Negative Pressure Wound Therapy in the Outpatient Setting

Policy Number: 1.01.16
Origination: 7/2001

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. A systematic review of RCTs and case series found a faster rate of wound healing with NPWT compared to control interventions. The evidence is insufficient to determine the effects of the technology on health outcomes.
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 developed in January 1998 and has been updated regularly with searches of the MEDLINE database. The most recent literature update was performed through November 6, 2017.

Evidence reviews assess the clinical evidence to determine whether the use of a technology improves the net health outcome. Broadly defined, health outcomes are length of life, quality of life, and ability to function—including benefits and harms. Every clinical condition has specific outcomes that are important to patients and to managing the course of that condition. Validated outcome measures are necessary to ascertain whether a condition improves or worsens; and whether the magnitude of that change is clinically significant. The net health outcome is a balance of benefits and harms.

To assess whether the evidence is sufficient to draw conclusions about the net health outcome of a technology, 2 domains are examined: the relevance and the quality and credibility. To be relevant, studies must represent one or more intended clinical use of the technology in the intended population and compare an effective and appropriate alternative at a comparable intensity. For some conditions, the alternative will be supportive care or surveillance. The quality and credibility of the evidence depend on study design and conduct, minimizing bias and confounding that can generate incorrect findings. The randomized controlled trial (RCT) is preferred to assess efficacy; however, in some circumstances, nonrandomized studies may be adequate. RCTs are rarely large enough or long enough to capture less common adverse events and long-term effects. Other types of studies can be used for these purposes and to assess generalizability to broader clinical populations and settings of clinical practice.

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). Also, literature has been sought on the potential benefits of negative pressure wound therapy (NPWT) for the healing of acute wounds.
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, 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
In 2014, authors of a systematic review for the Agency for Healthcare Research and Quality and the Centers for Medicare & 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.³ There were 3 retrospective cohort studies on diabetic foot ulcers and arterial ulcers, an RCT and 2 retrospective cohort studies on pressure ulcers, and a retrospective cohort on venous ulcers. Six studies used the V.A.C., and the other used the SNaP device. Reviewers found that interpretation of available data was limited by variability in the types of comparator groups, methodologic limitations, and poor reporting of outcomes.⁴

Another Agency for Healthcare Research and Quality 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.⁵

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).⁶ 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]⁷ 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 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 with 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 the 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 with advanced moist wound therapy. Included were 342 patients with Wagner grade 2 or 3 foot ulcers of 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 vs 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 the risk of bias in the unblinded studies, there were higher rates 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 trials were considered to be at high risk of bias, and all evidence was considered to be of very low quality. Only 1 trial 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 was no significant group difference 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 might 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 were of low quality and at high risk of bias. Also, 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 the 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 would 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 use of 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 an 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.\textsuperscript{15} 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, the 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.\textsuperscript{16}

A 2017 retrospective case series by Ehrl et al examined outcomes for 51 patients treated for burned hands with topical negative pressure wound (TNPW) therapy at a single center; of the initial 51 patients, only 30 patients (47 hands) completed follow-up, which was conducted an average of 35 months after injury and included physical examination.\textsuperscript{17} Before TNPW therapy, patients received escharotomy or superficial débridement if needed, or split-thickness skin grafts for third-degree burns and the TNPW gloves used allowed caregivers to assess patients’ fingertips for perfusion. Ergotherapy was initiated following evidence of epithelialization. Primary end points were a dorsal extension of the fingers and capability of complete active fist closure, with the majority of patients achieving one or both outcomes: the first end point was reached in 85.1% (n=40) of the cases; the second end point was reached in 78.7% of hands (n=37). When evaluated using the Disabilities of the Arm, Shoulder, and Hand questionnaire (scoring range, 0-100; with 0=no disability), patients with injuries resulting in hypertrophic scarring had significantly worse scores (28.8) than patients without similar scarring (11.7; p<0.05). Despite a number of limitations, including heterogeneity of burned areas (2.5% to 70% throughout the series), the authors acknowledged TNPW therapy as standard treatment at the institution from which these data were drawn.

**Section Summary: Burn Wounds**
The evidence on NPWT as a primary treatment of partial-thickness burns is limited. A retrospective case series reported functional outcomes in most patients treated for hand burns with NPWT. One RCT on NPWT for skin grafts showed no benefit for graft take, wound epithelialization, or scar quality.

