NO. 91650

SURGICAL DRESSINGS AND WOUND CARE SUPPLIES

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Policy scope: This policy outlines medical necessity criteria, limitations, and exclusions for surgical dressings and surgical wound care supplies, when a qualifying wound is present.

Related policies:

- Hyperbaric Oxygen (HBO) Therapy No. 91151
- Durable Medical Equipment No. 91110
- Orthotics/Orthoses/Support Devices No. 91339
- Skin Substitutes and Soft Tissue Grafts No. 91560
- Platelet Rich Plasma/ Platelet Rich Fibrin Matrix/Autologous Blood-Derived Products/BMAC No. 91553

I. MEDICAL NECESSITY CRITERIA

Qualifying Wound Requirements:

Surgical dressings are considered medically necessary when a qualifying wound is present. A qualifying wound is defined as either of the following:

- A wound caused by, or treated by, a surgical procedure; or,

- Wound after debridement, regardless of the debridement technique

Products Eligible for Classification as Surgical Dressings Include:

- Primary dressings – Therapeutic or protective coverings applied directly to wounds or lesions on the skin or to openings through the skin; and

- Secondary dressings – Materials that serve a therapeutic or protective function and are used to secure or cover a primary dressing.

Surgical dressings and surgical wound care supplies are considered medically necessary for **qualifying wounds** when **all** the following **general and specific guidelines** are met:

A. General Guidelines:

1. **Qualifying Wound Present:**
   a. The member has a qualifying wound as defined above.

2. **Order and Supplier Requirements:**
   a. Member has a signed and dated written order from the treating practitioner for each item.

3. **Frequency Justification:**
   a. Medical necessity is documented in the member's medical record to support dressing changes that exceed the frequency recommendations outlined in this policy.

4. **Initial Wound Evaluation Documentation:**

   For an initial wound evaluation, clinical records from the treating practitioner, nursing facility, or home care provider must include **all** of the following:
   a. Type of qualifying wound
   b. Location, number, and size of each wound
   c. Identification of primary and/or secondary dressing(s)
   d. Amount of wound drainage
   e. Type of dressing(s) applied
   f. Quantity used per dressing change for each wound
   g. Frequency of dressing changes
   h. Any other relevant clinical information

5. **Ongoing Wound Supply Documentation:**

   Clinical documentation must support the **continued medical necessity** of wound dressings and supplies and must include the following:

   a. Ongoing Wound Evaluation:
      i. The wound(s) must be evaluated at least monthly by the treating practitioner or designee

ii. Weekly evaluations are expected for:
    - Members residing in a nursing facility, or
    - Wounds that are heavily draining or infected

iii. If an evaluation cannot be completed within the expected timeframe, the medical record must:
    - Explain why the evaluation was not performed, **and**
    - Describe alternative monitoring methods used to assess the continued need for dressings and supplies

6. **Required Elements of Wound Evaluations**:

   Each wound evaluation must document **all** of the following:
   a. The type of wound
   b. Location of the Wound
   c. Wound size (length x width) and depth
   d. Amount of drainage
   e. Any other relevant wound status information supporting continued treatment

B. Product-Specific Guidelines:

The member must meet all applicable medical necessity criteria for the specific surgical dressing or wound care product requested.

1. **Alginate or other Fiber Gelling Dressing**
   HCPCS: A6196, A6197, A6198, A6199
   a. Indications:
      i. Moderately to highly exudative, full-thickness wounds or wound cavities, (e.g., Stage III and Stage IV ulcers)
      ii. Requires a secondary dressing
   b. Dressing Change Frequency:
      i. Up to once per day
      - Use per dressing change:
        - Wound cover sheets:
          - One dressing of appropriate size per wound per change
        - Wound fillers (rope form):
          - Up to 2 units per dressing change
          - 1 unit = 6 inches of alginate or fiber gelling rope
   c. Maximum One-Month Supply:
      i. Dressings: Up to 30 per wound
      ii. Wound filler: Up to 60 units per wound (360 inches)
   d. Not Reasonable and Medically Necessary for:
      i. Dry or minimally exudative wounds
      ii. Third degree (full-thickness) burns
      iii. Wounds with exposed bone or tendon
      iv. Wounds covered with eschar

v. Use in combination with hydrating dressings (e.g., hydrogels)

2. **Collagen-Based Dressings and Wound Filler**
   HCPCS: A6010, A6011, A6021, A6022, A6023, A6024
   a. Indications:
      i. Full-thickness wounds or wound cavities (e.g., Stage III/ IV ulcers)
      ii. Wounds with light to moderate exudate
      iii. Wounds that have stalled or have not progressed toward a healing goal despite appropriate standard wound care
   b. Dressing Change Frequency:
      i. Up to once per day.
   c. Maximum One-Month Supply:
      i. Dressings: Up to 30 per wound
      ii. Wound filler: Up to 30 units per wound
   d. Not Reasonable and Medically Necessary:
      i. Closed surgical incisions
      ii. Wounds with heavy exudate
      iii. Wounds with heavy eschar
      iv. Third-degree burns
      v. Presence of active vasculitis

3. **Composite Dressing**
   HCPCS: A6203, A6204, A6205
   a. Indications:
      i. Moderately to highly exudative wounds requiring absorption and protection from contamination (e.g., fistulas or sinuses, surgical wound)
   b. Dressing Change Frequency:
      i. Up to 3 times per week
      ii. One wound cover per dressing change
   c. Maximum One-Month Supply:
      i. Dressings: Up to 12 dressings per wound

4. **Contact Layer Dressings**
   HCPCS: A6206, A6207, A6208
   a. Indications:
      i. Open wound bed to protect the wound tissue from direct contact with other agents or dressings
      applied to the wound; requires a secondary dressing.
   b. Dressing Change Frequency:
      i. Up to once per week
      ii. Contact layer dressings are not intended to be changed with each dressing change
   c. Maximum One-Month Supply:
      i. Dressings: Up to 4 per wound
   d. Not Reasonable and Medically Necessary:
      i. Use with dressings that contain a non-adherent or semi-adherent layer
      ii. Stage I pressure ulcers

iii. Third-degree burns
iv. Dry wounds
v. Wounds covered with eschar

5. **Foam Dressing and Foam Wound Filler**
   HCPCS: A6209, A6210, A6211, A6212, A6213, A6214, A6215
   a. Indications:
      i. Primary dressing for moderate to heavy exudative Full-thickness wounds or wound cavities (e.g., Stage III/ IV ulcers); or
      ii. Secondary dressing for wounds with very heavy exudate.
   b. Dressing Change Frequency:
      i. Foam Dressings:
         - Up to 3 times per week when used as a primary dressing or a secondary dressing for wounds with heavy exudate.
      ii. Foam Wound Filler: up to once per day.
   c. Maximum One-Month Supply:
      i. Foam dressings: Up to 12 per wound.
      ii. Foam wound fillers: Up to 30 per wound *(1 unit = 1 gram)*
   d. Not reasonable and medically necessary:
      i. Third-degree or full thickness burns; or
      ii. Dry or non-draining wounds.

