Coverage Policy

Coverage for negative pressure wound therapy/vacuum-assisted closure devices and accessories is subject to the terms, conditions and limitations of the applicable benefit plan’s Durable Medical Equipment (DME) benefit and schedule of copayments. Please refer to the applicable benefit plan document to determine benefit availability and the terms, conditions and limitations of coverage.

If coverage is available for negative pressure wound therapy/vacuum-assisted closure and accessories, the following conditions of coverage apply.

Cigna covers powered negative pressure wound therapy (NPWT)/vacuum-assisted closure (VAC) (Current Procedural Terminology [CPT] code 97605, 97606) (HCPCS code A6550, E2402) for nonhealing wounds as medically necessary when any ONE of the following conditions exists:

- There are complications of a surgically created wound (e.g., dehiscence, poststernotomy disunion with exposed sternal bone, poststernotomy mediastinitis, or postoperative disunion of the abdominal wall).
- There is a traumatic wound (e.g., preoperative flap or graft, exposed bones, tendons, or vessels) and a need for accelerated formation of granulation tissue not achievable by other topical wound treatments (e.g., the individual has comorbidities that will not allow for healing times usually achievable with other available topical wound treatments).
• There is a chronic, nonhealing ulcer with lack of improvement for at least the previous 30 days despite standard wound therapy, including the application of moist topical dressings, debridement of necrotic tissue (if present), maintenance of an adequate nutritional status, and weekly evaluations with documentation of wound measurements (i.e., length, width, and depth) in ONE of the following clinical situations:

  ➢ Chronic Stage III or Stage IV pressure ulcer:
    o The individual has been on an appropriate turning and repositioning regimen.
    o The individual has used an appropriate pressure relief device (e.g., low air loss bed, alternating pressure mattress) for pressure ulcers on the posterior trunk or pelvis.
    o The individual’s moisture and incontinence have been appropriately addressed.
  ➢ Chronic diabetic neuropathic ulcer:
    o The individual has been on a comprehensive diabetic management program.
    o The individual has had appropriate foot care.
    o The individual has been nonweight bearing if appropriate.
  ➢ Chronic venous ulcer:
    o Compression garments/dressings have been consistently applied.
    o Leg elevation and ambulation have been encouraged.

Cigna covers medically necessary powered NPWT for up to four consecutive months, including any time during which NPWT was applied in an inpatient setting prior to discharge to home or a wound clinic. The use of NPWT beyond four months will be covered only when medical necessity continues to be met as previously outlined and there is evidence of clear benefit from the NPWT treatment already received.

Cigna covers up to 15 dressing kits (A6550) and 10 canister sets (A7000) per month as medically necessary unless there is documentation of a large volume of drainage (i.e., > 90 ml of exudate per day) or the wound size requires more than one dressing kit for each dressing change.

Cigna does not cover powered NPWT/VAC or associated equipment and supplies for nonhealing wounds or ulcers under ANY of the following conditions because it is considered not medically necessary (this list may not be all-inclusive):

• An appropriate medical professional is not supervising or performing weekly wound measurement and assessment functions as well as the negative pressure wound therapy dressing changes required.
• Wound healing has occurred to the extent that negative pressure wound therapy is no longer necessary.
• The depth of the wound is less than 1 mm, as wounds of this depth cannot accommodate the sponge.
• Uniform granulation tissue has been obtained.
• The individual cannot tolerate the use of NPWT.
• The wound is infected.
• There is no progression of healing of the wound on two successive dressing changes and/or up to 30 days.

Cigna does not cover disposable non-powered mechanical or single use non-electrically powered NPWT/VAC (HCPCS code A9272, G0456, G0457) for any indication because it is considered experimental, investigational or unproven.

General Background

This information on negative pressure wound therapy/vacuum-assisted closure (VAC) for nonhealing wounds has been developed through consideration of medical necessity and generally accepted standards of medical practice, as well as review of medical literature and government approval status.

Chronic wounds, also known as ulcers, are wounds that have a biological or physiologic reason for not healing. Chronic wounds have not completed the process of healing in the expected period, usually 30 days, or have
proceeded through the healing phase without establishing the expected functional result. These wounds generally do not close without intervention and are sometimes unresponsive to healing interventions. Diabetic foot ulcers/sores, pressure ulcers or bed sores, venous leg ulcers, and sternal wound infections are all considered chronic wounds because their etiologies delay and prevent healing and they persist without proper medical care (ECRI, 2009).

