Indiana Health Coverage Programs

P R O V I D E R B U L L E T I N

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To: All Indiana Health Coverage Programs Durable Medical Equipment Providers, Physicians, Home Health Care Providers, Hospitals, and Long Term Care Providers

Subject: Negative Pressure Wound Therapy

Overview

Effective 45 days from publication of this bulletin, Indiana Health Coverage Programs (IHCP) will provide coverage for negative pressure wound therapy (NPWT) in a home-care setting or a long-term care setting based on the criteria described in this bulletin. Prior authorization is required, and the service will be reimbursed as a capped rental item.

NPWT is a controlled application of subatmospheric pressure to a wound. NPWT is achieved using an electrical pump to convey, intermittently or continuously, subatmospheric pressure through a connecting tube to a specialized wound dressing. This specialized dressing includes a resilient open cell foam surface dressing, sealed with an occlusive dressing that is meant to contain the subatmospheric pressure at the wound site and promote wound healing.

A medical clearance form was developed to assist providers in supplying documentation to support the medical necessity of NPWT. A copy of the new medical clearance form is included in this bulletin and may be copied for use by providers as needed.

Prior Authorization of NPWT

Prior authorization is required for reimbursement of NPWT. The provider must submit a completed prior authorization form and a completed medical clearance form signed by the physician to the HCE Prior Authorization Unit for review of medical necessity. To be considered medically necessary, the member must have a stage III or IV pressure ulcer, neuropathic ulcer, venous or arterial insufficiency ulcer, or

chronic (present for at least 60 days) ulcer of mixed etiology. A complete wound program described in the criteria listed below, as applicable depending on the type of wound, must have been tried and failed prior to application of the NPWT.

Criteria for Wound Therapy

1. For all ulcers or wounds, all of the following minimum general measures of a wound therapy program must be addressed or applied prior to application of NPWT:
   - Documentation in a patient's medical record of evaluation, care, and wound measurements by a licensed medical professional
   - Application of dressings to maintain a moist wound environment
   - Debridement of necrotic tissue if present
   - Evaluation of and provision for adequate nutritional status
2. In addition to criterion one, stage III or IV pressure ulcers must also be evaluated for all of the following components:
   - The patient has been appropriately turned and positioned and has a current turning and positioning plan in place.
   - If the wound is on the trunk or the pelvis, the patient has used a group 2 or 3 support surface.
   - The patient's moisture and incontinence has been appropriately managed.
3. In addition to criterion one, neuropathic ulcers must also be evaluated for all of the following components:
   - The patient has been on a comprehensive diabetic or other applicable disease management program.
   - Reduction in pressure on a foot ulcer has been accomplished with appropriate modalities.
4. In addition to criterion one, venous stasis ulcers must also be evaluated for all of the following components:
   - Compression bandages or garments have been consistently applied.
   - Leg elevation and ambulation have been encouraged.

Continued Coverage

To obtain prior authorization for continued service after the initial prior authorization of NPWT, documentation of the following must be included with the request:

- Indication that a licensed medical professional has directly performed or supervised the performance of the dressing changes.
- Progress and changes in the ulcer. (If there is no progress in one month, or from month to month, the approval for the NPWT will be discontinued.)
- A completed NPWT medical clearance form signed and dated by the ordering physician.

Prior Authorization Timeframes

The NPWT is only authorized for four weeks at a time. Each new request requires a statement from the treating physician describing the initial condition of the wound including measurements, efforts taken to address wound care, and the changes in the wound therapy being applied to affect wound healing.

- Each new physician's order for continued use of NPWT requires a new prior authorization period. If a prior authorization is modified and authorized for less time than the physician's order had requested initially, a new prior authorization form and updated physician's orders must be obtained before the current authorization expires.
- Authorization for coverage beyond four months in a home care setting will be given individual consideration based on additional documentation that sets out the reason for continuing us of NPWT.

Supplies

Supplies for the NPWT must be prior authorized. Dressing sets are packaged five or ten to a case. Each dressing set equals one unit and includes, but is not limited to, a resilient open cell foam surface dressing, drainage tubing, and an occlusive dressing that creates a seal around the wound site to maintain subatmospheric pressure at the wound. No more than 15 units for dressing sets, any size, will be authorized per wound, per month. No more than ten canisters, any size, per wound, per month, will be authorized unless documentation is submitted with the request to identify proof of an increased amount of supplies.