6. **Gauze-Impregnated with Water or Normal Saline**
   HCPCS: A6228, A6229, A6230
   a. Indications:
      i. No proven medical necessity compared to **non-impregnated gauze moistened at the time of use**
      ii. Considered **not reasonable and not medically necessary**

7. **Gauze-Impregnated with Other than Water or Normal Saline**
   HCPCS: A6222, A6223, A6224, A6231, A6232, A6233; A6266
   a. Indications:
      i. Based on the characteristics of the impregnating material and wound needs
   b. Dressing Change Frequency:
      i. Up to once per day.
   c. Maximum One-Month Supply:
      i. Dressings: Up to 30 per wound

8. **Gauze- Non-impregnated**
   HCPCS: A6216, A6217, A6218, A6219, A6220, A6221; A6402, A6203, A6404
   a. Indications:
      i. Partial or full-thickness wounds with minimal to moderate exudate
   b. Dressing Change Frequency:
      i. Without border: up to 3 times per day
      ii. With adhesive border: Up to once per day

c. Maximum One-Month Supply:
    i. Without border: Up to 200 per wound
    ii. With border: Up to 62 per wound
d. Not Reasonable and Medically Necessary:
    i. Stacking more than **two gauze pads** in one area
    ii. Use solely for cleansing or debridement when not left in place

9. Gradient Compression Stockings/Wraps

HCPCS: A6531, A6532, A6545

a. Indications:
    i. Treatment of an open venous stasis ulcer meeting qualifying wound requirements. May have straps or zippers.
    ii. These compression stockings/wraps are used specifically as a **secondary dressing over the primary dressing** and are washable and intended to be reused and NOT changed with each dressing change.
b. Replacement Frequency:
    i. Replacement is limited to **no more than once every six (6) months per limb**, unless medical necessity for earlier replacement is documented
    ii. **Replacement prior to six (6) months** may be considered medically necessary for indications such as:
        - Loss of compression integrity; or
        - Significant change in limb size; or
        - Damage
    iii. Replacement earlier than 6 months requires clear documentation, such as:
        - Loss of compression integrity
        - Significant change in limb size
        - Loss of compression integrity
        - Significant change in limb size
c. Not Reasonable and Medically Necessary:
    i. No Ulcer Present*****, including
        - Venous insufficiency without ulceration
        - Ulcer prevention or recurrence
        - Lymphedema without an open ulcer

*****With no ulcer being present, the stockings/wraps do not meet the definition of a surgical dressing, as there is no qualifying wound.

10. Hydrocolloid Dressing or Hydrocolloid Wound Filler

HCPCS: A6234, A6235, A6236, A6237, A6238, A6239, A6240, A6241

a. Indications:
    i. Lightly to moderately exudating wounds
b. Dressing Change Frequency:
    i. Dressings: Up to 3 times per week
    ii. Wound fillers (paste or dry form): Up to 3 times per week
c. Maximum One-Month Supply:
    i. Dressings: Up to 12 per wound

ii. Wound Fillers: Up to 3 units per wound

d. Not reasonable and Medically Necessary:
   i. Full-thickness burns
   ii. Heavily exudative wounds
   iii. Deep tunnels, tracts, or undermining
   iv. Exposed tendon or bone
   v. Fungal or herpetic lesions

11. Hydrogel Dressing and Hydrogel Wound Filler

HCPCS: A6242, A6243, A6244, A6245, A6246, A6247, A6248

a. Indication:
   i. Full-thickness wounds or wound cavities (e.g., stage III/ IV ulcers) with minimal or no exudate
b. Dressing Change Frequency:
   i. Dressings:
      - Adhesive border: Up to 3 times per week.
      - Non-adhesive border: Up to once per day
   ii. Wound fillers: Up to once per day
c. Maximum One-Month Supply:
   i. Dressings:
      - Adhesive border: Up to 12 per wound
      - Non-adhesive border: Up to 30 per wound
   ii. Wound fillers:
      - Up to 3 units per wound *(3 fluid ounces)*
d. Not Reasonable and Medically Necessary:
   i. Stage II ulcers
   ii. Full-thickness burns
   iii. Heavily exudative wounds
   iv. Use with absorptive dressings (e.g., alginates)
   v. Concurrent use of multiple hydrogel products on the same wound

12. Light Compression Bandages, Moderate/High Compression Bandage, Self-Adherent Bandage, Conforming Bandages and Padding Bandages

HCPCS: A6441, A6442, A6443, A6444, A6445, A6446, A6447, A6448, A6449, A6450, A6451, A5452, A6453, A6454, A6455, A6457

a. Indications:
   i. Light compression, conforming or self-adherent bandages used as secondary dressings over a qualified wound
   ii. Moderate/ high compression, conforming, padding or self-adherent bandages used as part of a multi-layer compression bandage system for venous stasis ulcer(s)
b. Dressing Change Frequency:
   i. Once per week unless part of a multi-layer compression bandage system.
c. Maximum One-Month Supply:
   i. Up to 4 per wound
d. Not Reasonable and Medically Necessary:
   i. Used for non-wound indications including:
      - Strains

- Sprains
- Edema without ulceration
- Any situation other than use as a dressing for a qualifying wound

13. Packing Strips

HCPCS: A6407

a. Indications:
   i. Placement into open wounds to eliminate dead space, absorb exudate, or maintain a moist wound surface
b. Dressing Change Frequency:
   i. 1 unit (1 linear yard) per day
c. Maximum One-Month Supply:
   i. Up to 30 units (30 linear yards) per wound
d. Not reasonable and Medically Necessary:
   i. Dry or minimally exudative wounds
   ii. Superficial wounds

14. Specialty Absorptive Dressings

HCPCS: A6251, A6252, A6253, A6254, A6255, A6256

a. Indications:
   i. Moderate to highly exudative full-thickness wounds (e.g., Stage III/IV ulcers)
b. Dressing Change Frequency:
   i. Without adhesive border: Once per day
   ii. With adhesive border: Every other day
c. Maximum One-Month Supply:
   i. Without border: Up to 30 per wound
   ii. With border: Up to 15 per wound
d. Not reasonable and Medically Necessary:
   i. Dry wounds
   ii. Wounds with minimal or no exudate

15. Tape

HCPCS: A4450, A4452

a. Indications:
   i. Securing wound covers that do not have an adhesive border
b. Tape Change Frequency:
   i. Determined by the frequency of the wound cover change
c. Utilization Guidelines:
   i. Tape quantities must be reasonable and based on the size of the wound cover:
      - **≤16 sq in:** Up to **2 units** (36 sq in / 3 ft)
      - **>16–48 sq in:** Up to **3 units** (54 sq in / 4.5 ft)
      - **>48 sq in:** Up to **4 units** (72 sq in / 12 ft)
d. Maximum One-Month Supply:
   i. 240 units (4,860 sq. in. / 360 ft.)
e. Not Reasonable and Medically Necessary:
   i. Use with adhesive border dressings

16. **Transparent Film Dressings**
    HCPCS: A6257, A6258, A6259
    a. Indications:
        i. Open partial-thickness (Stage II) wounds with minimal exudate
        ii. Closed or epithelializing wounds
    b. Dressing Change Frequency:
        i. Up to 3 times per week
    c. Maximum One-Month Supply:
        i. Up to 12 per wound
    d. Not Reasonable and Medically Necessary:
        i. Moderately to heavily exudative wounds
        ii. Full-thickness burns
        iii. Infected wounds

17. **Wound Fillers, Not Elsewhere Classified**
    HCPCS: A6261, A6262
    a. Indications:
        i. Primary dressing placed into open wounds to eliminate dead space, absorb exudate, or maintain a moist wound surface.
    b. Dressing Change Frequency:
        i. Up to once per day
    c. Maximum One-Month Supply:
        i. Up to 3 units per wound
    d. Not Reasonable and Medically Necessary:
        i. Dry wounds
        ii. Wounds with minimal or no exudate

18. **Wound Pouch**
    HCPCS: A6154
    a. Indication:
        i. Adherence to skin surrounding a wound to collect drainage.
    b. Dressing Change Frequency:
        i. Up to three times per week
    c. Maximum One-Month Supply: 12 pouches
    d. Not Reasonable and Medically Necessary:
        i. Intact skin
        ii. Prophylactic skin protection
        iii. Incontinence management
        iv. Cosmetic or convenience purposes

19. **Zinc Paste Impregnated Bandages (e.g., Unna boots dressing)**
    HCPCS: A6456
    a. Indications:
        i. Venous leg ulcers
    b. Dressing Change Frequency:
        i. Once per week
    c. Maximum One-Month Supply: 4 bandages per wound
    d. Not Reasonable and Medically Necessary:

i. No Ulcer Present
ii. Used for prophylactic indications
iii. Used for non-wound indications

Limitations:

A. Supply Amount

1. No more than a **one-month supply** of dressings is considered medically necessary at one time, unless documentation supports the need for a larger quantity in the home setting.
   Note: A calendar month runs from a date in one month to the same date in the following month.

B. Supplier Oversight

1. Suppliers must monitor how many dressings the member is actually using and adjust the quantity supplied as needed.

C. Adhesive Border Dressings

1. Dressings with an adhesive border are designed to secure directly to the skin and do not usually require additional dressings or tape. Use of extra tape should be supported by documentation.