**Traumatic and Surgical Wounds**
Identified studies have 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.\textsuperscript{18} 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, four included orthopedic patients, and two included general surgery and trauma surgery patients. All trials had an 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 outcomes data on the number of wounds healed, adverse events, and resource use. Reviewers concluded that there was 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 trial participants 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 (the difference was not statistically significant). 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 would support the efficacy of the 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 with standard wound care.\(^\text{23}\)

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.\(^\text{24}\) At a mean of 113 days follow-up, there were no significant differences in the proportions 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 the healing of the radial forearm free flap donor site.\(^\text{25}\) 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.\(^\text{26}\) Complete wound healing was achieved at a median of 84 days in the NPWT group and 93 days in controls.

Danne et al published a retrospective study comparing NPWT with alginate-based or gauze daily dressing in 2017, using data from 73 patients who were treated between 2006 and 2015 for natal cleft pilonidal sinus.\(^\text{27}\) Most patients (n=62) were assigned open healing following surgery, and 9 patients with wounds smaller than 1 cm had primary closure. The primary outcomes of interest were time to healing and, where applicable, failure to heal. For the former, patients in the daily dressing group took a median of 10 weeks (95% CI, 7 to 17 weeks) to heal, compared with 8 weeks (95% CI, 7 to 9 weeks) in the NPWT group. This difference (p=0.116) was not statistically significant, as was the difference between groups for recurrence of the pilonidal sinus (12.5% of the daily dressing group vs 3.1% of the NPWT group had disease recurrence, p=0.355); however, investigators noted that both outcomes were favorable for the NPWT group. In subgroup analysis of patients with comorbidities vs those without, there was a significantly improved likelihood of healing for the latter; given the presence of comorbidities such as previous pilonidal sinus surgery, infective skin conditions, morbid obesity, or type 1 diabetes, patients with such risks had a hazard ratio of 13.10 (95% CI, 3.90 to 44.04) compared with those free of comorbidities (p<0.001). While a number of patients were lost to follow-up, of those at the final analysis, 72.4% in the daily dressing group reached epithelialization, compared with 93.6% in the NPWT group, prompting investigators to call for larger prospective studies of the intervention.

**Section Summary: Traumatic and Surgical Wounds**
The evidence on the use of 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, a small RCT suggested that prophylactic NPWT might reduce the number of dressing changes and pain when used in an outpatient setting. A small retrospective study reported improved epithelialization in patients free of comorbidities treated with NPWT. 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 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 on results of a planned interim analysis of an RCT comparing the SNaP Wound Care System with the Vacuum Assisted Closure (V.A.C.) Therapy for the treatment of chronic lower-extremity wounds.28 Final results of this industry-sponsored multicenter noninferiority trial were reported in 2012.29 The trial enrolled 132 patients with lower-extremity venous or diabetic ulcers with a surface area between 1 cm² and 100 cm² 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 (2015) 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 with the V.A.C. system (38.2%; p=0.008).30 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.31 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 to treat controls, and a large number of dropouts. The
authors noted that patients in the SNaP-treated group might 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 on an RCT with 220 patients that evaluated the use of the PICO device in a surgical center immediately after hip and knee arthroplasties. The device was left on for 7 days, including the time after the hospital stay. Strengths of the trial included power and intention-to-treat 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). However, 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 blister occurrence was reported to be reduced when the dressing was stretched less.

In 2015, Schwartz et al reported on an industry-funded pilot study assessing 12 patients who had small wounds of various types (total, 13 wounds). A key selection criterion was a 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 the skin-graft donor sites.

O'Leary et al published an RCT in 2017 that allocated 50 patients to standard wound dressing or negative pressure wound dressing after abdominal surgery; patients had class I, II, or II wounds, and the treatment group was given the PICO dressing. Surgical site infection was evaluated at 4 and 30 days following surgery, and results were analyzed both on per-protocol and intention-to-treat bases. Caregivers did not find a significant difference between groups after 4 days (p=0.516); however, at 30-day follow-up, rates of surgical site infections were significantly lower for the group receiving negative pressure dressing than for the control group, both in per-protocol analysis (8.3% vs 32.0%, p=0.043) and intention-to-treat analysis (12% vs 32%, p=0.073). Univariate analysis showed a significant association between standard wound dressing and the likelihood of a surgical site infection (p=0.040); for secondary outcomes (eg, cosmetic outcome, patient satisfaction), the authors reported no difference between groups. The mean length of stay was shorter for patients who received negative pressure dressings (6.1 days) than for control patients; however, when all reasons for delayed discharge were accounted for, the difference was not statistically significant (p=0.89). While comparatively small, this trial would indicate that negative pressure dressings resulted in a beneficial outcome for patients
recovering from abdominal surgery regarding the occurrence of surgical site infections.

**Prevena System**

Prevena is a single-use NPWT system designed specifically for incisions. In 2013, Grauhann et al reported on 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 reduced 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 (NCT02195310) involving a larger number of patients with sternal midline incisions was terminated in early 2017.

