MP 1.01.16
Negative Pressure Wound Therapy in the Outpatient Setting

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POLICY

Initiation of Powered Negative Pressure Wound Therapy

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 (e.g., diabetes, nutrition, relief of pressure), 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
- Wounds in patients with underlying clinical conditions that are known to negatively impact wound healing, which are nonhealing (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 NPWT.); 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.

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 an 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.

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 the 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 are considered **not medically necessary**.

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

**POLICY GUIDELINES**

Contraindications to the use of negative pressure wound therapy (NPWT) systems include the following conditions as noted by in a 2009 U.S. Food and Drug Administration (FDA) alert: necrotic tissue with eschar, untreated osteomyelitis, nonenteric and unexplored fistulae, malignancy in the wound, exposed nerve, exposed anastomotic site, and exposed organ.

In a 2011 update, 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. Most reports of wound infection were related to the retention of dressing pieces in the wounds. FDA recommendations for health care 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. FDA reported that the safety and effectiveness of NPWT systems in newborns, infants, and children had not been established 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 of 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 NPWT 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, and relief of pressure.

The focus of these policy statements and guidelines is for the use of NPWT in the outpatient setting.
**Negative Pressure Wound Therapy in the Outpatient Setting**

**Coding**

Please see the Codes table for details.

**BENEFIT APPLICATION**

**BLUECARD/NATIONAL ACCOUNT ISSUES**

State or federal mandates (e.g., FEP) may dictate that all FDA-approved or cleared devices may not be considered investigational and thus these devices may be assessed only on the basis of their medical necessity.

**BACKGROUND**

**Chronic Wounds**

**Management**

The management and treatment of chronic wounds, including decubitus ulcers, is challenging. Most chronic wounds will heal only if the underlying cause (i.e., venous stasis, pressure, infection) is addressed. Also, cleaning the wound to remove nonviable tissue, microorganisms, and foreign bodies is essential to create optimal conditions for either re-epithelialization (i.e., healing by secondary intention) or preparation for wound closure with skin grafts or flaps (i.e., healing by primary intention). Therefore, debridement, irrigation, whirlpool treatments, and wet-to-dry dressings are common components of chronic wound care.

Negative pressure wound therapy (NPWT) involves the 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 Wound Care System 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 the 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 FDA for 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), RENASYSTM EZ PLUS (Smith & Nephew), For you NPWT NP32 Device (For you Medical Electronics), and PICO Single Use Negative Pressure Wound Therapy System (Smith & Nephew).

Portable systems include the RENASYSTM 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 (Spiracur, acquired by Acelity in 2015), is a class II device requiring notification to market but not having the FDA premarket approval. In 2009, it was cleared for marketing by the FDA through the 510(k) pathway (K081406) and is designed to remove small amounts of exudate from chronic, traumatic, dehisced, acute, or subacute wounds and diabetic and pressure ulcers.

NPWT devices with instillation include the V.A.C. VERAFL® Therapy device (KCI/Acelity). It was cleared for marketing in 2011 by the FDA through the 510(k) pathway (K103156) and is designed to allow for controlled delivery and drainage of topical antiseptic and antimicrobial wound treatment solutions and suspensions.

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

In November 2009, the FDA issued an alert concerning complications and deaths associated with NPWT systems. An updated alert was issued in February 2011.\[\]

FDA product code: OMP.

**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 October 31, 2019. Evidence reviews assess the clinical evidence to determine whether the use of technology improves the net health outcome. Broadly defined, health outcomes are the length of life, quality of life (QOL), and ability to function—including benefits and harms. Every clinical condition has specific outcomes that are important to patients and 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 technology, 2 domains are examined: the relevance, and 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 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. Literature updates for this review have focused on comparative trials with the features described in the 2000 TEC Assessment (e.g., enrollment of patients with wounds refractory to standard treatment, randomization, optimal standard wound care treatment in the control arm, and clinically important endpoints). 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 (i.e., requiring an electrical power source or batteries) or nonpowered (mechanical). Most evidence found in the literature is for electrically powered devices with large canisters (e.g., the Vacuum-Assisted Closure Therapy 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
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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 endpoints of interest for trials of wound closure are as follows, consistent with guidance from the FDA for the industry in developing products for the 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

**Systematic Reviews**

The authors of a systematic review for the Agency for Healthcare Research and Quality and the Centers for Medicare & Medicaid Services (2014) 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 Smart Negative Pressure (SNaP) Wound Care System 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

A 2019 Cochrane review update evaluated NPWT compared with standard dressings for surgical wound healing by primary closure. Thirty RCTs were included for analysis (n = 2957).⁶ NPWT was associated with a reduced risk of surgical site infection (SSI) (23 studies [n=2547], relative risk [RR] 0.67; 95% CI, 0.53 to 0.85; I²=8.51%). However, subgroup analysis by surgery type only maintained a significant benefit for groin surgery (4 studies [n=206]; RR 0.48; 95% CI, 0.3 to 0.74; I²=0%) and did not show a significant difference for abdominal and colorectal surgery, Caesarean section, hip/knee arthroplasty, open fractures, vascular surgery, sternotomy surgery laparotomy, and mixed procedures. No significant difference was found for the rates of mortality and wound dehiscence between treatments. Certainty of evidence was deemed low per GRADE criteria, with only 3 trials allocating more than 100 participants. Very low-grade certainty evidence suggests a higher risk of developing skin blisters with NPWT (6 studies [n=597]; RR 6.64; 95% CI, 3.16 to 13.95). Studies were generally limited by imprecision or high-risk of bias in allocation concealment and blinding of outcome assessors. The analysis was also limited by inclusion of studies with mixed or unclear intervention types and no subgroup analysis for traditional and portable or single-use systems. Additionally, one study featured the use of a new generation V.A.C. device utilizing instillation. Nine studies identified the PICO system, 4 studies identified the Prevena system, 4 studies described but did not clearly identify portable or single-use devices, 3 studies identified the V.A.C. device, and 9 studies described but did not clearly identify an NPWT device.