Submitting Claims

Claims must be submitted on a HCFA-1500 form using the appropriate K-codes. Health Care Financing Administration Common Procedure Coding System (HCPCS) codes K0538, K0539, and K0540 are described in Table 1.1 with maximum fees and monthly allowable amounts listed.

Table 1.1 – HCPCS Codes for NPWT

HCPCS Code	Description of Code	Maximum Fee	Maximum Monthly Allowable Units
K0538	Stationary portable electrical pump that provides controlled subatmospheric pressure	$913.33 per month	A maximum of one unit will be authorized per month. If more than one wound exists, use a Y-connector for the additional wound site.
K0539	Dressing set includes, but is not limited to, the following: resilient open cell foam dressing, drainage tubing, and occlusive dressing	$24.65 per dressing set	15 per month, all sizes; per wound
K0540	Wound drainage canister	$22.50 per canister	Ten per month, any size; per wound

Hospital Reimbursement

When the NPWT is used in a hospital, reimbursement for the NPWT is included in the hospital diagnosis-related groups (DRG) rate.

Additional Questions

Questions about this bulletin may be directed to the Health Care Excel Medical Policy Department at (317) 347-4500. Questions about the billing procedures referenced in this bulletin may be directed to EDS Customer Assistance at (317) 655-3240 in the Indianapolis local area or 1-800-577-1278.

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Medical Clearance Form

Negative Pressure Wound Therapy

Section A	**Certification Date**	**Initial: __/__/__**	**Revised: __/__/__**
Patient name Address		Supplier name Address	
Phone number (____)_____	RID number _____	Phone number (____) _____	Provider number _____
Place of service _____ Name and address of facility (if applicable)	HCPCS Code	PT DOB____/___/___/; Sex___(M/F) HT_____(IN); WT_____(LBS) Physician name Address Physician UPIN number _____ Physician telephone ( ) _____	

Section B	**Information in this Section May Not Be Completed by the Supplier of the Items/Supplies**
Estimated length of need (Number of months_____)	Dx codes (ICD-9) _____ _____ _____ _____
Answers	Circle Y for Yes, N for No, or NA for Not applicable
Y N NA	Is the patient's nutritional status adequate for wound healing? Describe the diet.
Y N NA	Has a moist wound environment dressings been tried and failed? If yes, please describe what type of dressing was used.
Y N NA	If necrotic tissue is present, has debridement been attempted?
Y N NA	Does the patient have osteomyelitis? If yes, what is the treatment regimen?
Y N NA	Is there a fistula within the vicinity of the wound or cancer in the wound?
Y N NA	Is there a documented history of previous wound management regimen, including wound measurements available for review on request by the IHCP?

Section C	**Wound Description** **Fill this section out for the primary wound and fill out a supplemental form for each additional wound.**

Type of wound (check one)	**Wound site: _____**	
Arterial insufficiency ulcer _____		
Stage 3 or 4 pressure ulcer _____	**Approximate age of wound _____**	
Chronic ulcer of mixed etiology _____		
Venous stasis ulcer _____	**Wound measurements**	
Neuropathic ulcer (such as diabetic) _____	**Current**	**One month ago**
Traumatic (such as pre-op graft or flap) _____	Length ___cm	Length ____cm
Surgically created (such as dehisced) _____	Width ____cm	Width ____cm
	Depth ___cm	Depth ____cm
	Exudate	
	Current	**One month ago**
	Slight _____	Slight _____
	Moderate _____	Moderate _____
	Heavy _____	Heavy _____

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Medical Clearance Form (continued)

Negative Pressure Wound Therapy

Section D	**Complete this section in addition to the previous sections according to the type of wound the patient has. Place an X in the appropriate box.**

D1 Complete these questions for Pressure ulcers

Has the patient been on a turning schedule?	Yes	☐	No	☐
Is the patient using a group 2 or group 3 support surface?	Yes	☐	No	☐
Have moisture and incontinence been appropriately managed?	Yes	☐	No	☐

If any of the answers above are answered no and these treatment measures have been considered and ruled out, please explain.

D2 Complete these questions for Neuropathic ulcers

Has the patient been on a comprehensive diabetic management program?	Yes	☐	No	☐
Has reduction in pressure on a foot ulcer been accomplished with appropriate modalities?	Yes	☐	No	☐

If either of the answers above are No, and these treatment measures have been considered and ruled out, please explain.

