, and strap; the cartridge acts as the negative pressure source. The system is reported to generate negative pressure levels similar to other NPWT systems. This system is fully disposable.

The focus of this evidence review is use of NPWT in the outpatient setting. It is recognized that patients may begin using the device in the inpatient setting as they transition to the outpatient setting.

Regulatory Status
Negative pressure therapy or suction devices cleared by the U.S. Food and Drug Administration (FDA) for the purpose of treating chronic wounds include, but are not limited to: Vacuum Assisted Closure® Therapy (V.A.C., also known as negative pressure wound therapy; KCI); Versatile 1™ (V1) Wound Vacuum System (Blue Sky Medical), RENASYS™ EZ PLUS (Smith & Nephew), Foryou NPWT NP32 Device (Foryou Medical Electronics), and PICO Single Use Negative Pressure Wound Therapy System (Smith & Nephew).

Portable systems include the RENASYS™ GO (Smith & Nephew), XLR8 PLUS (Genadyne Biotechnologies), extrICARE® 2400 NPWT System (Devon Medical), the V.A.C. Via™ (KCI), and the PICO™ Single-Use Negative Pressure Wound Therapy System (Smith & Nephew). The Prevena™ Incision Management System (KCI) is designed specifically for closed surgical incisions.

A nonpowered NPWT device, the SNaP® Wound Care System from Spiracur, is a class II device requiring notification to market but not having FDA premarket
approval. In 2009, it was cleared for marketing by FDA through the 510(k) (K081406) and is designed to remove small amounts of exudate from chronic, traumatic, dehisced, acute, or subacute wounds and diabetic and pressure ulcers.

No NPWT device has been cleared for use in infants and children.

In November 2009, FDA issued an alert concerning complications and deaths associated with NPWT systems. An updated alert was issued in February 2011.1

**Rationale**
This evidence review was originally developed in January 1998 and has been updated regularly with searches of the MEDLINE database. This review was informed by a 2000 TEC Assessment that evaluated negative pressure therapy of pressure ulcers, venous ulcers, and diabetic ulcers.2 Literature updates for this review have focused on comparative trials with the features described in the 2000 TEC Assessment (eg, enrollment of patients with wounds refractory to standard treatment, randomization, optimal standard wound care treatment in the control arm, and clinically important end points). In addition, literature has been sought on the potential benefits of negative pressure wound therapy (NPWT) for healing of acute wounds. The most recent literature update was performed through November 28, 2016.

NPWT devices are classified as either powered (ie, requiring an electrical power source or batteries) or nonpowered (mechanical). Most evidence found in the literature is for electrically powered devices with large canisters (eg, such as the vacuum-assisted device [V.A.C. system]), and so the main discussion of evidence refers to this type of device. A number of portable devices have entered the market and are particularly relevant for use in the outpatient setting. Some portable devices are designed specifically for surgical incisions. Evidence on the newer portable devices is discussed following the review of evidence on the larger electrically powered devices.

The primary end points of interest for trials of wound closure are as follows, consistent with guidance from the U.S. Food and Drug Administration for industry in developing products for treatment of chronic cutaneous ulcer and burn wounds:

1. Incidence of complete wound closure.
2. Time to complete wound closure (reflecting accelerated wound closure).
3. Incidence of complete wound closure following surgical wound closure.
4. Pain control.

**Mixed Wound Types**

**Systematic Reviews**
Particularly relevant for this evidence review is the effect of NPWT when used in the home setting. In 2014, authors of a systematic review for the Agency for Healthcare Research and Quality (AHRQ) and the Centers for Medicare and
Medicaid Services reported that due to insufficient evidence, they were unable to draw conclusions about the efficacy or safety of NPWT in the home setting. There were 3 retrospective cohort studies on diabetic foot ulcers and arterial ulcers, 1 randomized controlled trial (RCT) and 2 retrospective cohort studies on pressure ulcers, and 1 retrospective cohort on venous ulcers. Six studies used the V.A.C. and 1 used the SNaP device. Reviewers found that interpretation of the data available was limited by variability in the types of comparator groups, methodologic limitations, and poor reporting of outcomes.

Another AHRQ assessment was performed to inform the HCPCS coding decisions for NPWT devices. This 2009 assessment found no studies showing a therapeutic distinction between different NPWT devices.

**Diabetic Lower-Extremity Ulcers and Amputation Wounds**

A 2013 Cochrane review of NPWT for treating foot wounds in patients with diabetes included 5 randomized trials (total N=605 participants). Two of the 5 trials had a total of 502 participants; the remaining 3 trials were small, with limited reporting, and with an unclear risk of bias. One of the larger studies (Blume et al [2008] described next) was conducted in patients with diabetic foot ulcers, and the second in patients with postamputation wounds. There were statistically significant improvements in the proportion of wounds healed and the time to healing. For the proportion of wounds that healed, the relative risk (RR) was 1.44 (95% confidence interval [CI], 1.03 to 2.01) and for the time to ulcer healing the relative risk was 1.85 (95% CI, 1.40 to 2.45). The data also suggested that NPWT reduced the risk of amputation compared to moist wound therapy. Reviewers concluded that there was some evidence to suggest that NPWT was more effective than standard care, but the findings were uncertain due to risk of bias in the unblinded studies. Reviewers recommended further study to reduce uncertainty around decision making.