D. Multiple Dressings on the Same Wound

1. Using more than one type of wound filler or wound cover on the same wound is not medically necessary.
2. **Exception:** An alginate or other fiber-gelling dressing, or a saline-, water-, or hydrogel-impregnated gauze, may require a secondary wound cover.

E. Dressing Change Frequency

1. Dressing change frequency depends on the type of dressing used. When multiple dressing components are used together, their change schedules should be similar. The dressing in direct contact with the wound determines the overall change frequency. Combining dressings with different change intervals is not medically necessary.

F. Dressing Size

1. Dressings must be appropriately sized to the wound. Wound covers should generally extend about **2 inches beyond the wound edges**. For example, a 2 × 2 inch wound typically requires a 4 × 4-inch dressing.

Exclusions:

A. Non-Qualifying Products

Products that cannot be used as a primary or secondary dressing on a qualifying wound of the skin, or that do not provide a therapeutic or protective function, do not meet the definition of a surgical dressing and are not considered medically necessary.

These include, but are not limited to, the following:

1. Skin sealants or barrier products (A6250)
2. Gloves (A4927)

3. Wound cleansers or irrigating solutions (A6260)
4. Enzymatic debriding agents (not eligible for coverage under the surgical dressing benefit. These products are not separately payable when used in the outpatient hospital setting and may be covered under the pharmacy benefit for home use, when applicable)
5. Solutions used only to moisten gauze (e.g., saline, sterile water)
6. Topical Antibiotics
7. Topical Antiseptics
8. Gauze or other materials used solely for cleansing or debridement and not left in place as a dressing
9. First-aid type adhesive bandages (e.g., Band-Aid or similar product) (A6413)
10. Small adhesive bandages not primarily intended for wound treatment (A9270)
11. Surgical stockings not used as surgical dressings for qualifying wounds (A4490, A4495, A4500, A4510)
12. Silicone gel sheets (A6025) (this code represents use of sheets for the treatment of keloids or other scars, not a surgical wound).
13. Elastic stockings, support hose, foot coverings, leotards, knee supports, or surgical leggings
14. Non-elastic binders for an extremity (A4465)
15. Dressings that do not require a prescription and are available over the counter
16. Take-home supplies provided to a member
17. The following gradient compression stockings are not considered surgical dressings and do not meet the definition of a qualifying dressing under this policy: A6530, A6533, A6534, A6535, A6536, A6537, A6538, A6539, A6540, A6541, A6544, A6549

B. Provider-Applied Dressings

1. When a physician or other provider applies surgical dressings as part of a professional service, the dressings are considered incidental to the procedure and are not separately payable.

Experimental/Investigational:

A. Non-Qualifying Clinical Situations

Surgical dressings and wound care supplies are not covered under the Surgical Dressings benefit when a qualifying wound is not present or when there is insufficient evidence of clinical benefit.

Examples include, but are not limited to, the following:

1. Drainage from a cutaneous fistula that has not been caused by or treated through a surgical procedure.
2. Stage I pressure ulcers with intact skin.
3. First-degree burns.
4. Minor traumatic wounds that do not require surgical closure or debridement (e.g., skin tears or abrasions).
5. Venipuncture or arterial puncture sites (e.g., blood draw sites), except when related to an indwelling catheter or needle.

II. CENTERS FOR MEDICARE & MEDICAID SERVICES (CMS) COVERAGE DETERMINATION

Any applicable federal or state mandates will take precedence over this medical coverage policy.

Medicare: Refer to the CMS Online Manual System (IOMs) and Transmittals.
For the most current applicable CMS National Coverage Determination (NCD)/Local Coverage Determination (LCD)/Local Coverage Article (LCA) refer to CMS Medicare Coverage Database.

The information below is current as of the review date for this policy. However, the coverage issues and policies maintained by CMS are updated and/or revised periodically. Therefore, the most current CMS information may not be contained in this document. MAC jurisdiction for purposes of local coverage determinations is governed by the geographic service area where the Medicare Advantage plan is contracted to provide the service. Please refer to the Medicare Coverage Database website for the most current applicable NCD, LCD, LCA, and CMS Online Manual System/Transmittals.

National Coverage Determinations (NCDs)	
NCD - Treatment of Decubitus Ulcers (270.4)	
Local Coverage Determinations (LCDs)	
CGS Administrators, LLC	LCD - Surgical Dressings (L33831)
First Coast Service Options, Inc.	LCD - Wound Care (L37166)
National Government Services, Inc.	LCD - Debridement Services (L33614)
Noridian Healthcare Solutions	LCD - Surgical Dressings (L33831) LCD - Wound and Ulcer Care (L38902)
Novitas Solutions, Inc.	LCD - Wound Care (L35125)
Palmetto GBA	Not Identified
WPS Insurance Corporation	LCD - Wound Care (L37228)

III. BACKGROUND

Qualifying Surgical Wounds

This policy applies exclusively to **qualifying surgical wounds**. Surgical dressings are considered medically necessary **only** when a qualifying wound is present, defined as either:

- a **wound caused by or treated by a surgical procedure**; or
- **a wound following debridement**, regardless of the debridement technique.

All clinical principles, dressing selection strategies, and supporting evidence described below apply **only to qualifying surgical wounds** and are not intended for intact skin, preventive use, or non-surgical wound care.

Overview of Surgical Wound Management

Effective management of surgical wounds requires a structured, evidence-based approach that supports tissue repair while minimizing complications such as infection, dehiscence, delayed healing, and excessive exudate. International wound care guidance emphasizes that surgical wound healing is optimized through coordinated interventions including wound bed preparation, debridement when indicated, effective exudate management, and appropriate dressing selection based on wound characteristics and

healing stage. These principles are consistent with international wound care consensus guidance and Wound Healing Society (WHS) recommendations across multiple wound etiologies (Wounds International, 2023; World Union of Wound Healing Societies (WUWHS), 2019; Gould et al., 2024; Lavery et al., 2024).

Wound Bed Preparation
Wound bed preparation is a foundational principle in surgical wound management and is intended to create and maintain an environment conducive to healing. This approach is commonly described using the TIME framework, which addresses removal of nonviable tissue, control of infection and inflammation, maintenance of appropriate moisture balance, and advancement of the wound edge toward epithelialization. In surgical wounds, effective wound bed preparation supports appropriate dressing use and reduces postoperative wound complications (Wounds International, 2023; International Wound Infection Institute (IWII), 2022).

Debridement
Debridement is a core component of surgical wound care and may be performed intraoperatively or postoperatively to remove necrotic, devitalized, or contaminated tissue. Debridement reduces bacterial burden and biofilm, improves visualization of viable tissue, and facilitates progression from a prolonged inflammatory phase toward active healing. Accepted debridement techniques include sharp, mechanical, enzymatic, and autolytic methods, with selection based on wound characteristics and clinical judgment (Thomas et al., 2021; IWII, 2022). Wounds following debridement meet qualifying wound requirements under this policy and typically require ongoing surgical dressings.

Debridement is a core component of wound bed preparation that involves the removal of necrotic, devitalized, or infected tissue to restore a balanced wound environment and support healing. By eliminating physical and biological barriers to repair, debridement helps accelerate the healing process, reduce bacterial burden and biofilm, and lower the risk of infection and wound-related complications. It also facilitates the transition of chronic, non-healing wounds from a prolonged inflammatory state to one capable of progressing toward healing (Thomas et al., 2021).

The method and frequency of debridement may vary based on the clinical setting, wound characteristics, and clinician expertise. Examples of debridement methods include (examples given are not all-inclusive):

- **Surgical** (e.g., sharp instrument or laser)
- **Mechanical** (e.g., irrigation or wet-to-dry dressings)
- **Chemical** (e.g., topical application of enzymes)
- **Autolytic** (e.g., application of occlusive dressings to an open wound)

Wounds following debridement, regardless of technique, meet qualifying wound requirements under this policy and typically require ongoing surgical dressings to support healing and exudate management.

Exudate Management in Surgical Wounds
Wound exudate is a normal component of healing following surgery; however, excessive, insufficient, or poorly managed exudate may delay healing and contribute to peri-wound skin breakdown and infection risk. Effective exudate management in surgical wounds focuses on maintaining moisture balance, protecting surrounding skin,

minimizing wound-related symptoms, and supporting patient mobility and recovery. Dressing selection and change frequency should reflect the volume, consistency, and duration of exudate and should be reassessed as wound conditions evolve (WUWHS, 2019; Wounds International, 2023).