While there are numerous treatments that have been proposed to treat chronic wounds, some have not been well-studied and therefore their safety and effectiveness are as yet unproven. Proposed approaches include: ultrasound, laser, electromagnetic therapy (EM), electrical stimulation (ES), hyperbaric oxygen, gene therapy, surgical debridement, surgical revascularization of the affected area, myocutaneous skin flaps or grafting, wet-to-dry dressings, negative pressure wound therapy, vacuum-assisted closure, and the use of certain bioengineered skin substitutes. When clinically appropriate, all of these interventions are used in combination with aggressive medical management of the underlying wound etiology.

**Powered Negative Pressure Wound Therapy (NPWT) or Vacuum-Assisted Closure (VAC)**

There are various names to describe the treatment of a wound with topical negative pressure including sub-atmospheric pressure therapy or dressing, vacuum sealing technique, VAC, NPWT or dressing, foam suction dressing, vacuum compression, vacuum pack, sealed surface wound suction or sealing aspirative therapy (National Institute for Health and Clinical Excellence [NICE]., 2005).

NPWT is intended to be used in hospitals, clinics, long term care and home care settings. NPWT systems include a vacuum pump, drainage tubing, and a dressing set. The pump may be stationary or portable, rely on AC or battery power, allows for regulation of the suction strength, has alarms to indicate loss of suction, and has a replaceable collection canister. The dressing sets may contain either gauze or foam dressing which is placed in the wound and an adhesive film drape for sealing the wound. The drainage tubes come in numerous configurations depending on the dressings used or wound being treated (ECRI, 2009).

NPWT involves application of a localized vacuum to draw the edges of the wound together and enhance new growth while providing a moist environment conducive to rapid wound healing. Negative pressure is produced in the wound bed by placing a dressing (i.e., open-celled reticulated foam or moistened gauze) in the wound and sealing the dressing to the skin with a transparent adhesive film dressing. A tube embedded in the dressing connects to a vacuum pump to produce subatmospheric pressure and drain off wound exudate. The vacuum pump provides either continuous or intermittent negative pressure, adjusted for the type of wound. Pressure is applied in the range of 5 to 125 mmHg (adjustable to higher pressures, depending on the particular device used). Manufacturers recommend changing the dressing at 48 hours, then two to three times per week as indicated (ECRI, 2009).

This technology is primarily intended for chronic wounds that have not healed when treated with other forms of wound care and for minimizing scarring on acute wounds by promoting healing through granulation tissue formation and re-epithelization . NPWT may be either a primary or secondary line of treatment, depending on the type of wound. The development of negative-pressure techniques for wound healing derives from two theories: removal of wound exudate decreases edema and concentrations of inhibitory factors and increases local blood flow, and negative pressure stretches and deforms the tissue and disturbs the extracellular matrix, which induces biochemical responses that promote wound healing (ECRI, 2009).

**Disposable Non-Powered Mechanical or Single Use Non-Electrically Powered NPWT/VAC:** Smaller disposable non-powered or single use NPWT devices have been proposed for the treatment of smaller wounds. These devices are used in the hospital, outpatient and/or home settings (Hudson, et al., 2013; Fong, et al., 2012; Lerman, et al., 2010b).

The Smart Negative Pressure (SNaP) Wound Care Device [Spiracur, Inc., Sunnyvale, CA], includes a disposable mechanical (i.e., spring loaded) cartridge to create a vacuum. The cartridge comes in three different pressures from 75-125 mm Hg. Additionally, the system includes a dressing and a strap with attachment clip to attach to the cartridge to the body. It has been proposed that both the traditional electrically powered and disposable, mechanical powered devices achieve the same air density reduction (negative pressure) (Fong, et al., 2012).
The pocket-sized disposable PICO™ Single Use Negative Pressure Wound Therapy System [Smith and Nephew, St Petersburg, FL], has an 80 mm Hg pump, two dressing kits and two batteries. This self-contained system is designed to stop working after seven days. It can be used in the hospital and home setting (Hudson, et al., 2013).

The V.A.C.Via™ Therapy System, [KCI, San Antonio, TX]) is a portable battery-operated, single patient use, disposable device that can be used for up to seven days. It includes a canister, alarm, tubing, dressing and can provide negative pressure at 75 or 125 mm Hg (Gabriel, et al., 2012).

**Chronic Wound Types**
Chronic ulcers of the skin include pressure ulcers, arterial ulcers, venous stasis ulcers, neuropathic diabetic ulcers.

**Pressure Ulcers:** A pressure ulcer is a result of pathologic changes in blood supply to the dermal and underlying tissues, usually because of compression of the tissue over a bony prominence. Pressure ulcers generally appear in soft tissue over a bony prominence (Thomas, 2013).