A systematic review and meta-analysis by Li et al (2019) was conducted comparing the effectiveness and safety of NPWT with standard surgical dressing or conventional therapy for prevention of SSI.² A total of 45 RCTs assessing 6624 adult patients were included for analysis. Studies utilized a variety of NPWT devices, including V.A.C., PICO, and Prevena systems. Inclusion criteria did not impose restrictions on SSI grading systems or on surgery types. Surgeries for infected or chronic non-healing wounds including diabetic, venous, and arterial ulcers were excluded. Overall, NPWT was associated with a 40% reduction
in SSI risk compared to control, with moderate heterogeneity (RR 0.58; 95% CI, 0.49 to 0.69; I²=19%; p<0.00001). This significant reduction in risk was particularly maintained in high-risk surgical patients (32 RCTs; RR 0.60; 95% CI, 0.50 to 0.73; I²=23%; p<0.00001). There was no significant effect of NPWT on wound dehiscence, hematoma occurrence, hospital admission, or length of hospital stay. The certainty of the evidence based on GRADE criteria was graded as low to very low due to serious risk of bias stemming from lack of blinding and methodological flaws in SSI assessment and standardization. The authors suggest that further studies are warranted to elucidate the optimal protocol for NPWT utilization.

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

**Clinical Context and Therapy Purpose**

The purpose of outpatient NPWT is to provide a treatment option that is an alternative to or an improvement on existing therapies in patients with diabetic lower-extremity ulcers or amputation wounds.

The question addressed in this evidence review is: Does NPWT improve outcomes when used for the outpatient treatment of pressure ulcers, diabetic foot ulcers, venous ulcers, burn wounds, and traumatic or surgical wounds; and to assess the evidence on the use of portable NPWT devices?

The following PICO was used to select literature to inform this review.

**Patients**

The relevant population of interest is individuals with diabetic lower-extremity ulcers or amputation wounds.

**Interventions**

The therapy being considered is outpatient NPWT.

**Comparators**

Comparators of interest include standard wound care.

**Outcomes**

The general outcomes of interest are symptoms, change in disease status, morbid events, QOL, and treatment-related morbidity. Though not completely standardized, follow-up for diabetic lower-extremity ulcers or amputation wounds symptoms would typically occur in the months to years after starting treatment.

**Study Selection Criteria**

Methodologically credible studies were selected using the following principles:

a. To assess efficacy outcomes, comparative controlled prospective trials were sought, with a preference for RCTs;

b. In the absence of such trials, comparative observational studies were sought, with a preference for prospective studies;

c. To assess long-term outcomes and adverse events, single-arm studies that capture longer periods of follow-up and/or larger populations were sought;

d. Studies with duplicative or overlapping populations were excluded.
Systematic Reviews

A 2013 Cochrane review of NPWT for treating foot wounds in patients with diabetes was updated in 2018 to include 11 RCTs (n=972) with sample sizes ranging from 15 to 341 participants. Two studies addressed post-amputation wounds and all other studies described treatment of diabetic foot ulcers. Only one study comparing NPWT and moist dressings for post-amputation wounds reported a follow-up time (n=162), and a statistically significant improvement in the proportion of wounds healed (RR 1.44, 95% CI, 1.03 to 2.01) was demonstrated after a follow-up duration of 16 weeks. The median time to healing was 21 days shorter for the NPWT group (hazard ratio 1.91, 95% CI, 1.21 to 2.99) compared with moist dressings. Data from 3 studies suggest that people with diabetic foot ulcers allocated to NPWT may be at reduced risk of amputation compared to moist dressings (RR 0.33, 95% CI, 0.15 to 0.70, $I^2=0\%$). 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.

A systematic review by Wynn and Freeman (2019) evaluating NPWT for diabetic foot ulcers reported similar benefits in wound healing and the reduction of amputation incidence. However, reviewers emphasized limitations in the present body of evidence, including methodological flaws such as the absence of validated tools for the measurement of wound depth and area, lack of statistical power calculations, and heterogeneity in pressure settings employed during therapy.

Randomized Controlled Trials

The largest study of NPWT for diabetic foot ulcers was a multicenter industry-sponsored RCT by Blume et al (2008) that compared NPWT with advanced moist wound therapy. Included were 342 patients with Wagner grade 2 or grade 3 foot ulcers of at least 2 cm$^2$; 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 endpoint 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).

Nonrandomized Studies

Borys et al (2018) conducted a prospective observational study to assess the short-term efficacy, safety, and long-term outcomes of NPWT in treating diabetic foot ulcers. Researchers assigned 75 patients to NPWT (n=53) or standard care (n=22) based on wound size. Analysis after 1-year follow-up showed similar results for both groups, leading researchers to conclude NPWT is a safe alternative to but not necessarily more efficacious than the current standard of care. Limitations include small sample size, the observational design, and no consideration of risk factors other than wound size.

Section Summary: Diabetic Lower-Extremity Ulcers and Amputation Wounds

The evidence on NPWT for diabetic lower-extremity ulcers and amputation wounds includes RCTs and systematic reviews 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

Clinical Context and Therapy Purpose
The purpose of outpatient NPWT is to provide a treatment option that is an alternative to or an improvement on existing therapies in patients with chronic pressure ulcers.

The question addressed in this evidence review is: Does NPWT improve outcomes when used for the outpatient treatment of pressure ulcers, diabetic foot ulcers, venous ulcers, burn wounds, and traumatic or surgical wounds; and to assess the evidence on the use of portable NPWT devices?

The following PICO was used to select literature to inform this review.

**Patients**

The relevant population of interest is individuals with chronic pressure ulcers.

**Interventions**

The therapy being considered is outpatient NPWT.

**Comparators**

Comparators of interest include standard wound care.

**Outcomes**

The general outcomes of interest are symptoms, change in disease status, morbid events, QOL, and treatment-related morbidity. Though not completely standardized, follow-up for chronic pressure ulcers would typically occur in the months to years after starting treatment.

**Study Selection Criteria**

Methodologically credible studies were selected using the following principles:

- a. To assess efficacy outcomes, comparative controlled prospective trials were sought, with a preference for RCTs;
- b. In the absence of such trials, comparative observational studies were sought, with a preference for prospective studies.
- c. To assess long-term outcomes and adverse events, single-arm studies that capture longer periods of follow-up and/or larger populations were sought.