In 2016, Pauser et al reported on a small RCT (\( N = 21 \)) evaluating 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; also, a 2017 RCT compared the PICO device with standard dressing following abdominal surgery. Results showed some potential benefits but were not statistically significant. Further study in an outpatient setting is needed. One study of the SNaP 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. The evidence base for the Prevena System is not sufficiently robust for conclusions on efficacy to be drawn. 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 NPWT, the evidence includes 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. Also, 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 an 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 the 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, systematic reviews, and case series. 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 for this indication. 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. A retrospective case series reported functional outcomes for most patients who were treated with NPWT at a single center. 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, a small RCT has suggested that prophylactic NPWT may reduce the number of dressing changes and pain when used in an outpatient setting. A small retrospective study reported improved epithelialization with NPWT in patients free of comorbidities. 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 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; also, a 2017 RCT compared the PICO device with standard dressing following abdominal surgery. Results showed some benefits, though not statistically significant. One study with the Smart Negative Pressure 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 these technologies 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 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 input affirmed that therapeutic trials of negative pressure wound therapy 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 1. Recommendations on Use of NPWT in Chronic Wounds

<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>
<tr>
<td></td>
<td>“NPWT should be considered to achieve closure by secondary intention.... to reduce wound dimensions.... [and] to improve the quality of the wound bed.”</td>
<td>B</td>
</tr>
<tr>
<td>Diabetic foot ulcers</td>
<td>“NPWT must be considered as an advanced wound care therapy.... [and] must be considered to achieve healing by”</td>
<td>A</td>
</tr>
</tbody>
</table>
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.” |
| Venous leg ulcers | “If first line therapy (compression) is not efficacious, NPWT should be considered to prepare the wound for surgical closure....” |

NPWT: negative pressure wound therapy.

* Grade A: based on high-quality meta-analyses, systematic reviews of randomized controlled trials, or randomized controlled trials 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.

### International Multidisciplinary Consensus Recommendations

In 2017, Willy et al presented evidence-based consensus guidelines on the use of closed incision negative pressure therapy (ciNPT) following surgery. Among the studies found were 100 randomized controlled studies on ciNPT, most of which found an association between the use of ciNPT and improved outcomes. Based on the evidence, the consensus panel recommended that surgeons evaluate risk in patients before surgery to determine whether patient comorbidities (ie, obesity or diabetes) or the nature of the surgery presents an increased danger of infection. In such cases, the panel recommended the use of ciNPT.

### 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 and the Surgical Infection Society. The guidelines provided an IB recommendation (strong recommendation, moderate-quality evidence) that NPWT should be used to manage open wounds (excluding central nervous system injuries).

The 2012 guidelines from the Society for the diagnosis and treatment of diabetic foot infections stated that no adjunctive therapy has been proved 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 published guidelines on the treatment of pressure ulcers. The guidelines stated there was low-quality evidence that the overall treatment effect of NPWT did no differ from the standard of care.

### Association for the Advancement of Wound Care

In 2010, the Association for the Advancement of Wound Care published guidelines on the 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, the Association supported guidelines on the 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 with other adjunctive therapies.

**National Institute for Health and Care Excellence**

The National Institute for Health and Care Excellence (NICE) issued guidance in 2013 on NPWT for surgical wounds, concluding 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.”