The largest study of NPWT for diabetic foot ulcers was a 2008 multicenter industry-sponsored RCT by Blume et al that compared NPWT versus advanced moist wound therapy. Included were 342 patients with Wagner grade 2 or 3 foot ulcers at least 2 cm²; the chronicity of the ulcers was not described. Based on intention-to-treat analysis, a greater proportion of NPWT-treated foot ulcers achieved the primary end point of complete ulcer closure (43.2% vs 28.9%, p=0.007) within the 112-day active treatment phase. For the 240 (72%) patients who completed the active treatment phase, 60.8% of NPWT-treated ulcers closed compared with 40.0% of ulcers treated with advanced moist wound therapy. NPWT patients also experienced significantly fewer secondary amputations (4.1% vs 10.2%, p=0.035).

In 2005, Armstrong and Lavery reported on an RCT of NPWT using the V.A.C. system (n=77) compared with standard moist wound care (n=85) to treat nonhealing partial foot amputation wounds (average wound duration, 1.5 months) in patients with diabetes. Forty-three (56%) of NPWT patients achieved complete closure during the 16-week assessment period versus 33 (39%) of controls (p=0.040). Log-rank analysis showed the rate of complete closure was
significantly faster with NPWT than with standard care. Frequency and severity of adverse events were similar between groups, with wound infection being the most commonly observed (32% in both groups). A study published in 2010 by Dalla Paola et al also reported that NPWT resulted in more rapid development of granulation tissue, more rapid control of infections, and reduced time to complete closure (65 days vs 98 days) in patients with infected open minor amputations. Interpretation of this study is limited, because the size and chronicity of wounds prior to treatment were not recorded, and the assessments were nonblinded.

Section Summary: Diabetic Lower-Extremity Ulcers and Amputation Wounds
The evidence on NPWT for diabetic lower-extremity ulcers and amputation wounds includes RCTs and a systematic review of RCTs. Although there is some uncertainty due to risk of bias in the unblinded studies, there was a higher rate of wound healing and fewer amputations with NPWT, supporting its use for diabetic lower-extremity ulcers and amputation wounds.

Chronic Pressure Ulcers
A 2015 Cochrane review included 4 RCTs of NPWT (total N=149 patients) for treating pressure ulcers in any care setting, although most of the patients were treated in a hospital setting. Three studies were considered to be at high risk of bias and all evidence was considered to be of very low quality. Only 1 study reported on complete wound healing, which occurred in only 1 of the 12 study participants. Reviewers concluded that there is high uncertainty about the potential benefits and/or harms for this indication.

One representative trial, from 2003 (noted in the 2015 Cochrane review as "awaiting further information from the authors"), randomized 24 patients with pressure ulcers of the pelvic region to NPWT or standard wound care. All patients with pelvic pressure ulcers were eligible for enrollment and were not required to be refractory to standard treatment. There were no significant group differences for the main outcome measure, time to 50% reduction of wound volume (mean, 27 days in the NPWT group vs 28 days in the control group). Findings were limited by the small number of patients in the study, the possibility that the control group may not have received optimal wound management, and lack of information on the time to complete wound healing.

Section Summary: Chronic Pressure Ulcers
The evidence on outpatient NPWT for chronic pressure ulcers includes RCTs and systematic reviews, however, all trials are of low quality and at high risk of bias. In addition, most patients were treated in an inpatient setting.

Lower-Extremity Ulcers due to Venous Insufficiency
A 2015 Cochrane review of NPWT for venous insufficiency identified a single RCT with 60 patients. This trial, published by Vuerstaek et al (2006), was performed in an inpatient setting in conjunction with skin grafts, and compared the efficacy of NPWT using the V.A.C. system (n=30) with conventional moist wound care (n=30) in patients hospitalized with chronic venous and/or arterial leg ulcers of greater
than 6 months in duration. Full-thickness punch skin grafts from the thigh were applied, followed by 4 days of NPWT or conventional care to assure complete graft adherence. Each group then received standard care with nonadhesive dressings and compression therapy until complete healing (primary outcome) occurred. The median time to complete healing was 29 days in the NPWT group and 45 days in control group (p=0.001). Ninety percent of ulcers treated with NPWT healed within 43 days, compared with 48% in the control group. These results suggest that NPWT significantly hastened wound healing, although the use of skin autografts makes it difficult to discern the contribution of NPWT to the primary outcome. The 2015 Cochrane review did not identify any RCT evidence on the effectiveness of NPWT as a primary treatment for leg ulcers, nor was there any evidence on the use of NPWT in the home setting.

Section Summary: Lower-Extremity Ulcers due to Venous Insufficiency
A single RCT has been identified on NPWT for the treatment of lower-extremity ulcers due to venous insufficiency in the hospital setting. No evidence was identified on treatment in the home setting.