Initial treatment for pressure ulcers is aimed at relieving pressure by positioning the patient frequently and at a fixed interval to relieve pressure over the compromised area. A number of medical devices, classified as static or dynamic, are designed to relieve pressure. Static devices include air, gel, or water-filled containers that reduce the tissue-to-surface contact. Dynamic devices use a power source to fill compartments with air that support the patient's weight or alternate the pressure on different areas of the body. It is suggested that patients who fail to improve, or who have multiple pressure ulcers, should be considered for a dynamic type device, such as a low air loss bed or air fluidized bed (Thomas, 2013).

Other treatment measures of pressure ulcers include treating pain; assessing nutrition and hydration; removing necrotic debris; maintaining a moist wound environment, which is associated with more rapid healing rates compared to dressings that are allowed to dry; encouraging granulation tissue formation and promoting re-epithelialization; and controlling infection (Thomas, 2013).

**Staging of Pressure Ulcers**
When evaluating pressure ulcers, a staging system is typically used that measures tissue destruction by classifying wounds according to the tissue layers involved. In 2007, the National Pressure Ulcer Advisory Panel (NPUAP) redefined the definition of a pressure ulcer and the stages of pressure ulcers, including the original four stages and adding two stages on deep tissue injury and unstageable pressure ulcers. The stages are defined by the NPUAP as follows:

- **Suspected Deep Tissue Injury:** Purple or maroon localized area of discolored intact skin or blood-filled blister due to damage of underlying soft tissue from pressure and/or shear. The area may be preceded by tissue that is painful, firm, mushy, boggy, warmer or cooler as compared to adjacent tissue.

  Further description: Deep tissue injury may be difficult to detect in individuals with dark skin tones. Evolution may include a thin blister over a dark wound bed. The wound may further evolve and become covered by thin eschar. Evolution may be rapid exposing additional layers of tissue even with optimal treatment.

- **Stage I:** Intact skin with non-blanchable redness of a localized area usually over a bony prominence. Darkly pigmented skin may not have visible blanching; its color may differ from the surrounding area.

  Further description: The area may be painful, firm, soft, warmer or cooler as compared to adjacent tissue. Stage I may be difficult to detect in individuals with dark skin tones. May indicate "at risk" persons (a heralding sign of risk).

- **Stage II:** Partial thickness loss of dermis presenting as a shallow open ulcer with a red pink wound bed, without slough. May also present as an intact or open/ruptured serum-filled blister.
Further description: Presents as a shiny or dry shallow ulcer without slough or bruising. This stage should not be used to describe skin tears, tape burns, perineal dermatitis, maceration or excoriation. Bruising indicates suspected deep tissue injury.

- Stage III: Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle are not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling.

  Further description: The depth of a stage III pressure ulcer varies by anatomical location. The bridge of the nose, ear, occiput and malleolus do not have subcutaneous tissue and stage III ulcers can be shallow. In contrast, areas of significant adiposity can develop extremely deep stage III pressure ulcers. Bone/tendon is not visible or directly palpable.

- Stage IV: Full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present on some parts of the wound bed. Often include undermining and tunneling.

  Further description: The depth of a stage IV pressure ulcer varies by anatomical location. The bridge of the nose, ear, occiput and malleolus do not have subcutaneous tissue and these ulcers can be shallow. Stage IV ulcers can extend into muscle and/or supporting structures (e.g., fascia, tendon or joint capsule) making osteomyelitis possible. Exposed bone/tendon is visible or directly palpable.

- Unstageable: Full thickness tissue loss in which the base of the ulcer is covered by slough (yellow, tan, gray, green or brown) and/or eschar (tan, brown or black) in the wound bed.

  Further description: Until enough slough and/or eschar is removed to expose the base of the wound, the true depth, and therefore stage, cannot be determined. Stable (dry, adherent, intact without erythema or fluctuance) eschar on the heels serves as "the body's natural (biological) cover" and should not be removed.

Venous Stasis Ulcers: Venous stasis occurs due to the incompetence of either the superficial or deep venous systems. Chronic venous ulcers are usually due to the incompetence of the deep venous system and are commonly painless. The wound is usually shallow with irregular margins and pigmented surrounding skin. Compression is the gold standard of treatment of venous disease. After arterial disease has been excluded, reversal of the effects of venous hypertension through compression bandages and leg elevation is the recommended therapy (Bonilla-Martinez, et al., 2013).