A 2016 NICE guidance on diabetic foot problems, updated in 2016, has recommended consideration of NPWT after surgical débridement for diabetic foot ulcers on the advice of the multidisciplinary foot care service. 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. The guidance stated “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).” Also, 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. In the absence of a national coverage determination, 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>
<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>
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<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>NCT02739191</td>
<td>Negative Pressure Wound Therapy for Surgical Wounds of the Foot and Ankle</td>
<td>60</td>
<td>Aug 2017 (ongoing)</td>
</tr>
<tr>
<td>NCT02007018</td>
<td>Negative Pressure Wound Therapy Use to Decrease Surgical Nosocomial Events in Colorectal Resections (NEPTUNE)</td>
<td>300</td>
<td>Sep 2017 (ongoing)</td>
</tr>
<tr>
<td>NCT No.</td>
<td>Trial Name</td>
<td>Planned Enrollment</td>
<td>Completion Date</td>
</tr>
<tr>
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</tr>
<tr>
<td>NCT02461433</td>
<td>The SAVIOR Trial: Surgical Application of Vac Dressings In Obese Patients to Reduce Wound Complications</td>
<td>108</td>
<td>Sep 2017 (ongoing)</td>
</tr>
<tr>
<td>NCT02470806</td>
<td>A Prospective, Randomized, Comparative Effectiveness Study of a Single-Use, Negative Pressure Wound Therapy System (PICO) Versus a Traditional Negative Pressure Wound Therapy System (tNPWT) in the Treatment of Lower Extremity Ulcers</td>
<td>160</td>
<td>Nov 2017 (ongoing)</td>
</tr>
<tr>
<td>NCT02664168</td>
<td>A Prospective, Randomized, Comparative Study to Assess the Prevention of Surgical Site Infection (SSI's) in Revision Total Joint Arthroplasty Patients Treated With Single-Use Negative Pressure Wound Therapy (PICO™) or Standard Care Dressings (AQUACEL® Ag SURGICAL Dressing)</td>
<td>200</td>
<td>Feb 2018</td>
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<tr>
<td>NCT01528033</td>
<td>Treatment Study of Vacuum Assisted Closure for Postsurgical Subcutaneous Abdominal Wound Healing Impairments (SAWHI)</td>
<td>600</td>
<td>Jun 2018</td>
</tr>
<tr>
<td>NCT02309944</td>
<td>Negative Pressure Wound Therapy in Obese Gynecologic Oncology Patients</td>
<td>200</td>
<td>Dec 2018</td>
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<tr>
<td>NCT02509260</td>
<td>Prevena™ Incisional Negative Pressure Wound Therapy in Re-operative Colorectal Surgery</td>
<td>298</td>
<td>Dec 2018</td>
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<tr>
<td>NCT02799667</td>
<td>Randomized Controlled Trial: Do Single Use Negative Pressure Dressings Reduce Wound Complications in Women With a BMI &gt;40 kg/m2 Undergoing Cesarean Delivery at a Tertiary Medical Center?</td>
<td>242</td>
<td>May 2019</td>
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<tr>
<td>NCT01913132</td>
<td>PICO Above Groin Incisions After Vascular Surgery</td>
<td>160</td>
<td>Jun 2019</td>
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<tr>
<td>NCT02348034</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>Jul 2019</td>
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<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>
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<tr>
<td>NCT03144726</td>
<td>Single Center Prospective Randomized Control Trial on Negative Pressure Wound Therapy for Incisions Following Major Lower-limb Amputation to Reduce Surgical Site Infection</td>
<td>290</td>
<td>Jul 2020</td>
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<tr>
<td>NCT02682316</td>
<td>A Phase III Randomized Controlled Trial of Negative Pressure Wound Therapy in Post-Operative Incision Management</td>
<td>686</td>
<td>Feb 2021</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>
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<tr>
<td>NCT02813161</td>
<td>A Real World, Observational Registry of Diabetic Foot Ulcers and Quality of Care in Clinical Practice</td>
<td>10,000</td>
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<tr>
<td>Unpublished</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 (terminated)</td>
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<td></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 (unknown)</td>
</tr>
<tr>
<td></td>
<td>Negative Pressure Wound Therapy in High Risk Patients Undergoing Cesarean</td>
<td>440</td>
<td>Jan 2017 (unknown)</td>
</tr>
<tr>
<td></td>
<td>The Use of Prevena™ Incision Management System</td>
<td>341</td>
<td>Feb 2017</td>
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<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>NCT02064270a</td>
<td>A Prospective, Randomized, Controlled Clinical Study to Assess the Prevention of Postsurgical Incision Healing Complications in Patients Undergoing Primary or Revision Total Knee Arthroplasty (TKA) or Total Hip Arthroplasty (THA), Treated With Either Single-Use Negative Pressure Wound Therapy (NPWT) or Standard Postsurgical Dressings</td>
<td>1000</td>
<td>Mar 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>
</tbody>
</table>

NCT: national clinical trial.

a 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
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

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

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

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

Canister, disposable, used with suction pump, each
Canister, nondisposable, used with suction pump, each
Mechanical wound suction, disposable, includes dressing, all accessories and components, each

Negative pressure wound therapy electrical pump, stationary or portable
Suction pump, home model, portable, for use on wounds
Absorptive wound dressing for use with suction pump, home model, portable, pad size 16 sq in or less
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
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 stage of ulcer
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
S41.159S extender includes stage of healing
S51.001A- Open wound of elbow and forearm, code range, 7th digit extender includes stage of healing
S61.001A- Open wound of wrist, hand and fingers, code range, 7th digit extender includes stage of healing
S71.001A- Open wound of hip and thigh, code range, 7th digit extender includes stage of healing
S81.001A- Open wound of knee and lower leg, code range, 7th digit extender includes stage of healing
S91.001A- 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.
9/1/18  No policy statement changes.

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