

<b>HEALTH PLAN POLICY</b>	
<b>Policy Title:</b> Vacuum Assisted Wound Vac Therapy in the Outpatient Setting	<b>Policy Number:</b> MUM33 <b>Revision:</b> B
<b>Department:</b> Medical Management	<b>Sub-Department:</b> Utilization Management
<b>Applies to Product Lines:</b> <input type="checkbox"/> Medicaid <input checked="" type="checkbox"/> USFHP <input type="checkbox"/> Children's Health Insurance Plan <input checked="" type="checkbox"/> Commercial Insured <input checked="" type="checkbox"/> Health Insurance Exchange <input type="checkbox"/> Non Insured Business <input checked="" type="checkbox"/> Medicare	
<b>Origination/Effective Date:</b> 02/22/2018	
<b>Reviewed Date(s):</b>	<b>Revision Date(s):</b> 04/24/2019, 05/14/2020

**SCOPE:**

The purpose of this policy is to define the process utilized for medical necessity review for use of vacuum assisted wound therapy (also known as negative pressure wound therapy). These devices are used in the outpatient setting for the treatment of wound or ulcers related to decubitus ulcers, pressure sores, venous or arterial insufficiency ulcers or neuropathy. The health plan's review processes for these requests will have member have appropriate access to care based on benefit availability and interventions employed.

**DEFINITIONS AND ACRONYMS:**

- **Medical Necessity:** defined by the health plan as a determination that has been made by a licensed physician and/or qualified clinician for services requested that clinical documentation supports to be justified as reasonable, necessary, and appropriate, based on evidence based guidelines criteria and accepted clinical standards of practice for medical and behavioral health conditions.
- **Negative Pressure Wound Therapy (NPWT)**
- **Prior Authorization** - Prior Authorization is the assessment of a proposed service (such as an elective procedure, admission or therapy) to determine if the member has eligible coverage for the service and whether the request demonstrates medically necessity.
- **Vacuum Assisted Wound-Vac Therapy (VAWT)**

**POLICY:**

Vacuum Assisted Wound-Vac Therapy is indicated when the individual meets the following criteria:

- A. The member has completed a comprehensive wound care program including the following components:
  1. The wound has been clinically examined by a qualified medical professional and medical necessity has been identified by the examining medical professional
  2. Conventional wound management is ongoing (e.g. wound debridement, application of dressings to maintain a moist environment)
  3. Laboratory evaluation of nutritional status to promote wound healing (e.g. serum albumin, serum prealbumin)
  4. Comorbid health conditions are being appropriately managed to promote wound healing (e.g. diabetes, venous insufficiency, morbid obesity)
- B. Application of a VAWT or NPWT would be appropriate for one of the following eligible conditions:
  1. Stage III or stage IV decubitus or pressure ulcers in individuals that meet all of the following

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criteria:

- a. The individual has been turned and repositioned every two hours
- b. The individual has used group 2 or 3 support surfaces for the posterior truncal region or posterior pelvis
- c. Moisture and incontinence are managed appropriately (e.g. diapers, rectal tube)
2. Postoperatively following a skin graft or dermal substitute for acute or chronic wounds
3. An individual with diabetic skin ulcers who meets all of the following criteria:
  - a. Diabetes is managed as evidenced by a Hgb A1C of 9 or less
  - b. Wagner or University of Texas classification of a Grade 1 diabetic ulcer or wound that has not responded to conservative treatment after a period of 30 days
  - c. Wagner or University of Texas classification of a Grade 2 diabetic ulcer or wound
4. Arterial or Venous Insufficiency Ulcers in individuals who meet all of the following criteria:
  - a. Compression garments have been worn for a period of six (6) weeks or longer
  - b. The individual has participated in behavior modification for a minimum of six (6) weeks, including reduction in pressure to the affected site, reasonable restriction of activities that involve the affected site, weight reduction, smoking cessation, etc.
  - c. Ulcer has been present for thirty (30) days or longer
5. Open fracture
6. Postoperative sternotomy wound infections or mediastinus
7. Wound dehiscence
8. Complicated surgical wounds where accelerated granulation tissue is desired to promote wound healing and would not be achieved utilizing conventional wound treatments

Contraindications to Vacuum Assisted Wound-Vac Therapy would include, but are not limited to:

- Active bleeding or exposed vasculature
- Eschar or necrotic tissue is noted in the wound bed
- Exposed cortical bone, nerves or organs
- Malignancy in the wound
- Uncontrolled soft tissue infection or osteomyelitis
- Unexplored fistulas or fistulas to body organs or cavities
- Exposed anastomotic sites

Prior Authorization review of all care requests will be conducted utilizing nationally recognized evidenced-based medical necessity criteria. Utilization Review staff are licensed registered nurses and licensed vocational nurses. Additional review and oversight may also be done by other independently licensed physical, social and behavioral healthcare professionals.

Requests that do not meet the appropriate evidenced-based criteria guidelines for medical necessity and/or

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do not clearly show failure of an appropriate response to non-invasive evidenced-based interventions will be sent to the medical director for a medical necessity determination.

### REFERENCES:

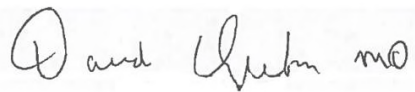
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### RELATED DOCUMENTS:

None



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### REVISION HISTORY:

Revision	Date	Description of Change	Committee
New	02/22/2018	Initial release.	Executive Leadership
A	04/24/2019	Annual review. Corrected minor typos.	Executive Leadership
B	05/14/2020	Annual review. No change to policy content.	Executive Leadership