Diabetic Neuropathic Ulcers: The major contributors to the formation of diabetic ulcers include neuropathy, foot deformity, and ischemia. It is estimated that 60–70% of diabetic ulcers are due to neuropathy, 15–20% are due to ischemia, and another 15–20% are due to a combination of both. The neuropathy is both sensory and motor and is secondary to persistently elevated glucose levels. Maintaining optimal blood sugar levels is important. The management of diabetic wounds involves local and systemic measures. Treatment options include relief of pressure at the wound site, surgical debridement, control of infection, and arterial reconstruction. It is recommended that treatment should address the possible presence of osteomyelitis, and should employ antibiotics that achieve adequate levels both in the bone and soft tissue. Other proposed therapeutic options include recombinant human growth factors, bioengineered skin substitutes, dressings comprised of extracellular matrix protein, and a variety of synthetic dressings (Barbul, 2005).

Complications of Surgically Created Wounds
NPWT has been proposed as an alternative to surgery to treat complications of surgically created wounds (e.g., sternal wound complication following cardiac surgery). NPWT has been used in patients who have complications of surgically created wounds (e.g., dehiscence) or traumatic wounds (e.g., flap or graft) when there is a need for accelerated formation of granulated tissue that cannot be achieved by traditional topical methods (e.g., the patient has a condition or comorbidity that will not allow for healing times achievable with other topical treatments). In addition, vacuum-assisted wound closure has also been utilized as a noninvasive treatment of deep sternal wound infections following cardiac surgery (i.e., poststernotomy mediastinitis), as an alternative to more invasive treatment such as surgery (e.g., secondary closure or secondary closure with vascularized muscle flaps).
Treatment options in postoperative nonhealing wounds include the following:

- management of infection (e.g., antibiotic therapy)
- wound incision and drainage
- debridement
- rewiring (postcardiac surgery)
- closed irrigation (with antibiotic solution)
- packing of wound
- delayed closure

**U.S. Food and Drug Administration (FDA)**

In February 2011, the FDA issued an FDA Safety Communication: Update on serious complications associated with negative pressure wound systems. The FDA issued the alert to make individuals aware of deaths and serious complications, especially bleeding and infection, associated with the use of Negative Pressure Wound Therapy (NPWT) systems, and to provide recommendations to reduce the risk. Although rare, these complications can occur wherever NPWT systems are used, including acute and long-term healthcare facilities and at home. Since issuing the 2009 Preliminary Public Health Notification and Advice for Patients, the FDA received reports of an additional six deaths and 97 injuries, for a total of 12 deaths and 174 injury reports since 2007. Bleeding continues to be the cause of the most serious adverse events, and was reported in 12 patients, including three of the additional death reports (FDA, 2011).

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. The FDA defines a child as greater than 2—12 years of age (FDA, 2011; FDA, 2004).

The FDA recommends selecting patients for NPWT carefully, after reviewing the most recent device labeling and instructions and that the patient is monitored frequently in an appropriate care setting by a trained practitioner. In determining the frequency of monitoring, consider the patient’s condition, including the wound status, wound location and co-morbidities. The FDA recommends numerous patient risk factors/characteristics to consider before NPWT use. The FDA recommends that NPWT is contraindicated for these wound types/conditions:

- necrotic tissue with eschar present
- untreated osteomyelitis
- non-enteric and unexplored fistulas
- malignancy in the wound
- exposed vasculature
- exposed nerves
- exposed anastomotic site
- exposed organs

Patient risk factors/characteristics to consider before NPWT use:

- patients at high risk for bleeding and hemorrhage
- patients on anticoagulants or platelet aggregation inhibitors
  - patients with:
    - friable vessels and infected blood vessels
    - vascular anastomosis
    - infected wounds
    - osteomyelitis
    - exposed organs, vessels, nerves, tendons, and ligaments
    - sharp edges in the wound (i.e. bone fragments)
    - spinal cord injury (stimulation of sympathetic nervous system)
    - enteric fistulas
- patients requiring:
  - MRI
  - Hyperbaric chamber
Defibrillation
- patient size and weight
- use near vagus nerve (bradycardia)
- circumferential dressing application
- mode of therapy- intermittent versus continuous negative pressure

**Powered NPWT Systems:** Numerous powered NPWT systems have received Class II clearance by the FDA through the 510(k) process including, but may not be limited to, the following:

- The V.A.C.® Therapy™ device (Kinetic Concepts, Inc. [KCI], San Antonio, TX)
- Versatile 1™ Wound Vacuum system (BlueSky Medical, Inc., Vista, CA).