Burn Wounds
A 2014 Cochrane review of NPWT for burn wounds identified 1 interim report (abstract) of an RCT on NPWT in patients with partial-thickness burns. The abstract did not provide enough evidence to draw any conclusions on the efficacy of NPWT on partial-thickness burn wounds.

Not included in the Cochrane review was a 2012 trial by Bloemen et al on the effect of NPWT on graft take in full-thickness burn wounds. This multicenter, 4-armed RCT enrolled 86 patients and compared a split-skin graft with or without a dermal substitute (MatriDerm), with or without NPWT. Outcome measures included graft take at 4 to 7 days after surgery, rate of wound epithelialization, and scar parameters at 3 and 12 months postoperatively. Graft take and wound epithelialization did not differ significantly between groups. Most measures of scar quality also did not differ significantly between groups.

An expert panel convened to develop evidence-based recommendations for the use of NPWT reported that the evidence base in 2011 was strongest for the use of NPWT on skin grafts and weakest as a primary treatment for burns.

Section Summary: Burn Wounds
The evidence on NPWT as a primary treatment of partial-thickness burns is limited. One RCT on NPWT for skin grafts showed no benefit for graft take, wound epithelialization, or scar quality.

Traumatic and Surgical Wounds
Identified studies described various wound types treated over periods ranging from several days to several months. Studies also differed by whether NPWT was used for nonhealing wounds or as a prophylactic treatment for surgical wounds in patients at high risk for nonhealing.
A 2014 Cochrane review evaluated the evidence on NPWT for skin grafts and surgical wounds expected to heal by primary intention. Healing by primary intention occurs when the wound edges are brought together with sutures, staples, tape, or glue, and contrasts with healing by secondary intention, where the wound is left open to heal from the bottom up (eg, for chronic or infected wounds). Nine randomized trials (total N=785 patients) were included in the review. Three trials involved skin graft patients, 4 included orthopedic patients, and 2 included general surgery and trauma surgery patients. All trials had unclear or high risk of bias. There were no differences between standard dressing and NPWT for surgical site infections, wound dehiscence, reoperation (in incisional wounds), seroma/hematoma, or failed skin grafts. Pain intensity was reported to be lower with "home-made" NPWT compared with commercial devices. Most or all studies appeared to have used short-term application of NPWT in an inpatient setting.

A 2015 Cochrane review evaluated the effects of NPWT on surgical wound healing by secondary intention in any care setting. Two studies (total N=69 patients) were identified for the review. Although each study reported a reduction in the median time to healing with NPWT, both provided limited outcome data on the number of wounds healed, adverse events, and resource use. Reviewers concluded that there is currently no rigorous RCT evidence available on the clinical effectiveness of NPWT in the treatment of surgical wounds healing by secondary intention.

A 2016 systematic review and meta-analysis by De Vries et al included 6 RCTs and 15 observational studies of surgical site infections after prophylactic NPWT. One study selected used a portable device (PICO, described below), while the others used a V.A.C. Unlike the 2014 Cochrane review, studies on skin grafts were not included. Meta-analysis of the RCTs showed that use of NPWT reduced the rate of surgical site infections (odds ratio, 0.56; 95% CI, 0.32 to 0.96; p=0.04), and reduced the surgical site infection rate from 140 to 83 per 1000 patients. However, the quality of evidence was rated as low due to high risk of bias in the nonblinded assessments and imprecision in the estimates.

The largest study on prophylactic NPWT for surgical wounds is a 2012 report from an investigator-initiated, industry-sponsored multicenter RCT of inpatient NPWT for closed surgical incisions. (A preliminary report was published in 2006.) Participants included 249 blunt trauma patients with 263 high-risk fractures (tibial plateau, pilon, calcaneus) requiring surgical stabilization. Patients were randomized to NPWT applied to the closed surgical incision or to standard postoperative dressings. All patients were maintained as inpatients until wound drainage was minimal, at which time NPWT was discontinued (mean, 59 hours; range, 21-213 hours). Patients in the NPWT group were ready for discharge in 2.5 days compared with 3.0 days for the control group (difference=NS). The NPWT group had significantly fewer infections (10% of fractures) than the control group (19% of fractures; p=0.049). Wound dehiscence after discharge was observed less frequently in the NPWT group (8.6%) than in the control group (16.5%). These results support the efficacy of short-term use of NPWT when used under highly
controlled conditions of inpatient care, but not the effectiveness of NPWT in the outpatient setting. A small 2015 RCT (N=20) of NPWT in an outpatient setting reported that patients treated with NPWT required significantly fewer dressing changes, reported significantly less pain, and experienced quality-of-life improvements compared to standard wound care.\textsuperscript{22}