Studies with duplicative or overlapping populations were excluded.

**Systematic Reviews**

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 there is high uncertainty about the potential benefits and/or harms for this indication.

**Randomized Controlled Trials**

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

Clinical Context and Therapy Purpose

The purpose of outpatient NPWT is to provide a treatment option that is an alternative to or an improvement on existing therapies in patients with lower-extremity ulcers due to venous insufficiency.

The question addressed in this evidence review is: Does NPWT improve outcomes when used for the outpatient treatment of pressure ulcers, diabetic foot ulcers, venous ulcers, burn wounds, and traumatic or surgical wounds; and to assess the evidence on the use of portable NPWT devices?

The following PICO was used to select literature to inform this review.

Patients

The relevant population of interest is individuals with lower-extremity ulcers due to venous insufficiency.

Interventions

The therapy being considered is outpatient NPWT.

Comparators

Comparators of interest include compression therapy.

Outcomes

The general outcomes of interest are symptoms, change in disease status, morbid events, QOL, and treatment-related morbidity. Though not completely standardized, follow-up for lower-extremity ulcers due to venous insufficiency symptoms would typically occur in the months to years after starting treatment.

Study Selection Criteria

Methodologically credible studies were selected using the following principles:

a. To assess efficacy outcomes, comparative controlled prospective trials were sought, with a preference for RCTs;

b. In the absence of such trials, comparative observational studies were sought, with a preference for prospective studies.

c. To assess longer-term outcomes and adverse events, single-arm studies that capture longer periods of follow-up and/or larger populations were sought.

d. Studies with duplicative or overlapping populations were excluded.

Randomized Controlled Trials

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
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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

Clinical Context and Therapy Purpose

The purpose of outpatient NPWT is to provide a treatment option that is an alternative to or an improvement on existing therapies in patients with burn wounds.

The question addressed in this evidence review is: Does NPWT improve outcomes when used for the outpatient treatment of pressure ulcers, diabetic foot ulcers, venous ulcers, burn wounds, and traumatic or surgical wounds; and to assess the evidence on the use of portable NPWT devices?

The following PICO was used to select literature to inform this review.

Patients
The relevant population of interest is individuals with burn wounds.

Interventions
The therapy being considered is outpatient NPWT.

Comparators
Comparators of interest include standard wound care.

Outcomes
The general outcomes of interest are symptoms, change in disease status, morbid events, QOL, and treatment-related morbidity. Follow-up at months to years if of interest to monitor relevant outcomes.

Study Selection Criteria
Methodologically credible studies were selected using the following principles:

a. To assess efficacy outcomes, comparative controlled prospective trials were sought, with a preference for RCTs;
b. In the absence of such trials, comparative observational studies were sought, with a preference for prospective studies.
c. To assess long-term outcomes and adverse events, single-arm studies that capture longer periods of follow-up and/or larger populations were sought.
d. Studies with duplicative or overlapping populations were excluded.

**Randomized Controlled Trials**

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 trial by Bloemen et al (2012) on the effect of NPWT on graft take in full-thickness burn wounds. This multicenter, 4-armed RCT enrolled 86 patients and compared a split-skin graft with or without a dermal substitute (MatriDerm), with or without NPWT. Outcome measures included graft take at 4 to 7 days after surgery, 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.

**Case Series**

A retrospective case series by Ehrl et al (2017) 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. 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. Ergotherpay was initiated following evidence of epithelialization. Primary endpoints 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 endpoint was reached in 85.1% (n=40) of the cases; the second endpoint 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**

**Clinical Context and Therapy Purpose**

The purpose of outpatient NPWT is to provide a treatment option that is an alternative to or an improvement on existing therapies in patients with traumatic or surgical wounds.

The question addressed in this evidence review is: Does NPWT improve outcomes when used for the outpatient treatment of pressure ulcers, diabetic foot ulcers, venous ulcers, burn wounds, and traumatic or surgical wounds; and to assess the evidence on the use of portable NPWT devices?
The following PICO was used to select literature to inform this review.

**Patients**
The relevant population of interest is individuals with traumatic or surgical wounds.

**Interventions**
The therapy being considered is outpatient NPWT.

**Comparators**
Comparators of interest include standard wound care.

**Outcomes**
The general outcomes of interest are symptoms, change in disease status, morbid events, QOL, and treatment-related morbidity. Follow-up within weeks to months if of interest for outpatient NPWT to monitor relevant outcomes.

**Study Selection Criteria**
Methodologically credible studies were selected using the following principles:

- To assess efficacy outcomes, comparative controlled prospective trials were sought, with a preference for RCTs;
- In the absence of such trials, comparative observational studies were sought, with a preference for prospective studies.
- To assess long-term outcomes and adverse events, single-arm studies that capture longer periods of follow-up and/or larger populations were sought.
- Studies with duplicative or overlapping populations were excluded.

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.

**Systematic Reviews**
Selected systematic reviews and meta-analyses evaluating the use of NPWT in surgical and/or traumatic wounds are summarized in Table 1.

**Table 1. Summary of SR-MAs of NPWT versus Standard Therapy in Surgical Wounds**

<table>
<thead>
<tr>
<th>Review</th>
<th>RCT</th>
<th>Other Studies</th>
<th>Participants $^1$</th>
<th>N (Range)</th>
<th>Major Outcomes</th>
<th>Study Quality</th>
<th>Relevance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cochrane (2014)$^{20}$</td>
<td>9</td>
<td>0</td>
<td>Individuals with wounds expected to heal by primary intention (e.g., surgical closure, skin grafts)</td>
<td>785</td>
<td>SSI (NSD) Wound dehiscence (NSD) Reoperation (NSD) Seroma/hematoma (NSD) Skin graft failure (NSD)</td>
<td>Unclear or high risk of bias noted</td>
<td>Unclear; inclusion of “home-made” devices and focus on inpatient therapy</td>
</tr>
<tr>
<td>De Vries et al (2016)$^{21}$</td>
<td>6</td>
<td>15</td>
<td>Individuals treated with prophylactic NPWT in clean and</td>
<td>RCT: 277 (13-141) Other: Surgical site infection (RCT: p=0.04; Other: p&lt;0.00001; NSD for trauma/orthopedic surgery)</td>
<td>Low quality of evidence due to lack of blinding in outcome</td>
<td>Unclear; focus on inpatient therapy</td>
<td></td>
</tr>
</tbody>
</table>
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<table>
<thead>
<tr>
<th></th>
<th>contaminated surgery</th>
<th>1099 (23-237)</th>
<th>assessment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cochrane (2018)²</td>
<td>7</td>
<td>0</td>
<td>Individuals with open traumatic wounds (open fractures and other types)</td>
</tr>
</tbody>
</table>