Appropriate Dressing Selection for Surgical Wounds
Surgical dressings are medical supplies used to protect surgical wounds, manage exudate, support an optimal healing environment, and reduce the risk of infection or further tissue injury. No single dressing type has been shown to be universally superior for surgical wound healing; rather, dressings are selected based on functional need and wound-specific characteristics, including wound depth, tissue exposure, level of exudate, anatomic location, and risk of contamination (WHS, 2023; International Working Group on the Diabetic Foot [IWGDF], 2023).

An ideal surgical dressing prevents contamination, maintains a moist wound environment, minimizes trauma to the wound and surrounding skin, and allows patient comfort and mobility. For higher-risk surgical wounds or wounds with moderate exudate, preferred dressings are those that absorb and retain larger volumes of fluid, reduce dressing change frequency, and allow visual assessment of surrounding skin. International consensus further identifies key functional properties of an ideal dressing, including flexibility, secure fixation, absorbency, protection of peri-wound skin, waterproof barrier function, and elimination of dead space when clinically indicated (Wounds International, 2023; WUWHS, 2019).

The Wound Healing Society (WHS) notes that surgical dressings used as part of wound bed preparation may consist of primary and secondary dressings. A primary dressing is selected to directly support healing at the wound surface, while secondary dressings are used to secure the primary dressing, provide additional absorption, or protect surrounding tissue, particularly in moderate- to high-exudating surgical wounds. Certain products, such as transparent film dressings, may function as either a primary or secondary dressing depending on surgical wound characteristics and clinical intent (Gould et al., 2024).

Guidance from the International Working Group on the Diabetic Foot (IWGDF) supports dressing selection principles that are applicable to surgically managed wounds (ulcers), emphasizing that dressings should absorb exudate, maintain a moist wound healing environment, and be selected based on functional need and cost considerations appropriate to the healthcare setting. The IWGDF does not recommend routine use of topical antimicrobial or antiseptic dressings for wound healing in the absence of diabetes related foot ulcers (IWGDF, 2023).

Dressing selection should be guided primarily by wound depth and level of exudate to support an optimal healing environment:

- **Dry surgical wounds** generally require moisture-donating dressings, such as hydrogels, with or without a foam or low-adherent cover, to rehydrate the wound bed and facilitate autolytic debridement.
- **Surgical wounds with low levels of exudate** benefit from dressings that maintain moisture balance, including hydrogels, foams, low-adherent dressings, or hydrated polyurethane dressings.

- **Moderate to heavily exuding surgical wounds** require absorbent dressings capable of managing larger fluid volumes and protecting peri-wound skin, such as alginates, carboxymethylcellulose (hydrofiber) dressings, foams, superabsorbent dressings, and, when clinically appropriate, negative pressure wound therapy.
- **As surgical wounds progress to epithelialization with minimal or no exudate**, low-adherent or protective cover dressings may be used to protect fragile new tissue and prevent desiccation.
- **In deep or cavity surgical wounds**, dressing selection should account for wound depth, with strips, ribbons, or rope forms of appropriate dressing material used to gently fill dead space according to the level of exudate, supporting absorption while avoiding overpacking and tissue trauma (WUWHS, 2019; Wounds UK, 2010).

Pressure Injury Staging (When Surgically Treated)
When pressure injuries are treated surgically or following surgical debridement, standardized staging definitions are used to describe wound depth and tissue involvement. Accurate staging supports appropriate surgical wound management and dressing selection (American College of Surgeons [ACS], 2018).

Pressure Injury Staging (National Pressure Injury Advisory Panel (NPIAP), 2019)

Stage	Description
Stage 1	Intact skin with persistent, non-blanchable redness. Early changes in sensation, temperature, or firmness may occur before visible skin changes. Purple or maroon discoloration indicates deeper injury.
Stage 2	Partial-thickness skin loss with exposed dermis. The wound bed is pink or red, moist, and may appear as a blister. No slough, eschar, or visible deeper tissue. Excludes moisture-associated skin damage and traumatic wounds.
Stage 3	Full-thickness skin loss with visible subcutaneous fat. Granulation tissue, rolled wound edges, slough, or eschar may be present. Undermining or tunneling may occur; muscle, tendon, or bone are not exposed.
Stage 4	Full-thickness skin and tissue loss with exposed or palpable fascia, muscle, tendon, or bone. Slough, eschar, undermining, and tunneling are commonly present.
Unstageable	Full-thickness skin and tissue loss in which the depth cannot be determined due to slough or eschar. Once removed, the injury will be classified as Stage 3 or Stage 4. Stable eschar on heels or ischemic limbs should not be removed.
Deep Tissue Pressure Injury	Persistent deep red, maroon, or purple discoloration of intact or non-intact skin. Often preceded by pain or temperature changes. Caused by prolonged pressure and shear and may rapidly worsen or resolve.

Wound Dressings and Compression Devices

Surgical wound dressings and related compression devices may be categorized by material composition and functional properties, including absorptive dressings, moisture-retentive dressings, gauze-based products, contact layers, specialty dressings, and compression systems. Each category serves a distinct role in the management of qualifying surgical wounds. Selection is guided by wound characteristics, exudate level, and therapeutic goals rather than product brand or cost alone. Bandages and compression systems may be used to secure dressings, protect surgical wounds, reduce edema, and deliver therapeutic compression when clinically indicated and when a qualifying wound is present.

Consistent with society-level guidance, the following product categories are supported by clinical literature for use in appropriately selected surgical wounds, based on wound characteristics and functional need:

Absorptive and Moisture-Managing Dressings:

- *Alginate or Other Fiber Gelling Dressing / Wound Filler*
  - Highly absorbent dressings composed of calcium alginate or similar fibers that interact with wound exudate to form a gel, supporting moisture balance and autolytic debridement. These dressings are used for moderate to heavily exudative wounds and may be applied as wound covers or cavity fillers.
- *Foam Dressing or Wound Filler*
  - Polyurethane or silicone-based dressings designed to absorb moderate to heavy exudate while providing cushioning and thermal insulation. Foam dressings may be used as primary wound covers or as fillers for cavity wounds.
- *Specialty Absorptive Dressing*
  - Dressings engineered for wounds with very high levels of exudate, often incorporating super-absorbent materials to reduce peri-wound maceration and maintain moisture balance.

Biologic and Advanced Dressings:

- *Collagen Dressing or Wound Filler*
  - Dressings containing native or processed collagen intended to provide a scaffold for cellular migration and to help modulate the wound environment in selected chronic or non-healing wounds.
- *Composite Dressing*
  - Multi-layer dressings that combine absorbent pads, adhesive borders, and protective backing materials, allowing them to function as both primary and secondary dressings.

Contact and Cover Dressings (also referred to as non-adherent dressings)**:**

- *Contact Layer*
  - Low-adherent dressings placed directly on the wound bed to prevent adherence and minimize trauma during dressing changes while allowing exudate to pass to a secondary dressing.
- *Transparent Film Dressing*

- Thin, semi-permeable polyurethane membranes that protect superficial wounds while allowing gas exchange; these dressings are not absorbent and are used primarily for protection.

Gauze-Based Dressings:

- *Gauze, Non-Impregnated*
  - Woven or non-woven cotton dressings used for wound coverage, absorption, protection, or packing; typically require frequent changes and secondary fixation.
- *Gauze, Impregnated, With Other Than Water, Normal Saline, Hydrogel, or Zinc Paste*
  - Gauze impregnated with substances such as petrolatum or antimicrobial agents to reduce adherence or deliver topical therapy.
- *Gauze, Impregnated, Water or Normal Saline*
  - Pre-moistened gauze intended to provide short-term moisture; these dressings do not provide clinical benefit over non-impregnated gauze moistened at the time of use.

Moisture-Retentive Dressings (used to support moisture balance):

- *Hydrocolloid Dressing*
  - Occlusive or semi-occlusive dressings that form a gel upon contact with wound exudate, promoting autolytic debridement in wounds with low to moderate exudate
- *Hydrogel Dressing*
  - Water- or glycerin-based dressings that donate moisture to dry or necrotic wounds and support autolytic debridement; typically require a secondary dressing.