Other randomized studies have reported no benefit for NPWT for surgical wounds, as reflected in the conclusions of the 2015 Cochrane review (described above). For example, the RCT by Masden et al (2012) examined the use of NPWT for surgical closures at high risk for nonhealing in 81 patients with comorbidities that included diabetes and peripheral vascular disease.\textsuperscript{23} At a mean of 113 days follow-up, there was no significant difference in the proportion of patients with wound infection, time to develop infection, or dehiscence between NPWT and dry dressing groups. Chio and Agrawal (2010) published results of a randomized trial of 54 patients comparing NPWT with a static pressure dressing for healing of the radial forearm free flap donor site.\textsuperscript{24} There were no statistically significant differences in wound complications or graft failure (percentage of area for graft failure, 7.2\% for negative pressure vs 4.5\% for standard dressing). Biter et al (2014) found no significant advantage of 2 weeks of NPWT in 49 patients who underwent surgical excision for pilonidal sinus disease.\textsuperscript{25} Complete wound healing was achieved at a median of 84 days in the NPWT group and 93 days in controls.

**Section Summary: Traumatic and Surgical Wounds**

The evidence on NPWT for individuals who have traumatic or surgical wounds includes RCTs and systematic reviews. One RCT found no benefit of NPWT on graft take and wound epithelialization in patients with full-thickness burns. NPWT showed no benefit for the treatment of patients with surgical wounds or skin grafts healing by primary intention, and a systematic review of NPWT for traumatic and surgical wounds found no differences between standard dressing and NPWT for any wound outcome measure. However, 1 small RCT suggested that prophylactic NPWT may reduce the number of dressing changes and pain when used in an outpatient setting. Additional study in a larger sample is needed to evaluate this outcome measure.

**Portable Single-Use NPWT Devices for Any Wound Type (Acute and nonhealing)**

**SNaP Wound Care System**

The portable, nonpowered (mechanical) gauze-based Smart Negative Pressure (SNaP) Wound Care System became available in 2009. The device is designed to remove small amounts of exudate from chronic, traumatic, dehisced, acute, or subacute wounds and diabetic and pressure ulcers.

In 2011, Armstrong et al reported results of a planned interim analysis of an RCT comparing the SNaP Wound Care System and the Vacuum Assisted Closure (V.A.C.) Therapy for the treatment of chronic lower-extremity wounds.\textsuperscript{26} Final results of this industry-sponsored multicenter noninferiority trial were reported in 2012.\textsuperscript{27} The trial enrolled 132 patients with lower-extremity venous or diabetic
ulcers with a surface area between 1 and 100 cm\(^2\) and diameter less than 10 cm present for more than 30 days despite appropriate care having. Dressings were changed per the manufacturer’s direction: 2 times per week in the SNaP group and 3 times per week in the V.A.C. group. Patients were assessed for up to 16 weeks or until complete wound closure; 83 (63%) patients completed the study. Intention-to-treat analysis with the last observation carried forward showed noninferiority in the primary outcome of wound size reduction at 4, 8, 12, and 16 weeks. When adjusted for differences in wound size at baseline, SNaP-treated subjects showed noninferiority to V.A.C.-treated subjects at 4, 12, and 16 weeks. Kaplan-Meier analysis showed no significant difference in complete wound closure between the 2 groups. At the final follow-up, 65.6% of the V.A.C. group and 63.6% of the SNaP group had wound closure. Survey data indicated that dressing changes required less time with the SNaP device, and use of the SNaP device interfered less with mobility and activity than the V.A.C. device. Subgroup analysis of 40 patients with venous leg ulcers who completed the study showed a significant improvement in the percentage of those with complete wound closure treated with SNaP (57.9%) compared to the V.A.C. system (38.2%; \(p=0.008\)).

This study had a high loss to follow-up and lacked a comparison with standard treatment protocols.

A 2010 retrospective study with historical controls compared NPWT using the SNaP device (\(n=28\)) with wound care protocols using Apligraf, Regranex, and skin grafting (\(n=42\)) for treatment of lower-extremity ulcers.\(^{29}\) Seven (25%) patients in the SNaP-treated group could not tolerate the treatment and were discontinued from the study because of complications; they were considered treatment failures. Between-group estimates of time-to-wound healing by Kaplan-Meier analysis favored the SNaP treatment group. This study is limited by the use of historical controls, multiple modalities used to treat controls, and large number of dropouts. The authors noted that patients in the SNaP-treated group may have benefited from being in an experimental environment, particularly because wounds in this group were seen twice per week compared with variable follow-up in historical controls.

**PICO Dressing**

PICO is a portable single-use NPWT system that comes with 2 sterile dressings and has a lifespan of 7 days. In 2016, Karlakki et al reported an RCT with 220 patients that evaluated use of the PICO device in the surgical center immediately after hip and knee arthroplasties.\(^{30}\) The device was left on for 7 days, including time after the hospital stay. Strengths of the study included power and ITT analysis, but evaluators were not blinded. There were trends toward reductions in hospital length of stay (0.9 days; 95% CI, -0.2 to 2.5 days; \(p=0.07\)) and postoperative surgical wound complications (8.4% control vs 2.0% PICO, \(p=0.06\)). Most of the difference in length of stay was due to wound complications in 2 outliers in the control group (up to 61 days). The level of wound exudate was significantly reduced by the PICO device (\(p=0.007\)), with 4% of the study group and 16% of the control group having grade 4 (scale grade, 0-4) exudate. Blisters were observed in 11% of patients treated with the PICO system, although the
occurrence of blisters was reported to be reduced when the dressing was stretched less.

