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Affected Programs: BadgerCare Plus Standard Plan, BadgerCare Plus Benchmark Plan, Medicaid
To: Home Health Agencies, Medical Equipment Vendors, Nurse Practitioners, Pharmacies, Physician Assistants, Physician Clinics, Physicians, HMOs and Other Managed Care Programs

Documentation Requirements and Changes to Prior Authorization and the Reimbursement Rate for Negative Pressure Wound Therapy Pumps

This *ForwardHealth Update* announces documentation requirements and changes to prior authorization and the reimbursement rate for negative pressure wound therapy pump services provided in the home, effective January 1, 2011.

General Information

In response to 2009-2011 biennial budget targets, the Department of Health Services, along with representative industry stakeholders, undertook the Medicaid and BadgerCare Plus Rate Reform project. As a result of the Rate Reform Project, ForwardHealth is changing the reimbursement rate and documentation requirements for the rental of negative pressure wound therapy pumps in order to do the following:

- Clarify coverage, documentation requirements, and appropriate use of negative pressure wound therapy pumps.
- Change the maximum allowable fee for negative pressure wound therapy pumps services.
- Remove prior authorization (PA) requirements.

These policy changes apply to services for members enrolled in Medicaid, the BadgerCare Plus Standard Plan, and the BadgerCare Plus Benchmark Plan.

Definition of Negative Pressure Wound Therapy Pumps

A negative pressure wound therapy pump is the controlled application of subatmospheric pressure to a wound using an electrical pump to intermittently or continuously convey atmospheric pressure through connecting tubing of a specialized wound dressing that is meant to contain the subatmospheric pressure at the wound site and thereby promote healing. The subatmospheric pressure conveyed to the wound is in a range of 100 mm/hg to greater than or equal to 200 mm/hg. The pump sounds an alarm when desired pressures are not being achieved (e.g., when there is a leak in the dressing seal) and when the canister to collect drainage from the wound is full.

Negative pressure wound therapy pumps are described in Healthcare Common Procedure Coding System (HCPCS) procedure code E2402 (Negative pressure wound therapy electrical pump, stationary or portable). The canister, dressing, and related supplies are included in the reimbursement for the negative pressure wound therapy pump.

Prior Authorization No Longer Required

For dates of service (DOS) on and after January 1, 2011, PA will no longer be required for the rental of negative pressure wound therapy pumps, HCPCS code E2402.

Coverage and Documentation Requirements

The rental of negative pressure wound therapy pumps and supplies is covered for services provided in the home when used for the treatment of ulcers and wounds that have not responded to traditional wound treatment methods. Before supplying negative pressure wound therapy pumps, providers are required to document in the member's medical record that the following treatments have been tried and have failed to achieve wound healing in the previous 30 days:

- For all ulcers and wounds:
  - ✓ Application of dressings to maintain a moist wound environment.
  - ✓ Debridement of necrotic tissue and treatment of osteomyelitis or wound infection, if present.
- For stage III or IV pressure ulcers, the member has been appropriately turned and positioned, has used a group 2 or 3 support surface for pressure ulcers on the posterior trunk or pelvis (a group 2 or 3 support surface is not required if the ulcer is not on the trunk or pelvis), and the member's moisture and incontinence have been appropriately managed.
- For neuropathic ulcers ,the member has been on a comprehensive diabetic management program and reduction in pressure on a foot or leg ulcer has been accomplished with appropriate modalities.
- For venous insufficiency ulcers, leg elevation and ambulation have been encouraged.
- For surgical wounds, the member has complications of a surgically created wound or a traumatic wound where there is documentation of the medical necessity for accelerated formation of granulation tissue that cannot be achieved by other available topical wound treatments.

If traditional wound treatment methods have not resulted in improvement, a negative pressure wound therapy pump may be ordered.

More than one negative pressure wound therapy pump billed per member, per day for the same time period is not covered. The negative pressure wound therapy pump must accommodate more than one wound dressing set for multiple wounds on a member.

Effective for DOS on and after January 1, 2011, detailed documentation showing medical necessity of the negative pressure wound therapy pump is required to be kept by the supplying durable medical equipment (DME) provider. A written physician's order for the use of negative pressure wound therapy pumps and supplies must be signed and dated by the treating physician and obtained by the provider before supplying the pump. The order is required to be kept on file by the provider.

If detailed documentation in the member's medical record is incomplete or does not show the medical necessity of the negative pressure wound therapy pump and supplies, payments may be subject to recoupment.