NPWT: negative pressure wound therapy; NSD: no significant difference; RCT: randomized controlled trial; SR-MA: systematic review and meta-analysis; SSI: surgical site infection.

² Assessment according to Cochrane risk of bias criteria.

A 2014 Cochrane review evaluated the evidence on NPWT for skin grafts and surgical wounds expected to heal by primary intention. Healing by primary intention occurs when the wound edges are brought together with sutures, staples, tape, or glue, and contrasts with healing by secondary intention, where the wound is left open to heal from the bottom up (e.g., for chronic or infected wounds). Nine randomized trials (total n=785 patients) were included in the review. Three trials involved skin graft patients, 4 included orthopedic patients, and 2 included general surgery and trauma surgery patients. All trials had an unclear or high-risk of bias. There were no differences between standard dressing and NPWT for SSIs, 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 systematic review and meta-analysis by De Vries et al (2016) included 6 RCTs and 15 observational studies of SSIs 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 SSIs (odds ratio [OR], 0.56; 95% CI, 0.32 to 0.96; p=0.04), and reduced the SSI 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. Subgroup meta-analysis of 4 RCTs in orthopedic/trauma surgery did not demonstrate significant benefit in regard to reducing risk of SSI (OR 0.58; 95% CI, 0.32 to 1.07).

A 2018 Cochrane review evaluated the effects of NPWT for open traumatic wounds (e.g., open fractures or soft tissue wounds) managed in any care setting. Seven RCTs were identified for the review with sample sizes ranging from 40 to 586 participants. Four studies (n=596) compared NPWT at 125 mmHg with standard care for open fracture wounds. Pooled data revealed no significant difference between groups in the number of participants with healed wounds (RR 0.48, 95% CI 0.81 to 1.27; I²=56%). Pooled data from 2 studies (n=509) utilizing NPWT at 125 mmHg on other open traumatic wounds demonstrated no significant difference in risk of wound infection compared to standard care (RR 0.48, 95% CI 0.81 to 1.27: I²=56%). Pooled data from 2 studies (n=509) utilizing NPWT at 125 mmHg on other open traumatic wounds demonstrated no significant difference in risk of wound infection compared to standard care (RR 0.60, 95% CI, 0.31 to 1.18). One study (n=493) assessing NPWT at 75 mmHg against standard care in other open traumatic wounds did not demonstrate a significant difference for wound infection risk (RR 0.44, 95% CI, 0.17 to 1.10). One study comparing NPWT at 125 mmHg against 75 mmHg in other open traumatic wounds also failed to demonstrate a significant difference in wound infection risk (RR 1.04, 95% CI, 0.31 to 3.51). Evidence was deemed low to very low in certainty and quality due to imprecision and risk of bias.

In contrast, a systematic review and meta-analysis by Liu et al (2018) highlighted a significantly lower infection rate, shorter wound coverage time, shorter wound healing time, and shorter hospitalization duration for NPWT versus conventional wound dressings in the treatment of open fractures (all
Three of 6 included RCTs overlapped with the Cochrane review and one significantly weighted RCT (n=460) (see Costa et al [2018] in Table 2 below) failing to demonstrate a benefit in infection risk for NPWT was missing in the Liu et al (2018) analysis, the only RCT identified by Cochrane to conduct blinded outcome assessment of wound healing and infection. However, the risk of bias in the Liu et al (2018) review was similarly reported as high or unclear. The baseline characteristics of cohort studies included in the analysis suffered from high heterogeneity, with most studies failing to achieve comparable initial injury severity scores based on the Gustilo-Anderson open fracture classification system. Finally, due to the severity of open fracture injuries, the outpatient clinical utility of NPWT for this form of trauma is unclear with most studies focusing on inpatient applications.

Sahebally et al (2018) performed a systematic review with meta-analysis to evaluate the effects of NPWT on SSIs in closed laparotomy incisions. Researchers searched 4 databases through December 31, 2017, and screened bibliographies of retrieved studies to find further studies; 9 unique studies (3 RCTs, 2 prospective studies, and 4 retrospective studies) representing 1266 unique patients were included in the review. The analysis determined that NPWT was associated with a significantly lower rate of SSI compared with standard wound dressing (pooled OR: 0.25; 95% CI: 0.12-0.52; p<0.001). The review was limited by including mostly non-randomized studies and use of different NPWT devices.

**Randomized Controlled Trials**

Selected RCTs of NPWT for surgical or traumatic wounds are summarized in Table 2.