Specialty Wound Management Devices:

- *Wound Filler, Not Elsewhere Classified*
  - Materials used to pack deep, tunneling, or cavity wounds when standard wound fillers are not appropriate.
- *Wound Pouch*
  - Collection devices designed to contain high-volume wound or fistula drainage and protect surrounding skin.

Bandages, Tape, and Compression Systems:

- *Zinc Paste Impregnated Bandage*
  - Bandages containing zinc oxide used primarily in the management of venous statis ulcers, providing skin protection and mild compression.
- *Tape*
  - Adhesive materials used to secure dressing or medical devices; selection is based on skin condition and anticipated duration of use.
- *Light Compression Bandage*
  - Bandages providing mild compression for support or edema control.
- *Moderate/High Compression Bandage*

    - Bandages delivering therapeutic levels of compression, commonly used in venous insufficiency.
- *Self-Adherent Bandage*
    - Cohesive bandages that adhere to themselves without adhesive, used to secure dressings and provide support.
- *Conforming Bandage*
    - Flexible bandages designed to adapt to body contours and joint areas.
- *Padding Bandage*
    - Bandages used to cushion wounds, distribute pressure, and protect underlying tissue.
- *Gradient Compression Wrap*
    - Compression systems designed to deliver graduated pressure, typically highest distally and decreasing proximally, for management of venous insufficiency or lymphedema.

Contraindications for wound dressings are determined by dressing category, wound characteristics, and manufacturer instructions for use. Authoritative sources, including World Union of Wound Healing Societies (WUWHS) consensus documents, WoundSource clinical guidance, and manufacturer labeling, describe clinical situations in which specific dressing types should be avoided. Common examples include the use of highly absorbent dressings on dry or minimally exudative wounds, which may result in wound desiccation, and the use of occlusive dressings in the presence of untreated infection, which may impair drainage and worsen infection.

Alginate and other fiber-gelling dressings are highly absorbent wound care products designed to interact with wound exudate to form a hydrophilic gel and are most effective in moderately to highly exudative full-thickness wounds and wound cavities, including surgically treated Stage III and IV pressure ulcers (Wound Care Education Institute [WCEI], 2026; Qu et al., 2023). While systematic reviews of randomized controlled trials demonstrate that alginate dressings can improve exudate management, reduce dressing change frequency, and decrease wound-related pain compared with traditional dressings, these benefits are dependent on appropriate wound selection, particularly the presence of substantial exudate (Qu et al., 2023).

Consistent with society-level dressing selection principles, alginate and fiber-gelling dressings are not appropriate for dry or minimally exudative wounds, as their high absorptive capacity may desiccate the wound bed and impede healing. They are also contraindicated in wounds covered with eschar, where devitalized tissue must be addressed prior to use, and in third-degree (full-thickness) burns, which require burn-specific management strategies. In addition, Centers for Medicare & Medicaid Services (CMS) and clinical guidance indicate that alginate dressings should not be used concurrently with hydrating dressings such as hydrogels, as this represents duplicative or conflicting moisture management without added clinical benefit (CMS, 2024).

Collagen-based dressings and wound fillers are bioactive wound care products designed to support healing in full-thickness wounds and wound cavities by providing a temporary extracellular matrix scaffold that promotes cellular migration and granulation tissue formation and helps modulate excessive protease activity. Society-level wound care guidance recognizes collagen dressings as an adjunctive therapy for wounds that

have stalled or failed to progress toward a healing goal despite appropriate standard wound care, including adequate debridement, moisture balance, and management of underlying contributing factors (e.g., offloading, compression, or revascularization) (Wound, Ostomy and Continence Nurses Society [WOCN], 2021). Systematic reviews and narrative syntheses suggest that collagen dressings may improve healing outcomes in selected wounds when used as part of comprehensive wound management; however, these benefits are context-dependent and rely on appropriate wound selection and control of exudate and inflammation (Shi et al., 2023; Alberts et al., 2025).

Consistent with their mechanism of action, collagen-based dressings and wound fillers are not appropriate for wounds with heavy exudate, where frequent saturation limits effective collagen interaction with the wound bed and reduces bioactive function. They are also contraindicated in wounds covered with heavy eschar, where necrotic tissue must be removed before bioactive dressings can function, and in third-degree (full-thickness) burns, which require burn-specific management strategies rather than standard surgical dressings. In addition, collagen dressings are not indicated in the presence of active vasculitis, where uncontrolled inflammatory disease undermines wound healing and may worsen tissue injury. Use of collagen products outside these parameters may negate potential benefit and contribute to delayed or ineffective wound healing.

Contact layer dressings are thin, non-adherent interfaces placed directly on an open wound bed to protect fragile tissue and minimize trauma during dressing changes. Society-level wound care guidance characterizes contact layers as protective interfaces rather than absorptive or therapeutic dressings, emphasizing that they must be used in conjunction with a secondary dressing to manage exudate and secure the wound environment. Their primary function is to prevent adherence of secondary dressings or topical agents while allowing exudate to pass through to an overlying absorbent dressing (WoundSource, 2025). Consistent with this role, contact layer dressings are intended to remain in place for extended periods and are not designed to be changed with each secondary dressing change. CMS coverage guidance reflects this function by specifying a usual change frequency of up to once per week, reinforcing their role as a stable wound interface rather than a consumable dressing (Centers for Medicare & Medicaid Services [CMS], 2024).

Based on their mechanism of action, contact layer dressings are not medically appropriate when used with dressings that already incorporate a non-adherent or semi-adherent layer, as this represents duplicative functionality without added clinical benefit. They are also contraindicated in wounds that do not require protection of the wound bed, including Stage I pressure ulcers with intact skin, dry or non-draining wounds, wounds covered with eschar, and third-degree (full-thickness) burns, where alternative wound-specific management strategies are required. Use of contact layer dressings in these settings does not meet reasonable and necessary criteria due to lack of clinical utility and potential interference with appropriate wound assessment or treatment.

Foam dressings are absorptive wound care products designed to manage moderate to heavy wound exudate, particularly in full-thickness wounds and wound cavities. Society-level guidance recognizes that foam dressings support moist wound healing by absorbing excess exudate while providing thermal insulation and protecting peri-wound skin from maceration, allowing their use as either primary dressings for exudative

wounds or secondary dressings when exudate levels are very high (Nair et al., 2024). Clinical reviews describe foam dressings as most effective when exudate control is necessary to reduce prolonged inflammation and infection risk, noting that their clinical benefit is closely tied to appropriate wound selection and exudate burden (Hargis et al., 2024).

Consistent with their absorptive mechanism, foam dressings are not appropriate for dry or minimally exudative wounds, where insufficient moisture may result in wound bed desiccation and delayed healing. They are also not indicated for wounds where absorptive capacity is unnecessary, as inappropriate use may obscure wound assessment and contribute to overutilization without clinical benefit. Consensus guidance further supports limitations on dressing change frequency and quantity to reflect typical clinical use, emphasizing that foam dressings should be reserved for situations in which active exudate management is clinically indicated (Hargis et al., 2024; Nair et al., 2024).

Society-level wound care guidance emphasizes that the primary clinical function of saline-based gauze dressings is moisture provision, a function that can be achieved effectively by moistening standard non-impregnated gauze at the point of care. Available evidence does not demonstrate that factory-impregnated saline gauze improves wound healing outcomes, reduces infection risk, or decreases dressing change frequency when compared with non-impregnated gauze moistened as needed. As a result, routine use of pre-impregnated saline gauze is not supported as a distinct medical necessity. Contemporary reviews of wound management characterize gauze-based dressings as legacy interventions, noting that while they may temporarily maintain moisture, they do not sustain an optimal wound environment and typically require frequent re-wetting or replacement. Importantly, pre-impregnated saline gauze does not overcome these limitations and does not meaningfully alter healing trajectories compared with standard moistened gauze, underscoring the lack of added clinical benefit associated with routine use (Popescu et al., 2023).