Documentation showing medical necessity is required to be recorded and maintained in a member's medical record, including the following:

- Signed and dated physician order obtained prior to the application of the negative pressure wound therapy pump.
- Wound origin and history, including date wound first occurred.
- Evaluation and treatment plan.
- Weekly wound measurements (including length, width, and depth) and description (including type and amount of drainage) by a licensed health care professional.
- Evaluation and provision for adequate nutritional status, including required lab work for recent albumin and total protein levels. If lab work is not within normal range (albumin 3.4-5.4 g/dl and total

protein 5.6-8.4 g/dl) dietary assessment and additional intervention measures to improve levels must be documented.
- Type of diet, appetite, height, weight, and notation of recent weight loss, if applicable.
- Dates and number of hours per day that negative pressure wound therapy pump is in use. The device should only be used by qualified, trained, and authorized personnel.

Use of the negative pressure wound therapy pump is no longer covered when the treating physician determines wound healing has occurred to the degree that the negative pressure wound therapy pump is no longer needed or when any measureable degree of wound healing has failed to occur over the course of a month.

Allowable Place of Service Codes

Allowable place of service (POS) codes for negative pressure wound therapy pump services provided by DME providers are 11 (office) and 12 (home). Durable medical equipment providers cannot be directly reimbursed for negative pressure wound therapy pump services to members residing in a nursing home.

Definition of Lack of Improvement of a Wound

Lack of improvement of a wound is defined as a lack of improvement in the quantitative measurements of wound characteristics including wound length and width (surface area) or depth measured serially and documented over a specific interval of time. Wound healing is defined as improvement (smaller size) in either surface area or depth of the wound.

Inappropriate and Noncovered Use

The use of negative pressure wound therapy pumps is not appropriate and therefore not covered in the following situations:
- Presence of necrotic tissue with eschar, if debridement is not attempted.
- The presence of a fistula to an organ or body cavity within the vicinity of the wound.
- When cancer is present near or in the wound.
- If untreated infection or osteomyelitis is noted in the wound.

Reimbursement Rate

Effective for DOS on and after January 1, 2011, the maximum allowable fee for the rental of negative pressure wound therapy pumps will be $48.62 per member, per day up to 90 days for the lifetime of a member. The canister, dressings, and related supplies (procedure code A7000 [Canister, disposable, used with suction pump, each] and procedure code A6550 [Wound care set, for negative pressure wound therapy electrical pump, includes all supplies and accessories]) are included as part of the reimbursement for the negative pressure wound therapy pump and are not separately reimbursable.

The maximum allowable fee of $48.62 is allowed per member, per day up to 90 days for the lifetime of a member. Modifier "RR" (Rental) is required to be indicated with procedure code E2402 on claims submitted for the initial 90 days.

After the lifetime 90 days, the maximum allowable fee will be reduced to $24.31 and allowable up to an additional 90 days for a rolling 12 months. Modifiers "RR" and "52" (Reduced services) are required to be indicated with procedure code E2402 on claims submitted for the reduced rate after the lifetime 90 days of payments are exhausted.

The lifetime limit and the rolling 12-month limit for negative pressure wound therapy pumps will be calculated regardless of POS, based on a combination of nursing home and in-home services. If a claim is denied because the member's lifetime limit is exhausted, providers may resubmit the claim with modifier "52."

Once the limit is reached for the additional 90 days for the rolling 12 months, the service is considered noncovered and may not be billed to Standard Plan members or Medicaid members or to their families under any circumstances and cannot be appealed. This includes the use of negative pressure wound therapy pumps for purposes that do not qualify for reimbursement.

Benchmark Plan Service Limitations

The Benchmark Plan allows up to $2,500.00 per member per enrollment year for DME. The rental of negative pressure wound therapy pumps counts toward the $2,500.00 limit. Once the DME limit is reached, the member may be billed for the service. Providers should make payment arrangements with the member in advance and are strongly encouraged to obtain a written statement in advance documenting that the member has accepted responsibility for the payment of the service.

Information Regarding Managed Care Organizations

This *ForwardHealth Update* contains fee-for-service policy and applies to services members receive on a fee-for-service basis only. For managed care policy, contact the appropriate managed care organization. Managed care organizations are required to provide at least the same benefits as those provided under fee-for-service arrangements.

The *ForwardHealth Update* is the first source of program policy and billing information for providers.

Wisconsin Medicaid, BadgerCare Plus, SeniorCare, and Wisconsin Chronic Disease Program are administered by the Division of Health Care Access and Accountability, Wisconsin Department of Health Services (DHS). The Wisconsin Well Woman Program is administered by the Division of Public Health, Wisconsin DHS.

For questions, call Provider Services at (800) 947-9627 or visit our Web site at *www.forwardhealth.wi.gov/*.

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