The FDA indications for use for the V.A.C. Therapy device state that: “The V.A.C. System is a powered suction pump system that is intended for use on patients who would benefit from a suction device, particularly as the device may promote wound* healing, including patients who would benefit from vacuum assisted drainage and removal of infectious material or other fluids from wounds under the influence of continuous and/or alternating suction pressures. *The V.A.C. is intended for patients with chronic, acute, traumatic, subacute and dehisced wounds, partial-thickness burns, diabetic ulcers, pressure ulcers, flaps and grafts” (FDA, 2002).

**Disposable Non-Powered Mechanical or Single Use NPWT/VAC:** Numerous disposable NPWT systems have received Class II clearance by the FDA through the 510(k) process.

The Smart Negative Pressure (SNaP)® Wound Care Device (Spiracur, Inc., Sunnyvale, CA) received Class II clearance by the FDA through the 510(k) process in 2009. The FDA identifies this generic type of device as, “A non-powered suction apparatus device intended for negative pressure wound therapy is a device that is indicated for wound management via application of negative pressure to the wound for removal of fluids, including wound exudate, irrigation fluids, and infectious materials. It is further indicated for management of wounds, burns, flaps and grafts” (FDA, 2009).

The FDA granted 510(k) Class II clearance for the PICO™ Single Use Negative Pressure Wound Therapy System (Smith and Nephew, St Petersburg, FL) on December 15, 2011. PICO was cleared as substantially equivalent to predicate devices Renasys Go (Smith & Nephew), NPD 1000 NPWT System (Kalypto Medical, Hastings, MN), and Prevena Incision Management System (KCI, San Antonio, TX). The intended use, indications and instructions for use for the subject and predicate devices are similar. According to the 510(k) clearance document, “the PICO is indicated for patients who would benefit from a suction device (negative pressure wound therapy) as it may promote wound healing via removal of low to moderate levels of exudate and infectious materials. The PICO [single-use NPWT] System is suitable for use in both a hospital and homecare setting. Examples of appropriate wound types include: chronic, acute, traumatic, subacute and dehisced wounds, partial-thickness burns, ulcers (such as diabetic or pressure), flaps and grafts, closed surgical incisions” (FDA, 2011).

The FDA granted 510(k) Class II clearance for the V.A.C. Via™ Negative Pressure Wound Therapy System, (KCI, San Antonio, TX) on March 10, 2010. Equivalence is claimed to the KCI Acti V.A.C.™ Therapy System (KCI, San Antonio, TX). The intended use for the device states, “V.A.C. Via™ Negative Pressure Wound Therapy System is an integrated wound management system for use in acute, extended and home care settings. It is intended to create an environment that promotes wound healing by secondary or tertiary (delayed primary) intention by preparing the wound bed for closure, reducing edema, promoting granulation tissue formation and perfusion, and by removing exudates and infectious material. It is indicated for patients with chronic, acute, traumatic, subacute and dehisced wounds, partial-thickness burns, ulcers (such as .diabetic, pressure or venous insufficiency), flaps and grafts” (FDA, 2010).

**Literature Review Powered Negative Pressure Wound Therapy (NPWT) or Vacuum-Assisted Closure (VAC)**

The evidence supporting the use of powered NPWT in the treatment of chronic nonhealing wounds exists primarily in the form of nonrandomized, controlled trials; prospective and retrospective large and small case series; single center studies; and single case studies. Numerous systematic reviews have noted the lack of quality clinical evidence supporting the advantages of NPWT compared to other wound treatments. Despite a
lack of robust evidence to support its use, NPWT has been shown to be safe and effective for a variety of wound types and has become the accepted standard for a subgroup of patients who have failed a comprehensive, conventional wound therapy program that includes all reasonable, well-established alternative medical treatments. There is also moderate evidence to support the use of this therapy as an alternative to surgery (i.e., secondary closure with or without myocutaneous flap) or in preparation for surgery in patients with poststernotomy mediastinitis. There is insufficient evidence to support the routine use of NPWT (Zhang, et al., 2014; Shweiki, et al., 2013; Webster, et al., 2012; Xie, et al., 2010; Ubbink, et al., 2008; Armstrong, et al., 2007; 2005; Llanos, et al., 2006; Moisidis, et al., 2004; Stannard, et al., 2006; Andrews, et al., 2006; Luckraz, et al., 2003; Song, et al., 2003; Joseph, et al., 2000).