Non-impregnated gauze dressings are basic wound care products used to cover partial- or full-thickness wounds with minimal to moderate exudate (Ferraz, 2025). Society-level wound care guidance describes gauze as a versatile dressing that may function as a primary or secondary dressing depending on wound characteristics, though it has limited absorptive capacity and often requires frequent changes (Wounds UK, 2010). Use of non-impregnated gauze is intended for therapeutic wound coverage; gauze used solely for cleansing or debridement and not left in place does not meet the definition of a surgical dressing under Medicare policy (CMS, 2024). Excessive stacking of gauze without clinical justification is not supported, as dressing selection should be based on wound needs rather than volume of material applied. Utilization limits and exclusions reflect CMS surgical dressing coverage criteria (CMS, 2024).

Gradient compression stockings and wraps deliver graduated external pressure, typically highest at the ankle and decreasing proximally, and are used to reduce venous hypertension in the management of active venous stasis ulcers when arterial perfusion is adequate. Society-level guidance recognizes compression therapy as a cornerstone of venous ulcer treatment; however, under the Surgical Dressing benefit, gradient compression stockings and wraps are considered medically necessary only when used for the treatment of an open, qualifying venous stasis ulcer (Nair et al., 2024; De Maeseneer et al., 2022).

Use of gradient compression stockings or wraps in the absence of an active ulcer, including for venous insufficiency alone, ulcer prevention, recurrence prevention, or treatment of lymphedema without ulceration, does not meet the definition of a surgical dressing and is therefore not reasonable and medically necessary. Use outside these parameters lacks therapeutic relevance to an active surgical wound and is inconsistent with both coverage standards and established society guidelines.

Professional society guidelines, including those from the Wound Healing Society, European and international venous ulcer consensus groups, further characterize compression stockings and wraps as durable compression devices intended for extended use, with replacement based on loss of clinical effectiveness, fit, or integrity rather than routine or frequent change (EWMA, 2019; Mosti et al., 2024).

Hydrocolloid dressings and wound fillers are moisture-retentive, occlusive or semi-occlusive products intended for wounds with light to moderate exudate, where containment of drainage supports autolytic debridement and epithelialization. Society-level wound care guidance supports their use only in appropriately selected wounds where exudate levels can be effectively managed within the dressing (WUWHS, 2019). Consistent with their occlusive properties, hydrocolloid dressings are not appropriate for heavily exudative wounds, where excess drainage may overwhelm the dressing and increase the risk of maceration. They are also contraindicated in deep cavity wounds with tunneling or undermining, infected wounds, and wounds with exposed tendon or bone, as these conditions exceed the functional capacity and safety profile of occlusive dressings and may impair wound assessment or drainage. Dressing change frequency is guided by exudate volume and dressing integrity, with extended wear times used only when clinically appropriate and when wound conditions allow safe occlusion (WUWHS, 2019).

Hydrogel dressings and wound fillers are moisture-donating products intended for dry or minimally exudative wounds, including full-thickness wounds and wound cavities, where rehydration of devitalized tissue supports autolytic debridement. Society-level wound care guidance supports their use only in wounds with insufficient moisture and emphasizes that hydrogels are not appropriate for heavily exudative wounds, where excess moisture may lead to peri-wound maceration and delayed healing (WUWHS, 2019). Hydrogels are also not indicated for concurrent use with absorptive dressings, as combining moisture-donating and moisture-absorbing products represents conflicting wound management strategies and negates the intended function of each dressing type. Dressing change frequency is guided by product design and wound response, with daily changes commonly required for non-adhesive hydrogel dressings and wound fillers due to their limited retention capacity (WUWHS, 2019).

Light compression, conforming, self-adherent, and padding bandages are used primarily as secondary dressings to secure primary wound dressings, provide protection, and deliver light support or compression over a qualified wound. In patients with venous stasis ulcers, these bandages, particularly padding and conforming layers, may function as integral components of multi-layer compression bandage systems, which are supported by society-level guidance as standard therapy to reduce venous hypertension and support wound healing when arterial perfusion is adequate (European Wound Management Association [EWMA], 2019; Mosti et al., 2024; Wounds UK, 2023).

Based on their intended function, these bandages are not appropriate for non-wound indications, including musculoskeletal injuries, sprains, strains, or generalized edema in the absence of ulceration, as such use does not address an active wound and falls outside the definition of a surgical dressing. Use in non-wound conditions lacks therapeutic relevance to wound healing and does not meet reasonable and necessary criteria under surgical dressing coverage principles. Dressing change frequency is guided by wound status and compression system design, with weekly changes commonly used when clinically appropriate and when wound and vascular conditions permit (EWMA, 2019; Wounds UK, 2023).

Packing strips are used as primary dressings in the management of open, deep, or cavity wounds to loosely fill dead space and absorb exudate in support of granulation tissue formation and healing. Society-level wound care guidance emphasizes that appropriate packing is intended to prevent premature surface closure and fluid accumulation in wounds with depth, tunneling, or undermining; however, packing materials are not appropriate for dry or non-draining wounds, where absorptive products may desiccate the wound bed and impair healing (Wounds UK, 2025). Overpacking or use in wounds without measurable exudate may also contribute to tissue trauma and delayed healing. Dressing change frequency is guided by wound drainage, with daily changes commonly required in wounds with ongoing exudate to allow reassessment and prevent retained material (Wounds UK, 2025).

Specialty absorptive dressings are designed to manage moderate to high levels of wound exudate, particularly in full-thickness wounds such as surgically treated Stage III and IV pressure injuries. Society-level wound care guidance supports their use in heavily draining wounds to absorb excess fluid, reduce the risk of peri-wound maceration, and maintain an optimal moist wound environment; however, their clinical benefit is dependent on the presence of ongoing exudate (WUWHS, 2019). Due to their high absorptive capacity, specialty absorptive dressings are not appropriate for dry or non-draining wounds, where they may desiccate the wound bed and contribute to delayed healing. Dressing change frequency is guided by exudate volume and dressing design, with bordered products allowing for extended wear compared with non-bordered dressings only when wound conditions permit safe absorption and monitoring (WUWHS, 2019).

Transparent film dressings are semi-permeable, non-absorptive products used to protect superficial or partial-thickness wounds and closed or epithelializing surgical wounds with minimal exudate. Society-level wound care guidance recognizes that these dressings provide a protective barrier while allowing gas exchange and visual monitoring of the wound; however, their lack of absorptive capacity limits appropriate use to wounds with minimal drainage (South & West Devon Formulary, 2024). Accordingly, transparent film dressings are not appropriate for wounds with moderate to heavy exudate, where fluid accumulation may lead to maceration, nor are they indicated for full-thickness wounds, including full-thickness burns, which require dressings with greater moisture-handling capability. Use outside these parameters may impede wound healing and does not align with established wound care guidance (South & West Devon Formulary, 2024).

Wound fillers are used as primary dressings in the management of open, deep, or cavity wounds to address dead space and absorb exudate in support of granulation tissue formation and healing. Society-level guidance and expert consensus emphasize

that elimination of dead space is essential to prevent premature surface closure, fluid accumulation, and delayed healing; however, appropriate use is dependent on wound depth, the presence of tunneling or undermining, and measurable exudate volume (Wounds UK, 2025). Consistent with this guidance, wound fillers are not appropriate for dry wounds or wounds with little to no drainage, as absorptive materials may desiccate the wound bed and impair healing. Use in shallow wounds without dead space or in non-draining wounds does not align with their intended function and may contribute to delayed wound progression. Dressing change frequency is guided by ongoing wound assessment, particularly exudate level, with daily changes commonly required in wounds with moderate to heavy drainage to prevent retained material and allow appropriate monitoring (Wounds UK, 2025).

Wound drainage pouches are adjunctive devices intended for use only in the management of actively draining wounds when standard dressings are insufficient to contain exudate or adequately protect peri-wound skin. Society-level guidance emphasizes that wound pouching systems function to collect wound drainage, protect surrounding skin, and support hygiene and patient comfort, and are appropriate only in the presence of an open, draining wound (WOCN, 2024). Consistent with this guidance, wound drainage pouches are not appropriate for intact skin, prophylactic or preventive applications, or non-draining wounds, as use in these settings does not provide therapeutic benefit and falls outside their intended clinical function. Use for convenience, incontinence management, or cosmetic purposes does not meet reasonable and necessary criteria under surgical dressing coverage principles (WOCN, 2024).