In 2015, Schwartz et al reported an industry-funded pilot study with 12 patients who had small wounds of various types (total, 13 wounds). A key inclusion criterion was complete failure to progress over the previous 4 weeks. During the 4 weeks of PICO application, wound size decreased and wound appearance improved. There was no control group in this pilot study and no wound closures during the short follow-up period. The authors noted that in unpublished data, the device was not effective on skin-graft donor sites.

**Prevena System**
Prevena is a single-use NPWT system designed specifically for incisions. In 2013, Grauhan et al reported a pseudorandomized trial (alternating assignment) with 150 consecutive obese patients who underwent cardiac surgery via a median sternotomy. Use of the Prevena system for 6 to 7 days beginning immediately after suturing led to a reduction in rates of wound infection (4%) compared with standard wound care (4.16%; p=0.027). Gram-positive skin flora were found in 1 patient in the Prevena group and in 10 patients in the wound care group. This study was performed in an inpatient setting. A randomized trial involving a larger number of patients with sternal midline incisions is scheduled to be completed in 2017 (NCT02195310)

In 2016, Pauser et al reported a small RCT (N=21) of Prevena in patients who had hemiarthroplasty for femoral neck fractures. Use of the Prevena system significantly reduced seroma size, days of wound secretion, wound care time, and need for dressing changes.

**Section Summary: Portable Single-Use NPWT Devices for Any Wound Type**
The evidence on portable single-use NPWT includes an RCT of the PICO device, an RCT of the nonpowered SNaP System, and a pseudorandomized study of the Prevena Incision Management System. The PICO device was studied in an adequately powered but unblinded RCT of combined in- and outpatient use after total joint arthroplasty. Results showed some benefits that approached statistical significance. Further study in an outpatient setting is needed. One study of the SNaP nonpowered Wound Care System showed noninferiority to a V.A.C. device. However, interpretation of this study is limited by a high loss to follow-up and lack of a control group treated with dressings. These studies are insufficient to draw conclusions about the impact of single-use NPWT devices on the net health outcome compared with current care. Well-designed comparative studies with larger numbers of patients are needed.

**Summary of Evidence**
For individuals who have diabetic lower-extremity ulcers or amputation wounds who receive outpatient negative pressure wound therapy (NPWT), the evidence includes randomized controlled trials (RCTs) and a systematic review of RCTs. Relevant outcomes are symptoms, change in disease status, morbid events, quality of life, and treatment-related morbidity. There was a higher rate of wound
healing and fewer amputations with NPWT, although the studies were at risk of bias due to lack of blinding. The evidence is sufficient to determine that the technology results in a meaningful improvement in the net health outcome.

For individuals who have chronic pressure ulcers who receive outpatient NPWT, the evidence includes RCTs and systematic reviews. Relevant outcomes are symptoms, change in disease status, morbid events, quality of life, and treatment-related morbidity. All trials are of low quality and at high risk of bias. In addition, most study populations were treated in inpatient settings. The evidence is insufficient to determine the effects of the technology on health outcomes.

For individuals who have lower-extremity ulcers due to venous insufficiency who receive outpatient NPWT, the evidence includes 1 RCT and a systematic review. Relevant outcomes are symptoms, change in disease status, morbid events, quality of life, and treatment-related morbidity. A single RCT in patients with nonhealing leg ulcers who were treated with skin grafts found a faster rate of healing with NPWT when used in the inpatient setting. No studies were identified on the effectiveness of NPWT as a primary treatment for leg ulcers or for use of NPWT in the outpatient setting. The evidence is insufficient to determine the effects of the technology on health outcomes.

For individuals who have burn wounds who receive outpatient NPWT, the evidence includes RCTs and systematic reviews. Relevant outcomes are symptoms, change in disease status, morbid events, quality of life, and treatment-related morbidity. An interim report of an RCT evaluating NPWT in partial-thickness burns, summarized in a Cochrane review, did not permit conclusions on the efficacy of NPWT in partial-thickness burns. A separate RCT comparing NPWT with split-skin grafts in patients with full-thickness burns did not show differences in graft take and wound epithelialization. The evidence is insufficient to determine the effects of the technology on health outcomes.

For individuals who have traumatic or surgical wounds who receive outpatient NPWT, the evidence includes RCTs and systematic reviews. Relevant outcomes are symptoms, change in disease status, morbid events, quality of life, and treatment-related morbidity. There are limited data on NPWT as a primary treatment of partial-thickness burns. One RCT found no benefit of NPWT on graft take and wound epithelialization in patients with full-thickness burns. NPWT showed no benefit in the treatment of patients with surgical wounds or skin grafts healing by primary intention, and a systematic review of NPWT for traumatic and surgical wounds found no differences between standard dressing and NPWT for any wound outcome measure. However, 1 small RCT has suggested that prophylactic NPWT may reduce the number of dressing changes and pain when used in an outpatient setting. Additional study in larger samples is needed to evaluate this outcome measure. The evidence is insufficient to determine the effects of the technology on health outcomes.