The Centers for Medicare and Medicaid Services (CMS)/ Agency for Healthcare Research and Quality (AHRQ)/ ECRI Institute Evidence-based Practice Center: The CMS partnered with the AHRQ and commissioned a review of NPWT devices. AHRQ contracted with the ECRI Institute Evidence-based Practice Center to perform the review (AHRQ, 2009). A technology assessment report on NPWT prepared for the AHRQ found that “the systematic reviews of NPWT reveal several important points about this technology. First, all of the systematic reviews noted the lack of high-quality clinical evidence supporting the advantages of NPWT compared to other wound treatments. The lack of high-quality NPWT evidence resulted in many systematic reviewers relying on low-quality retrospective studies to judge the efficacy of this technology. Second, the other systematic reviews found no studies directly comparing different NPWT devices or components have been published. Direct comparison studies are especially important in determining which dressing approach (foam or gauze) may provide the best potential for wound healing. Third, other systematic reviews concluded that NPWT must be evaluated according to wound type. Wound healing varies according to the type of wound being treated and NPWT benefits described for one wound type cannot be transferred to other wound types. Most wound types have too little high-quality NPWT evidence to judge if NPWT is better than standard care for specific wounds. Studies comparing foam to gauze are needed for each wound type before decisions can be made about which systems or components offer significant therapeutic distinctions.”

Literature Review Disposable Non-Powered Mechanical or Single Use Non-Electrically Powered NPWT/VAC:
The available studies in the peer-reviewed scientific literature addressing disposable mechanical non-powered or single use non-electrically powered NPWT are generally limited by small sample size and lack of a comparator and therefore conclusions about the safety, efficacy and health outcomes cannot be made at this time. Additionally, many of the studies report that numerous patients were lost to follow-up or dropped out of the studies (Hudson, et al., 2013; Gabrielle, et al., 2013; Fraccalvieri, et al., 2012; Armstrong, et al., 2012; Armstrong, et al., 2011; Lerman, et al., 2010a, Lerman, et al., 2010b).

In a multicenter, comparative, randomized controlled trial the mechanically powered SNaP Wound Care System was compared with the electrically powered VAC Therapy System. Initial enrollment included 132 individuals. Seventeen patients dropped from study before treatment started for unknown reasons leaving 115 individuals available for follow-up data (i.e. 59 SNaP; 56 VAC). The inclusion criteria was for patients aged ≥18 years; lower extremity venous ulcer or diabetic ulcer with a surface area <100 cm² but larger than 1 cm², and <10 cm in widest diameter. Wounds were to have been present for >30 days despite appropriate wound care prior to entry. Adequate blood perfusion defined as either transcutaneous oxygen measurements of the dorsum of the foot >30 mmHg, skin perfusion pressure >30 mmHg, or an ankle/brachial index between 0.7 and 1.2. The wound was required to be in a location amendable to creation of an airtight seal using the provided dressings. Exclusion criteria included active infection redness, swelling, pain, purulent exudate), untreated osteomyelitis, pregnancy, allergies to wound care products used in the study and etiologies of the wound that included malignancy, burn, collagen vascular disease, sickle cell, vasculopathy, or pyoderma gangrenosum. A a diagnosis of active Charcot foot syndrome, wound location on toes or plantar surface of foot, uncontrolled hyperglycemia (glycated hemoglobin [HbA1C] >12%), end-stage renal disease requiring dialysis, active chemotherapy treatment, previous treatment with a NPWT device, growth factors, hyperbaric oxygen, or bioengineered tissue product within 30 days of enrollment. Patients were not enrolled if they exhibited greater than 30% wound surface area reduction in size at one week after the screening visit.

Each subject was randomly assigned (1:1) to treatment with either system in conjunction with appropriate off-loading and compression therapy. Subjects were evaluated on a weekly basis to complete wound closure (defined as complete reepithelialization without drainage) or for up to 16 weeks of therapy. Dressing changes were performed following manufacturer recommended instructions. Wound size and age of the wounds varied.
between the two groups. The primary outcomes evaluated in this study were percent wound closure at 4, 8, 12, and 16 weeks. To establish noninferiority to traditional NPWT, this study was powered assuming 80% wound closure with an 18.5% standard deviation (derived from previous study wounds treated with the SNaP system) for both groups at 16 weeks using a margin of noninferiority of 12.5%. Primary end point analysis of wound size reduction found that SNaP-treated subjects demonstrated non-inferiority to the VAC treated subjects at 4, 8, 12, and 16 weeks (p=0.0030, 0.0130, 0.0051, and 0.0044, respectively). Eighty-three patients (n=41 SNaP, n=42 VAC) completed the study with either healing or 16 weeks of therapy. Device related adverse events and complications such as infection were similar between treatment groups. The authors reported that wound types that may respond best to each form of wound interface layer during NPWT still need to be defined in additional studies. Additionally, further comparative effectiveness studies specifically designed to assess specific wound etiologies are warranted (Armstrong, et al., 2012).