**Table 2. Summary of Key RCTs of NPWT versus Standard Therapy in Surgical Wounds**

<table>
<thead>
<tr>
<th>Study; Trial</th>
<th>Surgery Received</th>
<th>No. of Participants</th>
<th>Notes on NPWT effectiveness</th>
<th>P-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stannard et al (2012)</td>
<td>Various, after fractures and other trauma</td>
<td>249</td>
<td>Fewer infections, less discharge than standard closure</td>
<td>0.049</td>
</tr>
<tr>
<td>Masden et al (2012)</td>
<td>Various</td>
<td>81</td>
<td>NSD in infection or healing</td>
<td>NR</td>
</tr>
<tr>
<td>Chio and Agrawal (2010)</td>
<td>Radial forearm donor site</td>
<td>43</td>
<td>NSD in wound complications or graft failure</td>
<td>NR</td>
</tr>
<tr>
<td>Javed et al (2018)</td>
<td>Open pancreaticoduodenectomy</td>
<td>123</td>
<td>9.7% of NPWT group developed infections, compared with 31.1% of standard closure group</td>
<td>0.003</td>
</tr>
<tr>
<td>Tanaydin et al (2018)</td>
<td>Bilateral breast reduction mammoplasty</td>
<td>32</td>
<td>Patients used as own control; NPWT associated with significantly lower risk of complication and improved pain and scarring compared with fixation strips</td>
<td>&lt;0.004</td>
</tr>
<tr>
<td>Costa et al (2018); WOLLF</td>
<td>Severe open fracture of the lower limb</td>
<td>460</td>
<td>NSD in self-rated disability, number of deep SSI, or QOL scores</td>
<td>Disability: 0.13 SSI: 0.64 QOL: NR</td>
</tr>
</tbody>
</table>

NPWT: negative pressure wound therapy; NR: not reported; NSD: no significant difference; QOL: quality of life; RCT: randomized controlled trial; SSI: surgical site infection.

One of the largest studies on prophylactic NPWT for surgical wounds is a report from an investigator-initiated, industry-sponsored multicenter RCT of inpatient NPWT for closed surgical incisions by Stannard et al (2012). (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...
Negative Pressure Wound Therapy in the Outpatient Setting

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 QOL improvements compared with standard wound care.31

Other randomized studies have reported no benefit for NPWT for surgical wounds, as reflected in the conclusions of various Cochrane reviews (described above).20,29 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.26 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.22 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.32 Complete wound healing was achieved at a median of 84 days in the NPWT group and 93 days in controls.

Javed et al (2018) conducted a single-site RCT to evaluate the efficacy of NPWT for SSI after an open pancreaticoduodenectomy. Researchers randomized 123 patients treated from January 2017 through February 2018 to either NPWT (n=62) or standard closure (n=61). In the study, 9.7% of patients who received NPWT developed a postoperative infection at the site, compared with 31.1% of patients who received standard closure, an RR of 0.31 (95% CI: 0.13-0.73; p=0.003). Limitations of the study included being conducted at a high-volume treatment center and a lack of blinding.28

Tanaydin et al (2018) conducted an RCT to compare NPWT to standard wound care after a bilateral breast reduction mammoplasty.31 In the study, 32 patients were given NPWT on one breast and fixation strips on the other, simultaneously serving as study group and control group. Sites treated with NPWT showed a significantly lower rate of complications (p<0.004) compared to fixation strips, as well as improved pain and scarring. Limitations included the small sample size and lack of blinding.

The Effect of Negative Pressure Wound Therapy vs Standard Wound Management on 12-Month Disability Among Adults With Severe Open Fracture of the Lower Limb (WOLLF trial by Costa et al (2018) randomized 460 patients with severe open fracture of the lower limb to NPWT (n=226) or standard wound management (n=234).33 The primary outcome was the Disability Rating Index score (range, 0 [no disability] to 100 [completely disabled]) at 12 months, with a minimal clinically important difference of 8 points. Secondary outcomes included deep infection and QOL measures based on the EuroQol 5-dimensions questionnaire. Eighty-eight percent of participants completed the trial. There were no statistically significant differences in disability scores (45.5 vs. 42.4; p=0.13), in the number of deep infections (16 [7.1%] vs. 19 [8.1%]; p=0.64), or in quality of life measures in the NPWT and standard wound management groups, respectively.
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)

Clinical Context and Therapy Purpose

The purpose of portable single-use outpatient NPWT is to provide a treatment option that is an alternative to or an improvement on existing therapies in patients with any wound type (acute or nonhealing).

The question addressed in this evidence review is: Does NPWT improve outcomes when used for the outpatient treatment of pressure ulcers, diabetic foot ulcers, venous ulcers, burn wounds, and traumatic or surgical wounds; and to assess the evidence on the use of portable NPWT devices?

The following PICO was used to select literature to inform this review.

Patients

The relevant population of interest is individuals with any wound type (acute or nonhealing).

Interventions

The therapy being considered is portable single-use outpatient NPWT.

Comparators

Comparators of interest include standard NPWT.

Outcomes

The general outcomes of interest are symptoms, change in disease status, morbid events, QOL, and treatment-related morbidity. Follow-up at weeks to months is of interest for portable, single-use outpatient NPWT to monitor relevant outcomes.

Study Selection Criteria

Methodologically credible studies were selected using the following principles:

a. To assess efficacy outcomes, comparative controlled prospective trials were sought, with a preference for RCTs;

b. In the absence of such trials, comparative observational studies were sought, with a preference for prospective studies.

c. To assess long-term outcomes and adverse events, single-arm studies that capture longer periods of follow-up and/or larger populations were sought.

Studies with duplicative or overlapping populations were excluded.

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.

Armstrong et al (2011) reported on results of a planned interim analysis of an RCT comparing the SNaP Wound Care System with the V.A.C. Therapy for the treatment of chronic lower-extremity wounds. Final results of this industry-sponsored multicenter noninferiority trial were reported in 2012. 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). 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 the treatment of lower-extremity ulcers. 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. Karlakki et al (2016) 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. Blisteres 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.
Schwartz et al (2015) 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 (2017) published an RCT that allocated 50 patients to standard wound dressing or negative pressure wound dressing after abdominal surgery; patients had class I, II, or III wounds, and the treatment group was given the PICO dressing. SSI 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 the 30-day follow-up, rates of SSIs 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 an SSI (p=0.040); for secondary outcomes (e.g., 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 SSIs.

Strugala and Martin (2017) published a meta-analysis of comparative trials evaluating the PICO system for the prevention of surgical site complications. A total of 1863 patients were represented by 10 RCTs and 7 observational studies. The rate of SSI was reduced by 51% with the PICO system compared to standard care (10 RCTs; RR 0.49; 95% CI, 0.34 to 0.69; p<0.0001). There was a significant reduction in wound dehiscence (17.4% vs. 12.8%; RR 0.71; 95% CI, 0.54 to 0.92; p<0.01) and mean hospital length of stay (-0.47 days; 95% CI, -0.71 to -0.23; p<0.0001) with the PICO system. It is unclear whether included studies captured outpatient utilization of the device.