For individuals who have any wound type (acute or nonhealing) who receive portable single-use outpatient NPWT, the evidence includes RCTs. Relevant
outcomes are symptoms, change in disease status, morbid events, quality of life, and treatment-related morbidity. The evidence includes an RCT of the PICO Single Use Negative Pressure Wound Therapy System, an RCT of the nonpowered Smart Negative Pressure (SNaP) Wound Care System, and a pseudorandomized study of the Prevena Incision Management System. The PICO device was studied in an adequately powered but unblinded RCT of combined in- and outpatient use following total joint arthroplasty. Results showed some benefits that approached statistical significance. Further study in an outpatient setting is needed. One study with the SNaP nonpowered Wound Care System showed noninferiority to a vacuum-assisted closure device. However, interpretation of this trial is limited by a high loss to follow-up and lack of a control group treated with dressings. These studies are insufficient to draw conclusions about its efficacy. Well-designed comparative studies with larger numbers of patients are needed to determine the effects of the technology with greater certainty. The evidence is insufficient to determine the effects of the technology on health outcomes.

Supplemental Information

Clinical Input From Physician Specialty Societies and Academic Medical Centers
While the various physician specialty societies and academic medical centers may collaborate with and make recommendations during this process, through the provision of appropriate reviewers, input received does not represent an endorsement or position statement by the physician specialty societies or academic medical centers, unless otherwise noted.

In response to requests, input was received from 2 physician specialty societies and 3 academic medical centers while this policy was under review in 2010. The input was near uniform in support of a therapeutic trial of negative pressure wound therapy (NPWT) for chronic pressure ulcers that have failed to heal; for traumatic or surgical wounds that have failed to close when there is exposed bone, cartilage, tendon, or foreign material within the wound; and for nonhealing wounds in patients with underlying clinical conditions known to negatively impact wound healing. Most of the input agreed that therapeutic trials of NPWT for other acute or chronic wounds would be not medically necessary.

Practice Guidelines and Position Statements

International Expert Panel on Negative Pressure Wound Therapy
In 2011, an international expert panel on negative pressure wound therapy (NPWT) provided evidence-based recommendations for the use of NPWT in chronic wounds. The panel made the following recommendations for the use of NPWT (see Table 1).

<table>
<thead>
<tr>
<th>Condition</th>
<th>Recommendation</th>
<th>Grade</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pressure ulcers, grade 3-4</td>
<td>“NPWT may be used until surgical closure is possible/desirable”</td>
<td>C</td>
</tr>
</tbody>
</table>
“NPWT should be considered to achieve closure by secondary intention…. to reduce wound dimensions…. [and] to improve the quality of the wound bed.”

**Diabetic foot ulcers**

“NPWT must be considered as an advanced wound care therapy…. [and] must be considered to achieve healing by secondary intention.”

“NPWT should be considered in an attempt to prevent amputation or reamputation.”

**Ischemic lower-limb wounds**

“…. NPWT … may be considered in specialist hands and never as an alternative for revascularisation.”

“…. NPWT is NOT indicated in acute limb ischemia.”

**Venous leg ulcers**

“If first line therapy (compression) is not efficacious, NPWT should be considered to prepare the wound for surgical closure.”

Grade A: based on high-quality meta-analyses, systematic reviews of randomized controlled trials [RCTs], or RCTs with very low risk of bias; grade B: based on high-quality systematic reviews of case-control or cohort studies; grade C: based on well-conducted case-control or cohort studies; grade D: based on case series or expert opinion.

### Infectious Diseases Society of America and Surgical Infection Society

Guidelines for the prevention of infections associated with combat-related injuries were endorsed in 2011 by the Infectious Diseases Society of America (IDSA) and the Surgical Infection Society. The guidelines provided a IB recommendation (strong recommendation, moderate-quality evidence) that NPWT should be used in the management of open wounds (excluding central nervous system injuries).

The 2012 guidelines from IDSA for the diagnosis and treatment of diabetic foot infections stated that no adjunctive therapy has been proven to improve resolution of infection, but for select diabetic foot wounds that are slow to heal, clinicians might consider using NPWT (weak recommendation, low quality evidence).

### American College of Physicians

In 2015, the American College of Physicians (ACP) published guidelines on the treatment of pressure ulcers. The guidelines stated that there was low-quality evidence that the overall treatment effect of NPWT did no differ from standard of care.

### Association for the Advancement of Wound Care

In 2010, the Association for the Advancement of Wound Care (AAWC) published guidelines on care of pressure ulcers. NPWT was included as a potential second-line intervention if first-line treatments did not result in wound healing (level B evidence). The guidelines indicated that patients must be selected carefully for this procedure.