Zinc paste–impregnated bandages are inelastic compression systems used in the management of active venous leg ulcers to reduce venous hypertension and support wound healing. International consensus guidance indicates that compression therapy, including zinc paste bandages, is appropriate only in the presence of an open venous ulcer and following appropriate vascular assessment to confirm adequate arterial perfusion (Mosti et al., 2024). Consistent with this guidance, zinc paste bandages are not recommended for use in the absence of an active ulcer, including for prophylactic indications, ulcer prevention or recurrence prevention, or for non-wound conditions. Use for indications other than treatment of an existing venous leg ulcer does not align with their intended therapeutic purpose and does not meet reasonable and necessary criteria under surgical dressing coverage principles (Mosti et al., 2024).

Surgical dressings and wound care supplies play a critical role in the management of qualifying surgical wounds when selected and used in accordance with wound characteristics, clinical function, and established society-level guidance. Appropriate dressing selection requires consideration of wound depth, exudate level, tissue condition, and stage of healing, while avoidance of contraindicated use is essential to prevent delayed healing, unnecessary utilization, or patient harm. The evidence and consensus guidance summarized above support the use of specific dressing categories only in clinically appropriate circumstances and underscore the importance of aligning dressing selection with functional need, manufacturer instructions for use, and reasonable and necessary standards of care.

IV. GUIDELINES / POSITION STATEMENTS

Medical/Professional Society	Guideline

Wound Healing Society (WHS)	WHS (Wound Healing Society) guidelines update: Diabetic foot ulcer treatment guidelines (2023) WHS guidelines for the treatment of pressure ulcers—2023 update Wound Healing Society 2015 update on guidelines for venous ulcers
National Pressure Injury Advisory Panel (NPIAP) Pan Pacific Pressure Injury Alliance (PPPIA) European Pressure Ulcer Advisory Panel (EPUAP)	Prevention and Treatment of Pressure Ulcers/Injury- Clinical Practice Guideline-2019
European Society for Vascular Surgery (ESVS)	Editor's Choice - European Society for Vascular Surgery (ESVS) 2022 Clinical Practice Guidelines on the Management of Chronic Venous Disease of the Lower Limbs
National Institute for Health and Care Excellence (NICE)	Compression products for treating venous leg ulcers: late-stage assessment (2025)
International Working Group of the Diabetic Foot (IWGDF)	Guidelines on interventions to enhance healing of foot ulcers in people with diabetes (IWGDF 2023 update) IWGDF-Guidelines-2023.pdf
World Union of Wound Healing Societies (WUWHS)	Wound Exudate- Effective assessment and management 2019 Leg ulceration in venous and arteriovenous insuffeciency.pdf (2024)
The International Surgical Wound Complications Advisory Panel (ISWCAP)	ISWCAP-Guideline for Post-Operative Incision Care 2025
Wound Ostomy and Continence Nurses Society (WOCNS)	LE Wounds Due to Venous, Arterial, DM-ND Disease-Clinical Resource Guide (10-5-21).docx

V. REGULATORY (US FOOD AND DRUG ADMINISTRATION)

See U.S. Food & Drug Administration (FDA) Medical Device Databases for the most current information.

Device	Premarket Approval, 513(f)(2)(De Novo), or 510(k) Number	Notice date
3M Tegaderm™ Transparent Film Dressing	K170754	11/21/2017
Opsite™ Transparent Adhesive Film (Smith+Nephew)	K852211	07/23/1985
DuoDERM® Extra Thin Flexible Hydrocolloid Dressing (ConvaTec)	K891696	05/04/1989
DuoDERM® Hydroactive Dressing (ConvaTec)	K973689	12/23/1997
Mepilex® Foam Dressing (Mölnlycke)	K983184	10/28/1998
Mepilex® Border Ag Foam Dressing	K100029	09/15/2010
Ag Foam Dressing Non-Adhesive, Ag Foam Dressing Adhesive, Silicone Ag Foam Dressing, Silicone Ag Foam Dressing with Border (Winner Medical Co., Ltd.)	K191819	05/14/2020
Allevyn™ Foam Dressing (Smith+Nephew)	K963096	10/25/1996
LUOFUCON® Silicone Ag+ Foam Dressing	K242856	11/13/2024
KALTOSTAT® Calcium Sodium Alginate Dressing (ConvaTec)	K910059	03/20/1991
CURITY Calcium Alginate Dressing	K925001	01/11/1993
Innovative Technologies Calcium Alginate Wound Dressing	K953781	09/01/1995
BIODERM Calcium Alginate Dressing	K980451	04/09/1998
FERRIS Polymem Calcium Alginate Sterile Wound Dressing	K984539	03/11/1999
SILVERLON CA (Calcium Alginate)	K053590	10/06/2006
Roosin Silver Calcium Alginate Dressing	K143335	06/01/2015
Durafiber™ Dressing (Smith+Nephew)	K103793	05/02/2011
AQUACEL® HYDROFIBER WOUND DRESSING AND AG HYDROFIBER DRESSING	K080383	05/02/2008

AQUACEL HYDROFIBER DRESSING AND AQUACEL AG WITH HYDROFIBER SILVER IMPREGNATED ANTIMICROBIAL DRESSING	K063271	04/16/2007
AQUACEL® Ag Surgical SP Dressing	K152926	01/21/2016
AQUACEL® AG EXTRA HYDROFIBER DRESSING WITH SILVER AND STRENGTHENING FIBER	K121275	07/25/2012
CONTREET-H ANTIMICROBIAL HYDROCOLLOID DRESSING	K013525	10/04/2002
X-STATIC SILVERSEAL HYDROCOLLOID FILM AND ISLAND DRESSING	K033900	01/14/2005
KENDALL ULTEC PRO AG+ HYDROCOLLOID DRESSING	K033453	04/29/2004
Comfeel Alginate Filler	K954857	11/14/1995
COMFEEL Alginate Dressing	K953497	09/29/1995
COMFEEL Plus Transparent Dressing	K942283	07/29/1994
PROMOGRAN Matrix Wound Dressing	K014129	02/14/2002
PROMOGRAN™ Collagen Matrix with ORC (3M / Acelity)	K251999	03/13/2026
Mepitel® Silicone Contact Layer (Mölnlycke)	K914604	03/25/1992
MEPITEL AG	K130040	02/12/2014
Fibracol® Plus Collagen Alginate Dressing (Acelity / 3M)	K925548	07/13/1993
Viscopaste® Zinc Oxide Paste Bandage (Smith+Nephew)	K863930	12/01/1986

VI. CODING

See also Priority Health Billing Policies:
PH Inpatient and Outpatient Incidental Services and Supplies Billing Policy No. 013
PH Surgical Dressings Billing Policy No. 032
PH Wound Care and Debridement Billing Policy No. 037
PH Negative Pressure Wound Therapy Pumps Billing Policy No. 072
PH DME Refill Requirements Billing Policy No. 087

CPT/HCPCS Codes

Tape

A4450	Tape, Non-Waterproof, Per 18 Square Inches
A4452	Tape, Waterproof, Per 18 Square Inches

Collagen-Based Dressings and Wound Fillers

A6010	Collagen based wound filler, dry form, per gram of collagen
A6011	Collagen Based Wound Filler, Gel/Paste, Per Gram of Collagen
A6021	Collagen Dressing <=16 Sq In
A6022	Collagen Dressing>6<=48 Sq In
A6023	Collagen Dressing >48 Sq In
A6024	Collagen Dressing Wound Filler

Wound Pouch

A6154	Wound Pouch Each

Alginate or other Fiber Gelling Dressings

A6196	Alginate Dressing <=16 Sq In
A6197	Alginate Dressing >16 <=48 Sq In
A6198	Alginate or other fiber gelling dressing, wound cover, sterile, pad size more than 48 sq. in., each dressing
A6199	Alginate or other fiber gelling dressing, wound filler, sterile, per 6 inches

Composite Dressings

A6203	Composite dressing, sterile, pad size 16 sq. in. or less, with any size adhesive border, each dressing
A6204	Composite dressing, sterile, pad size more than 16 sq. in. but less than or equal to 48 sq. in., with any size adhesive border, each dressing
A6205	Composite dressing, sterile, pad size more than 48 sq. in., with any size adhesive border, each dressing

Contact Layers

A6206	Contact layer, sterile, 16 sq. in. or less, each dressing
A6207	Contact layer, sterile, more than 16 sq. in. but less than or equal to 48 sq. in., each dressing
A6208	Contact layer, sterile, more than 48 sq. in., each dressing