Prevena System

Prevena is a single-use NPWT system designed specifically for incisions. Grauhan et al (2013) 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 vs. 16%; p=0.027). Gram-positive skin flora was 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, The Use of Prevena Incision Management System on Clean Closed Sternotomy Incisions in Subjects at High Risk for Surgical Site Occurrences (NCT02195310) involving a larger number of patients with sternal midline incisions was terminated in early 2017.

Pauser et al (2016) 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.

Gombert et al (2018) published findings from the Closed Incision Negative Pressure Therapy Reduces Surgical Site Infections in Vascular Surgery (AIMS) trial, a prospective RCT evaluating Prevena in patients undergoing vascular groin surgery for peripheral artery disease (n=204). The primary outcome was the rate of SSI with the Prevena System (n=98) compared to patients receiving standard wound dressings.
Negative Pressure Wound Therapy in the Outpatient Setting

(n=90). Ten patients were excluded as screening failures and 6 patients were excluded due to early occlusion of treated vessels requiring de novo surgery. The Prevena System was removed at 5-7 days postoperatively. Patients were evaluated on the day of discharge (day 7), and again at 15- and 30-days post-surgery by blinded wound care nurses. Wounds were evaluated clinically according to Szilagyi classification criteria (grades I-III). Prophylactic antibiotics were administered to 13.2% of the Prevena group and 31.1% of the control group (p=0.004). The control group experienced more frequent SSI (33.3%; 30/90) than the Prevena group (13.2%; 13/98; p=0.0015). However, the absolute risk difference of -20.1 per 100 (95% CI, -31.9 to 8.2) was based on an increased rate of Szilagyi I SSI (24.6% vs. 8.1%; p=0.0012). Bacterial swabs were performed in each case of suspected SSI. Only 10/43 suspected infections returned positive swabs, 5 in each treatment arm, suggesting the study may have been biased by methodological flaws relating to subjective SSI assessment.

Murphy et al (2019) published findings from the Negative Pressure Wound Therapy Use to Decrease Surgical Nosocomial Events in Colorectal Resections (NEPTUNE) trial, a single-center, superiority designed prospective randomized open blinded endpoint controlled trial evaluating the use of the Prevena System on closed incisions compared to standard gauze dressings in patients undergoing colorectal resection via laparotomy (n=300). The was no significant difference in the incidence of SSI at 30 days post-surgery between the Prevena and control groups (32% vs. 34%; p=0.68). No significant difference in length of hospital stay was reported.

Hussamy et al (2019) reported on an open-label RCT evaluating the Prevena System for incisional NPWT following cesarean delivery in women with class III obesity (Body Mass Index ≥ 40; n=222) compared to standard dressings (n=219). The overall composite wound morbidity rate was not significantly different between the Prevena and control cohorts (17% vs. 19%; RR 0.9; 95% CI, 0.5 to 1.4).

Singh et al (2018) performed a systematic review and meta-analysis to evaluate the efficacy of the Prevena System in reducing SSI in closed incisions compared to traditional dressings. The meta-analysis included 11 RCTs, 7 prospective studies, and 12 retrospective studies. The Prevena System showed a significant reduction in SSI (11 RCTs [n=1579]; OR 2.7; 95% CI, 2.0 to 3.6; I²=24%; p<00001). Analysis of studies by anatomical location (colorectal/abdominal, obstetrics, lower extremity, groin/vascular, and cardiac) continued to demonstrate a significant effect for the Prevena System in all categories based on the fixed-effects model. When the analyses were repeated with the random-effects model, a significant effect for the Prevena System was upheld for all anatomical categories except obstetrics (OR 1.7; 95% CI, 0.9 to 3.5; p=0.11). The analysis was limited by heterogeneity in outcome reporting and blinding practices. Only 4 of 30 included studies reported on wound categories established by the Centers for Disease Control.

Systematic Reviews

Yu et al (2019) published a meta-analysis of prophylactic NPWT after cesarean delivery in high-risk women with obesity. Six RCTs and 3 cohort studies primarily utilizing Prevena and PICO systems were included for analysis. Compared to standard wound dressings, NPWT was associated with a significantly lower risk of SSI from 7 pooled studies (RR 0.45; 95% CI 0.31 to 0.66; I²=9.9%). Absolute risk reduction was -6.0% (95% CI, -10% to -3.0%) with an NNT of 17. NPWT was also associated with a statistically significant reduction in the number of composite wound complications (9 studies, RR 0.68; 95% CI 0.49 to 0.94), but no other secondary outcome measures (i.e., dehiscence, seroma, endometritis, and hospital re-admission). The analysis was limited by heterogeneity in study inclusion criteria and outcome measures, including lack of standardized definitions for SSIs. Additionally, potential harms of treatment were not consistently reported across studies, whereas existing literature on the use of prophylactic NPWT in the context of other surgical procedures has reported high rates of side effects.
such as skin blisters, erythema, and wound bleeding. Review authors recommend larger definitive trials to clarify clinical utility.

**Section Summary: Portable Single-Use NPWT Devices for Any Wound Type**

The evidence on portable single-use NPWT includes systematic reviews, 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 systematic reviews of RCTs. The relevant outcomes are symptoms, change in disease status, morbid events, quality of life (QOL), 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. The relevant outcomes are symptoms, change in disease status, morbid events, QOL, 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. The relevant outcomes are symptoms, change in disease status, morbid events, QOL (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. The relevant outcomes are symptoms, change in disease status, morbid events, QOL, 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. The relevant outcomes are symptoms, change in disease status, morbid events, QOL, 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
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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 systematic reviews and RCTs. The relevant outcomes are symptoms, change in disease status, morbid events, QOL, 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.

Overall, the evidence from comparative clinical trials has demonstrated 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.

SUPPLEMENTAL INFORMATION

Clinical Input from Physician Specialty Societies and Academic Medical Centers

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

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

**Practice Guidelines and Position Statements**

*International Expert Panel on Negative Pressure Wound Therapy*

In 2011, an international expert panel on 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 3).