In 2010, AAWC also issued guidelines on care of venous ulcers. The guidelines listed NPWT as a potential adjunctive therapy if conservative therapy does not work in 30 days. The guidelines noted that there is limited evidence for NPWT (level B) compared to other adjunctive therapies.
National Institute for Health and Clinical Excellence
The U.K.’s National Institute for Health and Clinical Excellence (NICE) 2013 guidance on NPWT for surgical wounds concluded that “Current evidence on the safety and efficacy of negative pressure wound therapy (NPWT) for the open abdomen is adequate to support the use of this procedure.”40

A 2015 NICE guidance on diabetic foot problems, updated in 2016, recommends consideration of NPWT after surgical debridement for diabetic foot ulcers on the advice of the multidisciplinary foot care service.41 It was noted that the evidence reviewed for NPWT was limited and of low quality, and that it would be useful to have more evidence for this commonly used treatment.

In 2014, NICE issued a guidance on the prevention and management of pressure ulcers.42 The guidance states “Do not routinely offer adults negative pressure wound therapy to treat a pressure ulcer, unless it is necessary to reduce the number of dressing changes (for example, in a wound with a large amount of exudate).” In addition, the guidance did not recommend NPWT for neonates, infants, or children.

U.S. Preventive Services Task Force Recommendations
Not applicable.

Medicare National Coverage
There is no national coverage determination (NCD). In the absence of an NCD, coverage decisions are left to the discretion of local Medicare carriers.

Ongoing and Unpublished Clinical Trials
Some currently unpublished trials that might influence this review are listed in Table 2.

Table 2. Summary of Key Trials

<table>
<thead>
<tr>
<th>NCT No.</th>
<th>Trial Name</th>
<th>Planned Enrollment</th>
<th>Completion Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ongoing</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>NCT02127281a</td>
<td>Randomized Controlled Trial of Wound Management With Negative Pressure Dressing Versus Standard Dressing After Knee and Hip Revision Arthroplasty</td>
<td>160</td>
<td>Mar 2016 (ongoing)</td>
</tr>
<tr>
<td>NCT02020018a</td>
<td>Negative Pressure Wound Therapy for Prevention of Wound Infection After Heart Surgery</td>
<td>950</td>
<td>Dec 2016 (ongoing)</td>
</tr>
<tr>
<td>NCT02395159</td>
<td>Reduction of Groin Wound Infections After Vascular Surgery in Patients With Risk Factors by the Use a Negative Pressure Wound Incision Management System (KCI Prevena)</td>
<td>204</td>
<td>Dec 2016 (ongoing)</td>
</tr>
<tr>
<td>NCT02289157a</td>
<td>Negative Pressure Wound Therapy in High Risk Patients Undergoing Cesarean</td>
<td>440</td>
<td>Jan 2017</td>
</tr>
<tr>
<td>NCT02195310a</td>
<td>The Use of Prevena™ Incision Management System on Clean Closed Sternal Midline Incisions in Subjects at High Risk for Surgical Site Occurrences</td>
<td>341</td>
<td>Feb 2017</td>
</tr>
<tr>
<td>NCT02064270a</td>
<td>A Prospective, Randomized, Controlled Clinical Study to Assess the Prevention of Postsurgical Incision Healing Complications in Patients</td>
<td>1000</td>
<td>Mar 2017</td>
</tr>
<tr>
<td>NCT No.</td>
<td>Trial Name</td>
<td>Planned Enrollment</td>
<td>Completion Date</td>
</tr>
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</tr>
<tr>
<td>NCT02509260</td>
<td>A Randomized Controlled Trial of Prevena™ Incisional Negative Pressure Wound Therapy to Reduce Surgical Site Infection in Re-operative Colorectal Surgery</td>
<td>298</td>
<td>Jul 2017</td>
</tr>
<tr>
<td>NCT02007018a</td>
<td>Negative Pressure Wound Therapy Use to Decrease Surgical Nosocomial Events in Colorectal Resections (NEPTUNE)</td>
<td>300</td>
<td>Sep 2017</td>
</tr>
<tr>
<td>NCT02461433a</td>
<td>The SAVIOR Trial: Surgical Application of Vac Dressings In Obese Patients to Reduce Wound Complications</td>
<td>108</td>
<td>Sep 2017</td>
</tr>
<tr>
<td>NCT01890720a</td>
<td>Use of Incisional Negative Pressure Wound Therapy for Prevention of Postoperative Infections Following Caesarean Section in Women With BMI &gt;=30</td>
<td>870</td>
<td>Oct 2017</td>
</tr>
<tr>
<td>NCT01913132</td>
<td>PICO Versus Standard Dressing Above Groin Incisions After Vascular Surgery - a Prospective Randomized Trial</td>
<td>160</td>
<td>Dec 2017</td>
</tr>
<tr>
<td>NCT02309944a</td>
<td>Negative Pressure Wound Therapy in Obese Gynecologic Oncology Patients: A Randomized Controlled Trial</td>
<td>200</td>
<td>Dec 2017</td>
</tr>
<tr>
<td>NCT02348034a</td>
<td>A Randomized Controlled Trial Exploring the Ability of Negative Pressure Wound Therapy (NPWT) to Reduce Colorectal Surgical Site Infections (SSI)</td>
<td>398</td>
<td>Dec 2017</td>
</tr>
<tr>
<td>NCT02467998</td>
<td>The Registry of Negative Pressure Wound Therapy for Chronic Wounds and Ulcers</td>
<td>50,000</td>
<td>Jan 2020</td>
</tr>
<tr>
<td>NCT01821664</td>
<td>Vascular Graft Infections - Epidemiology, Best Treatment Options, Imaging Modalities and Impact of Negative Pressure Wound Therapy</td>
<td>1800</td>
<td>Mar 2023</td>
</tr>
<tr>
<td>Unpublished</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>NCT01191567</td>
<td>Negative Pressure Wound Therapy. Therapy Effects and the Impact on the Patient’s Quality of Life</td>
<td>200</td>
<td>Jan 2016</td>
</tr>
</tbody>
</table>