D3 Complete these questions for Surgical or Traumatic wounds

Does the patient have complications of a surgically created wound?	Yes	☐	No	☐
Does the patient have a traumatic wound?	Yes	☐	No	☐

Is there documentation for the medical necessity for accelerated formation of granulation tissue that cannot be achieved by other available topical wound treatments? If yes, please explain.

D4 Complete these questions for Venous Insufficiency ulcers

Have compression bandages or garments been consistently applied?	Yes	☐	No	☐
Has leg elevation and ambulation been encouraged?	Yes	☐	No	☐

If either of the answers above are No, and these treatment measures have been considered and ruled out, please explain.

D5 Complete these questions for Arterial or Chronic ulcers

Has relief of pressure over the wound been achieved?	Yes	☐	No	☐
Have moisture and incontinence been controlled?	Yes	☐	No	☐

If either of the answers above are No, and these treatment measures have been considered and ruled out, please explain.

Section E	**Physician Signature, Attestation, and Date**

I certify that I am the physician listed in section A of this form. I have received sections A through E of the certificate of medical necessity. All supplemental attachments and any statement on my letterhead, attached hereto, have been reviewed and signed by me. I certify that the medical necessity information is Section B thru D is true, accurate, and complete to the best of my knowledge, and I understand falsification, omission, or concealment of material fact in that section may subject me to civil or criminal liability.

Physician Signature:	**Date:**

Patient Name	**RID Number**
Negative Pressure wound Therapy Supplemental Form	
Supplemental Section C **(A supplement for each additional wound must be completed)**	**Wound number #_____**

Type of wound (check one)	**Wound site**: _____	
Arterial insufficiency ulcer _____		
Stage 3 or 4 pressure ulcer _____	**Approximate age of wound** _____	
Chronic ulcer of mixed etiology _____		
Venous stasis ulcer _____	**Wound measurements**	
Neuropathic ulcer (such as diabetic) _____	**Current**	**One month ago**
Traumatic (such as pre-op graft or flap) _____	Length___cm	Length___cm
Surgically created (such as dehisced) _____	Width____cm	Width____cm
	Depth____cm	Depth____cm
	Exudate	
	Current	**One month ago**
	Slight _____	Slight _____
	Moderate_____	Moderate_____
	Heavy _____	Heavy _____

Supplemental Section D	**Complete this section according to the type of wound in addition to the previous sections. Place an X in the appropriate box**

Supplemental D1 Complete these questions for Pressure ulcers				
Has the patient been on a turning schedule?	Yes	☐	No	☐
Is the patient using a group 2 or group 3 support surface?	Yes	☐	No	☐
Have moisture and incontinence been appropriately managed?	Yes	☐	No	☐
If any of the answers above are No, and these treatment measures have been considered and ruled out, please explain.				

Supplemental D2 Complete these questions for Neuropathic ulcers				
Has the patient been on a comprehensive diabetic management program?	Yes	☐	No	☐
Has reduction in pressure on a foot ulcer been accomplished with appropriate modalities?	Yes	☐	No	☐
If either of the answers above are No, and these treatment measures have been considered and ruled out, please explain.				

Supplemental D3 Complete these questions for Surgical or Traumatic wounds				
Does the patient have complications of a surgically created wound?	Yes	☐	No	☐
Does the patient have a traumatic wound?	Yes	☐	No	☐
Is there documentation for the medical necessity for accelerated formation of granulation tissue that cannot be achieved by other available topical wound treatments? If yes, please explain.				

Supplemental D4 Complete these questions for Venous Insufficiency ulcers				
Have compression bandages or garments been consistently applied?	Yes	☐	No	☐
Has leg elevation and ambulation been encouraged?	Yes	☐	No	☐
If either of the answers above are No, and these treatment measures have been considered and ruled out, please explain.				

Patient Name				RID Number
Negative Pressure wound Therapy Supplemental Form (continued)				
Supplemental D5 Complete these questions for Arterial or Chronic ulcers				
Has relief of pressure over the wound been achieved?	Yes	☐	No	☐
Have moisture and incontinence been controlled?	Yes	☐	No	☐
If either of the answers above are No, and these treatment measures have been considered and ruled out, please explain.				
Physician Signature:				**Date:**