**Table 3. Recommendations on Use of NPWT in Chronic Wounds**

<table>
<thead>
<tr>
<th>Condition</th>
<th>Recommendation</th>
<th>Gradea</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>Diabetic foot ulcers</td>
<td>“NPWT must be considered as an advanced wound care therapy,… [and] must be considered to achieve healing by secondary intention.”</td>
<td>A</td>
</tr>
<tr>
<td>Ischemic lower-limb wounds</td>
<td>“… NPWT … may be considered in specialist hands and never as an alternative for revascularisation.”</td>
<td>C</td>
</tr>
<tr>
<td>Venous leg ulcers</td>
<td>“If first-line therapy (compression) is not efficacious, NPWT should be considered to prepare the wound for surgical closure….”</td>
<td>B</td>
</tr>
</tbody>
</table>

NPWT: negative pressure wound therapy.

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

*International Multidisciplinary Consensus Recommendations*

Willy et al (2017) 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 (i.e., 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 the 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

The American College of Physicians (2015) published guidelines on the treatment of pressure ulcers. The guidelines stated there was low-quality evidence that the overall treatment effect of NPWT did not differ from the standard of care.

Association for the Advancement of Wound Care

The Association for the Advancement of Wound Care (2010) 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. The guidelines were updated in 2014 with additional validation.

The Association (2010) 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 there is limited evidence for NPWT (level B) compared with other adjunctive therapies.

National Institute for Health and Care Excellence

The NICE (2013) issued guidance 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 2015 NICE guidance on diabetic foot problems, updated in October 2019, 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.

The NICE (2014) issued 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 4.

<table>
<thead>
<tr>
<th>NCT No.</th>
<th>Trial Name</th>
<th>Planned Enrollment</th>
<th>Completion Date</th>
</tr>
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<tbody>
<tr>
<td>Ongoing</td>
<td>NCT02664168 A Prospective, Randomized, Comparative Study to Assess the</td>
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<td>Feb 2020 (recruiting)</td>
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<tr>
<td></td>
<td>Prevention of Surgical Site Infection (SSI’s) in Revision Total Joint</td>
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<tr>
<td></td>
<td>Arthroplasty Patients Treated with Single-Use Negative Pressure Wound</td>
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<td></td>
</tr>
<tr>
<td></td>
<td>Therapy (PICO™) or Standard Care Dressings (AQUACEL® Ag SURGICAL</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Dressing)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>NCT01528033*</td>
<td>Treatment Study of Vacuum-Assisted Closure for Postsurgical</td>
<td></td>
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</tr>
<tr>
<td>Trial ID</td>
<td>Title</td>
<td>Study Description</td>
<td>Enrollment</td>
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<tr>
<td>NCT02309944</td>
<td>Negative Pressure Wound Therapy in Obese Gynecologic Oncology Patients</td>
<td>Subcutaneous Abdominal Wound Healing Impairments (SAWHI)</td>
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<tr>
<td>NCT02509260</td>
<td>Prevena™ Incisional Negative Pressure Wound Therapy in Re-operative Colorectal Surgery</td>
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<tr>
<td>NCT01913132</td>
<td>PICO Versus Standard Dressing Above Groin Incisions After Vascular Surgery - a Prospective Randomized Trial</td>
<td></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>
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<tr>
<td>NCT02954835</td>
<td>Negative Pressure Therapy for Closed Groin Wounds in Patients Undergoing Vascular Surgery</td>
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<tr>
<td>NCT02467998</td>
<td>The Registry of Negative Pressure Wound Therapy for Chronic Wounds and Ulcers</td>
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<td>50,000</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>
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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>
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<tr>
<td>NCT01821664</td>
<td>Vascular Graft Infections - Epidemiology, Best Treatment Options, Imaging Modalities, and Impact of Negative Pressure Wound Therapy</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>
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<tr>
<td>Unpublished</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>
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<tr>
<td>NCT02020018</td>
<td>Negative Pressure Wound Therapy for Prevention of Wound Infection After Heart Surgery</td>
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<tr>
<td>NCT01191567</td>
<td>Negative Pressure Wound Therapy. Therapy Effects and the Impact on the Patient’s Quality of Life</td>
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<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></td>
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<tr>
<td>NCT02395159</td>
<td>Reduction of Groin Wound Infections After Vascular Surgery in Patients with Risk Factors by the Use a Negative Pressure Wound Incision Management System (KCI Prevena)</td>
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<tr>
<td>NCT02739191</td>
<td>Negative Pressure Wound Therapy for Surgical Wounds of the Foot and Ankle</td>
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<tr>
<td>NCT02195310</td>
<td>The Use of Prevena™ Incision Management System on Clean Closed Sternal Midline Incisions in Subjects at High Risk for Surgical Site Occurrences</td>
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</tr>
<tr>
<td>NCT02064270</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</td>
<td></td>
<td>526</td>
</tr>
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</table>
ESSENTIAL HEALTH BENEFITS

The Affordable Care Act (ACA) requires fully insured non-grandfathered individual and small group benefit plans to provide coverage for ten categories of Essential Health Benefits (“EHBs”), whether the benefit plans are offered through an Exchange or not. States can define EHBs for their respective state.

States vary on how they define the term small group. In Idaho, a small group employer is defined as an employer with at least two but no more than fifty eligible employees on the first day of the plan or contract year, the majority of whom are employed in Idaho. Large group employers, whether they are self-funded or fully insured, are not required to offer EHBs, but may voluntarily offer them.

The Affordable Care Act requires any benefit plan offering EHBs to remove all dollar limits for EHBs.