NCT: national clinical trial.

* Denotes industry-sponsored or cosponsored trial.

References


### Billing Coding / Physician Documentation Information

**97605**  
Negative pressure wound therapy (e.g., negative pressure therapy-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 (e.g., 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

**97607**  
Negative pressure wound therapy, (e.g., 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, (e.g., 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

**A6550**  
Wound care set, for negative pressure wound therapy electrical pump, includes all supplies and accessories

**A7000**  
Canister, disposable, used with suction pump, each

**A7001**  
Canister, nondisposable, used with suction pump, each

**A9272**  
Mechanical wound suction, disposable, includes dressing, all accessories and components, each

**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 sq in or less

**K0745**  
Absorptive wound dressing for use with suction pump, home model, portable, pad size more than 16 sq in but less than or equal to 48 sq in

**K0746**  
Absorptive wound dressing for use with suction pump, home model, portable, pad size greater than 48 sq in

### ICD-10 Codes
Pressure ulcer code range, specified site, code range includes options for all body areas as well as designation of stages.
Pressure ulcer code range, unspecified site, code range includes options for all body areas as well as designation of stages.

Open wound of head and face, code range, 7th digit extender includes stage of healing.
Open wound of neck, code range, 7th digit extender includes stage of healing.
Open wound of thorax, code range, 7th digit extender includes stage of healing.
Open wound of abdomen, lower back, pelvis and external genitals, code range, 7th digit extender includes stage of healing.
Open wound of shoulder and upper arm, code range, 7th digit extender includes stage of healing.
Open wound of elbow and forearm, code range, 7th digit extender includes stage of healing.
Open wound of wrist, hand and fingers, code range, 7th digit extender includes stage of healing.
Open wound of hip and thigh, code range, 7th digit extender includes stage of healing.
Open wound of knee and lower leg, code range, 7th digit extender includes stage of healing.
Open wound of ankle, foot and toes, code range, 7th digit extender includes stage of healing.

Codes G0456 and G0457 deleted 12/31/2014

**Policy Implementation/Update Information**

7/1/01 New policy added to DME section titled *Vacuum Assisted Closure*. Considered medically necessary for:
- Patient has a chronic Stage III or Stage IV pressure ulcer, venous or arterial insufficiency ulcer or a chronic ulcer of mixed etiology.
- A complete wound therapy program should have been tried or considered and ruled out prior to application of negative pressure wound therapy.

7/1/02 No policy statement changes.
7/1/03 No policy statement changes.
7/1/04 No policy statement changes.
9/1/06 Policy statement revised to indicate this to be investigational. Added to the Medical section. Title changed to *Negative Pressure Therapy for the Treatment of Chronic Wounds*. Final policy updated 2/1/07.
9/1/07 No policy statement changes.
9/1/08 No policy statement changes.
9/1/09 No policy statement changes.
7/1/10 Policy statements revised to indicate three types of wounds (including acute and chronic) were added as medically necessary for a therapeutic trial. All other uses in acute and chronic wounds is not medically
necessary.

9/1/10  No policy statement changes.
9/1/11  The term “powered” added to existing policy statements which are unchanged, new policy statement added that non-powered NPWT systems are investigational
1/1/12  Coding updated.
9/1/12  Policy statement for continuation of powered NPWT clarified
9/1/13  Updated coding. No policy statement changes.
9/1/14  No policy statement changes.
9/1/15  No policy statement changes. Codes updated to reflect revised and deleted codes.
9/1/16  No policy statement changes.
9/1/17  No policy statement changes.

State and Federal mandates and health plan contract language, including specific provisions/exclusions, take precedence over Medical Policy and must be considered first in determining eligibility for coverage. The medical policies contained herein are for informational purposes. The medical policies do not constitute medical advice or medical care. Treating health care providers are independent contractors and are neither employees nor agents Blue KC and are solely responsible for diagnosis, treatment and medical advice. No part of this publication may be reproduced, stored in a retrieval system or transmitted, in any form or by any means, electronic, photocopying, or otherwise, without permission from Blue KC.