The interim analysis to the above study compared the mechanically powered SNaP Wound Care System to the traditional electrically powered VAC Therapy System in the treatment of chronic lower extremity wounds. This 12-center randomized controlled trial of patients with noninfected, nonischemic, nonplantar lower extremity wounds enrolled 65 patients. The trial evaluated treatment for up to 16 weeks or till complete closure was achieved. Fifty-three patients (n=27 SNaP, n=26 VAC) completed at least 4 weeks of therapy. Thirty-three patients (n=18 SNaP, n=15 VAC) completed the study with either healing or 16 weeks of therapy. At the time of planned interim analysis, no significant differences in the proportion of subjects healed between the two devices evaluated were found. The percent wound size reduction between treatment groups was not significantly different at 4, 8, 12, and 16 weeks, with noninferiority analysis at 4 weeks of treatment reaching (p=0.019).

Wound size and age of wound differed between the two groups. Initial wound size in the standard VAC group was 8.8 sq cm and 4.3 sq cm in the SNaP group. Age of wound was 14 months in the VAC group and 8.3 months in the SNaP group. The proportion of patients experiencing one or more device-related adverse events was similar between the VAC and SNaP treatment groups (Armstrong, et al., 2011).

In a retrospective study with historical controls Lerman et al. (2010b) compared NPWT using the SNaP device (n=21) with wound care protocols that included the use of Apligraf, Regranex and skin grafting (n=42) for treatment of lower extremity ulcers. There were a total of 36 subjects enrolled prospectively in the first phase of the study, and 21 subjects completed treatment with the SNaP device. Of the 15 subjects that did not complete the study, seven subjects had complications (e.g., allergic reaction, wound infection) that required premature termination of SNaP treatment. Compared with the matched controls, there was a 47.4% absolute improvement in the percentage of wounds healed when subjects were treated with the SNaP device as compared with modern dressings over a 4-month period. The study is limited by study design, the multiple modalities used in treatment of the control group, and the large number of dropouts.

In a prospective multicenter study, Hudson et al. (2013) assessed overall functionality and performance of the disposable PICO NPWT system including the ability of the system to manage exudate without a canister, concomitant delivery of NPWT and wound progress towards healing during the treatment phase. The study included 20 individuals. Sixteen had closed surgical wounds, two had traumatic wounds and two received meshed split thickness skin grafts. The mean study duration was 10.7 days (range: 5–14 days) and the mean dressing wear time per individual patient was 4.6 days (range: 2–11). A total of 55% of the wounds had closed by the end of the 14-day study or earlier, with 40% of wounds progressing to closure. Two wounds were clinically infected and a further wound had clinical signs of infection at recruitment. Two of these wounds were successfully skin grafted during the treatment period. One device-related adverse event observed small blister-like lesions around the wound associated with the removal of adhesive film fixation strips. This study is limited by small sample size and lack of a comparator.

In a retrospective study, Gabrielle et al. (2013) evaluated use of the disposable, single-patient-use NPWT system (SP-NPWT) V.A.C.Via™ Therapy over dermal regeneration template (DRT) and/or skin grafts. SP-NPWT was initiated over a DRT and/or skin graft in 33 patients with 41 graft procedures. Endpoints were recorded and compared to a historical control group of 25 patients with 28 grafts bolstered with traditional rental NPWT (V.A.C.). Mean age was less for the SP-NPWT group versus the control and there were significantly more patients with peripheral vascular disease (PVD) in the SP-NPWT group compared with the control (12 versus 0, respectively). A greater number of acute wounds were present in the SP-NPWT group versus the control (26 versus 10, respectively). All other patient demographics and wound characteristics were similar. Mean follow-up time was 6.4 months for the SP-NPWT group and 12.7 months for the control group. Primary endpoint was time to hospital discharge, duration of SP-NPWT and graft take rate were collected and
compared to a historical control group of patients who received traditional rental NPWT over dermal regeneration template (DRT) and/or skin grafts. Average length of inpatient hospital stay was 0 days for the SP-NPWT group and six days for the control group. The average duration of SP-NPWT post-DRT or skin graft was 5.6 days and 7.0 days for the control. This study is limited by small sample size, lack of a comparator, and observer bias in estimating graft take. The authors reported that considerably more controlled research is necessary to measure efficacy of SP-NPWT in the adjunctive management of various wound types.