REFERENCES


**CODES**

<table>
<thead>
<tr>
<th>Codes</th>
<th>Number</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>CPT</td>
<td>97605</td>
<td>Negative pressure wound therapy (e.g., vacuum-assisted drainage collection), utilizing durable medical equipment (DME), including topical application(s), wound assessment, and instruction(s) for ongoing care, per session; total wound(s) surface area less than or equal to 50 square centimeters</td>
</tr>
<tr>
<td></td>
<td>97606</td>
<td>total wound(s) surface area greater than 50 square centimeters</td>
</tr>
<tr>
<td></td>
<td>97607</td>
<td>Negative pressure wound therapy (e.g., vacuum-assisted drainage collection), utilizing disposable, non-durable medical equipment including provision of exudate management collection system, topical application(s), wound assessment, and instructions for ongoing care, per session; total wound(s) surface area less than or equal to 50 square centimeters</td>
</tr>
<tr>
<td></td>
<td>97608</td>
<td>total wound(s) surface area greater than 50 square centimeters</td>
</tr>
<tr>
<td>HCPCS</td>
<td>A6550</td>
<td>Wound care set, for negative pressure wound therapy electrical pump, includes all supplies and accessories</td>
</tr>
<tr>
<td></td>
<td>A7000, A7001</td>
<td>Canister for use with suction pump, code range</td>
</tr>
<tr>
<td></td>
<td>A9272</td>
<td>Wound suction, disposable, includes dressing and all accessories and components, any type, each</td>
</tr>
<tr>
<td></td>
<td>E2402</td>
<td>Negative pressure wound therapy electrical pump, stationary or portable</td>
</tr>
<tr>
<td></td>
<td>K0743</td>
<td>Suction pump, home model, portable, for use on wounds</td>
</tr>
<tr>
<td></td>
<td>K0744, K0745, K0746</td>
<td>Code range for absorptive wound dressings to be used with home suction pump coded with K0743</td>
</tr>
<tr>
<td>ICD-10-CM</td>
<td>L89.000-L89.899</td>
<td>Pressure ulcer code range, specified site, code range includes options for all body areas as well as designation of stages</td>
</tr>
<tr>
<td></td>
<td>L89.90-L89.95</td>
<td>Pressure ulcer code range, unspecified site, code range includes options for stage of ulcer</td>
</tr>
<tr>
<td></td>
<td>S01.00x-S01.95xS</td>
<td>Open wound of head and face, code range, 7th digit extender includes stage of healing</td>
</tr>
<tr>
<td></td>
<td>S11.80x-S11.95xS</td>
<td>Open wound of neck, code range, 7th digit extender includes stage of healing</td>
</tr>
<tr>
<td></td>
<td>S31.00x-S31.839S</td>
<td>Open wound of abdomen, lower back, pelvis and external genitals, code range, 7th digit extender includes stage of healing</td>
</tr>
<tr>
<td></td>
<td>S41.001A-S41.159S</td>
<td>Open wound of shoulder and upper arm, code range, 7th digit extender includes stage of healing</td>
</tr>
<tr>
<td></td>
<td>S51.001A-S51.859S</td>
<td>Open wound of elbow and forearm, code range, 7th digit extender includes stage of healing</td>
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</tbody>
</table>
### POLICY HISTORY

<table>
<thead>
<tr>
<th>Date</th>
<th>Action</th>
<th>Reason</th>
</tr>
</thead>
<tbody>
<tr>
<td>01/09/14</td>
<td>Replace policy</td>
<td>Policy updated with literature review through December 5, 2013; references 16, 19, 20 added; policy statements unchanged</td>
</tr>
<tr>
<td>01/15/15</td>
<td>Replace policy</td>
<td>Policy updated with literature review through December 11, 2014; references 4, 22, 31 added and some references removed; policy statements unchanged</td>
</tr>
<tr>
<td>01/14/16</td>
<td>Replace policy</td>
<td>Policy updated with literature review through December 3, 2015; references 3, 10, 15-16, 18, 21-22, 25, 31, 33-35, and 40 added, and reordered. Policy statements unchanged</td>
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<tr>
<td>01/27/17</td>
<td>Replace policy</td>
<td>Policy updated with literature review through November 28, 2016; references 19 and 30 added. Policy statements unchanged</td>
</tr>
<tr>
<td>01/30/18</td>
<td>Replace policy</td>
<td>Blue Cross of Idaho adopted changes as noted. Policy updated with literature review through November 6, 2017; references 17, 27, 34, and 38 added; reference 1 updated. Policy statements unchanged.</td>
</tr>
<tr>
<td>01/24/19</td>
<td>Replace policy</td>
<td>Blue Cross of Idaho adopted changes as noted, effective 01/24/2019. Policy updated with literature review through November 15, 2018; references 8, and 27-30 added, reference 45 updated. Policy statements unchanged.</td>
</tr>
<tr>
<td>01/23/20</td>
<td>Replace policy</td>
<td>Blue Cross of Idaho adopted changes as noted, effective 01/23/2020. Policy updated with literature review through October 31, 2019; references added. Policy statements unchanged.</td>
</tr>
</tbody>
</table>

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**ICD-10-PCS**

ICD-10-PCS codes are only used for inpatient services. There is no specific ICD-10-PCS code for this therapy.

**Type of service**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>S61.001A-S61.559S</td>
<td>Open wound of wrist, hand and fingers, code range, 7th digit extender includes stage of healing</td>
</tr>
<tr>
<td>S71.001A-S71.159S</td>
<td>Open wound of hip and thigh, code range, 7th digit extender includes stage of healing</td>
</tr>
<tr>
<td>S81.001A-S81.859S</td>
<td>Open wound of knee and lower leg, code range, 7th digit extender includes stage of healing</td>
</tr>
<tr>
<td>S91.001A-S91.359S</td>
<td>Open wound of ankle, foot and toes, code range, 7th digit extender includes stage of healing</td>
</tr>
</tbody>
</table>

**Place of service**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>6A0Z0ZZ</td>
<td>Atmospheric control, single duration</td>
</tr>
<tr>
<td>6A0Z1ZZ</td>
<td>Atmospheric control, multiple durations</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Type of service</th>
<th>Place of service</th>
</tr>
</thead>
<tbody>
<tr>
<td>Durable medical equipment</td>
<td>Home</td>
</tr>
<tr>
<td></td>
<td>Inpatient</td>
</tr>
<tr>
<td></td>
<td>Skilled nursing facility</td>
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