Professional Societies/Organizations
The American Society of Plastic Surgeons (ASPS) evidence-based clinical practice guideline for chronic wounds of the lower extremity states, “Although the wound care literature is rife with uncontrolled studies reporting the effectiveness of negative pressure wound therapy, few prospective randomized trials exist. Despite a lack of strong evidence to support its use, negative pressure wound therapy has gained wide acceptance by multiple specialties for a myriad of wounds” (ASPS, 2007).

The American College of Foot and Ankle Surgeons (ACFAS) 2006 diabetic foot disorders clinical practice guideline addresses the treatment of diabetic foot infections. The authors state the primary treatment goal for diabetic foot ulcers is to obtain wound closure as expeditiously as possible. The authors state that along with other dressings, NPWT may be useful to aid in the healing of surgical wounds of the diabetic foot. If the wound fails to show signs of healing, the patient's vascularity, nutritional status, infection control, and wound offloading must be re-evaluated (Frykberg, et al., 2006).

Use Outside of the US
No relevant information found.

Summary
There is moderate evidence in the peer-reviewed published literature to indicate that NPWT using a powered device approved by the U.S. Food and Drug Administration (FDA) is effective for a specific subgroup of patients who have failed a comprehensive, conventional wound therapy program that includes all reasonable, well-established alternative medical treatments. There is also moderate evidence to support the use of this therapy as an alternative to surgery (i.e., secondary closure with or without myocutaneous flap) or in preparation for surgery in patients with poststernotomy mediastinitis. There is insufficient evidence to support the routine use of NPWT.

The available studies in the peer-reviewed scientific literature addressing disposable non-powered mechanical or single use non-electrically powered NPWT is generally limited by small sample size and lack of a comparator and therefore conclusions about the safety, efficacy and health outcomes cannot be made at this time.

Coding/Billing Information

Note: 1) This list of codes may not be all-inclusive.
    2) Deleted codes and codes which are not effective at the time the service is rendered may not be eligible for reimbursement.

Covered when medically necessary:

<table>
<thead>
<tr>
<th>CPT® Codes</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>97605</td>
<td>Negative pressure wound therapy (eg, vacuum assisted drainage collection), 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</td>
</tr>
<tr>
<td>97606</td>
<td>Negative pressure wound therapy (eg, vacuum assisted drainage collection), including topical application(s), wound assessment, and instruction(s) for ongoing care, per session; total wound(s) surface area greater than 50 square centimeters</td>
</tr>
<tr>
<td>HCPCS Codes</td>
<td>Description</td>
</tr>
<tr>
<td>-------------</td>
<td>-------------</td>
</tr>
<tr>
<td>A6550</td>
<td>Wound care set, for negative pressure wound therapy electrical pump, includes supplies and accessories</td>
</tr>
<tr>
<td>A7000</td>
<td>Canister, disposable, used with suction pump, each</td>
</tr>
<tr>
<td>E2402</td>
<td>Negative pressure wound therapy electrical pump, stationary or portable</td>
</tr>
<tr>
<td>K0743</td>
<td>Suction pump, home model, portable, for use on wounds</td>
</tr>
<tr>
<td>K0744</td>
<td>Absorptive wound dressing for use with suction pump, home model, portable, pad size 16 sq in or less</td>
</tr>
<tr>
<td>K0745</td>
<td>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</td>
</tr>
<tr>
<td>K0746</td>
<td>Absorptive wound dressing for use with suction pump, home model, portable, pad size greater than 48 sq in</td>
</tr>
</tbody>
</table>

**Experimental/Investigational/Unproven/Not Covered:**

<table>
<thead>
<tr>
<th>HCPCS Codes</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>A9272</td>
<td>Wound suction, disposable, includes dressing, all accessories and components, any type, each</td>
</tr>
<tr>
<td>G0456</td>
<td>Negative pressure wound therapy, (e.g. vacuum assisted drainage collection) using a mechanically-powered device, not durable medical equipment, including provision of cartridge and dressing(s), topical application(s), wound assessment, and instructions for ongoing care, per session; total wounds(s) surface area less than or equal to 50 sq cm</td>
</tr>
<tr>
<td>G0457</td>
<td>Negative pressure wound therapy, (e.g. vacuum assisted drainage collection) using a mechanically-powered device, not durable medical equipment, including provision of cartridge and dressing(s), topical application(s), wound assessment, and instructions for ongoing care, per session; total wounds(s) surface area greater than 50 sq cm</td>
</tr>
</tbody>
</table>


**References**