Foam Dressings and Wound Filler

A6209	Foam dressing, wound cover, sterile, pad size 16 sq. in. or less, without adhesive border, each dressing
A6210	Foam dressing, wound cover, sterile, pad size more than 16 sq. in. but less than or equal to 48 sq. in., without adhesive border, each dressing
A6211	Foam dressing, wound cover, sterile, pad size more than 48 sq. in., without adhesive border, each dressing
A6212	Foam dressing, wound cover, sterile, pad size 16 sq. in. or less, with any size adhesive border, each dressing
A6213	Foam dressing, wound cover, sterile, pad size more than 16 sq. in. but less than or equal to 48 sq. in., with any size adhesive border, each dressing
A6214	Foam dressing, wound cover, sterile, pad size more than 48 sq. in., with any size adhesive border, each dressing
A6215	Foam dressing, wound filler, sterile, per gram

Gauze-Non-Impregnated

A6216	Gauze, non-impregnated, non-sterile, pad size 16 sq. in. or less, without adhesive border, each dressing
A6217	Gauze, non-impregnated, non-sterile, pad size more than 16 sq. in. but less than or equal to 48 sq. in., without adhesive border, each dressing
A6218	Gauze, non-impregnated, non-sterile, pad size more than 48 sq. in., without adhesive border, each dressing
A6219	Gauze, non-impregnated, sterile, pad size 16 sq. in. or less, with any size adhesive border, each dressing
A6220	Gauze, non-impregnated, sterile, pad size more than 16 sq. in. but less than or equal to 48 sq. in., with any size adhesive border, each dressing
A6221	Gauze, non-impregnated, sterile, pad size more than 48 sq. in., with any size adhesive border, each dressing

Gauze- Impregnated with Other Than Water, Normal Saline, or Hydrogel

A6222	Gauze, impregnated with other than water, normal saline, or hydrogel, sterile, pad size 16 sq. in. or less, without adhesive border, each dressing
A6223	Gauze, impregnated with other than water, normal saline, or hydrogel, sterile, pad size more than 16 square inches, but less than or equal to 48 square inches, without adhesive border, each dressing
A6224	Gauze, impregnated with other than water, normal saline, or hydrogel, sterile, pad size more than 48 square inches, without adhesive border, each dressing
A6231	Gauze, impregnated, hydrogel, for direct wound contact, sterile, pad size 16 sq. in. or less, each dressing
A6232	Gauze, impregnated, hydrogel, for direct wound contact, sterile, pad size greater than 16 sq. in., but less than or equal to 48 sq. in., each dressing
A6233	Gauze, impregnated, hydrogel for direct wound contact, sterile, pad size more than 48 sq. in., each dressing

Hydrocolloid Dressings

A6234	Hydrocolloid dressing, wound cover, sterile, pad size 16 sq. in. or less, without adhesive border, each dressing
A6235	Hydrocolloid dressing, wound cover, sterile, pad size more than 16 sq. in. but less than or equal to 48 sq. in., without adhesive border, each dressing
A6236	Hydrocolloid dressing, wound cover, sterile, pad size more than 48 sq. in., without adhesive border, each dressing
A6237	Hydrocolloid dressing, wound cover, sterile, pad size 16 sq. in. or less, with any size adhesive border, each dressing
A6238	Hydrocolloid dressing, wound cover, sterile, pad size more than 16 sq. in. but less than or equal to 48 sq. in., with any size adhesive border, each dressing
A6239	Hydrocolloid dressing, wound cover, sterile, pad size more than 48 sq. in., with any size adhesive border, each dressing
A6240	Hydrocolloid dressing, wound filler, paste, sterile, per fluid ounce
A6241	Hydrocolloid dressing, wound filler, dry form, sterile, per gram

Hydrogel Dressings

A6242	Hydrogel dressing, wound cover, sterile, pad size 16 sq. in. or less, without adhesive border, each dressing
A6243	Hydrogel dressing, wound cover, sterile, pad size more than 16 sq. in. but less than or equal to 48 sq. in., without adhesive border, each dressing
A6244	Hydrogel dressing, wound cover, sterile, pad size more than 48 sq. in., without adhesive border, each dressing
A6245	Hydrogel dressing, wound cover, sterile, pad size 16 sq. in. or less, with any size adhesive border, each dressing
A6246	Hydrogel dressing, wound cover, sterile, pad size more than 16 sq. in. but less than or equal to 48 sq. in., with any size adhesive border, each dressing
A6247	Hydrogel dressing, wound cover, sterile, pad size more than 48 sq. in., with any size adhesive border, each dressing
A6248	Hydrogel dressing, wound filler, gel, per fluid ounce

Specialty Absorptive Dressings

A6251	Specialty absorptive dressing, wound cover, pad size 16 sq. in. or less, without adhesive border, each dressing
A6252	Specialty absorptive dressing, wound cover, sterile, pad size more than 16 sq. in. but less than or equal to 48 sq. in., without adhesive border, each dressing
A6253	Specialty absorptive dressing, wound cover, sterile, pad size more than 48 sq. in., without adhesive border, each dressing
A6254	Specialty absorptive dressing, wound cover, sterile, pad size 16 sq. in. or less, with any size adhesive border, each dressing
A6255	Specialty absorptive dressing, wound cover, sterile, pad size more than 16 sq. in. but less than or equal to 48 sq. in., with any size adhesive border, each dressing
A6256	Specialty absorptive dressing, wound cover, sterile, pad size more than 48 sq. in., with any size adhesive border, each dressing

Transparent Films

A6257	Transparent film, sterile, 16 sq. in. or less, each dressing
A6258	Transparent film, more than 16 sq. in. but less than or equal to 48 sq. in., each dressing
A6259	Transparent film, sterile, more than 48 sq. in., each dressing

Wound Filler, Not Elsewhere Classified

A6261	Wound filler, gel/paste, per fluid ounce, not elsewhere classified
A6262	Wound filler, dry form, per gram, not elsewhere classified

A6266	Gauze, impregnated, other than water, normal saline, or zinc paste, sterile, any width, per linear yard
A6402	Gauze, non-impregnated, sterile, pad size 16 sq. in. or less, without adhesive border, each dressing
A6403	Gauze, non-impregnated, sterile, pad size more than 16 sq. in., less than or equal to 48 sq. in., without adhesive border, each dressing
A6404	Gauze, non-impregnated, sterile, pad size more than 48 sq. in., without adhesive border, each dressing

Packing Strips

A6407	Packing strips, non-impregnated, sterile, up to 2 inches in width, per linear yard

Padding Bandages

A6441	Padding bandage, non-elastic, non-woven/non-knitted, width greater than or equal to three inches and less than five inches, per yard

Conforming Bandages

A6442	Conforming bandage, non-elastic, knitted/woven, non-sterile, width less than three inches, per yard
A6443	Conforming bandage, non-elastic, knitted/woven, non-sterile, width greater than or equal to three inches and less than five inches, per yard
A6444	Conforming bandage, non-elastic, knitted/woven, non-sterile, width greater than or equal to 5 inches, per yard
A6445	Conforming bandage, non-elastic, knitted/woven, sterile, width less than three inches, per yard
A6446	Conforming bandage, non-elastic, knitted/woven, sterile, width greater than or equal to three inches and less than five inches, per yard
A6447	Conforming bandage, non-elastic, knitted/woven, sterile, width greater than or equal to five inches, per yard

Light Compression Bandages

A6448	Light compression bandage, elastic, knitted/woven, width less than three inches, per yard
A6449	Light compression bandage, elastic, knitted/woven, width greater than or equal to three inches and less than five inches, per yard
A6450	Light compression bandage, elastic, knitted/woven, width greater than or equal to five inches, per yard

Moderate Compression Bandages

A6451	Moderate compression bandage, elastic, knitted/woven, load resistance of 1.25-to-1.34-foot pounds at 50% maximum stretch, width greater than or equal to three inches and less than five inches, per yard

High Compression Bandages

A6452	High compression bandage, elastic, knitted/woven, load resistance greater than or equal to 1.35-foot pounds at 50% maximum stretch, width greater than or equal to three inches and less than five inches, per yard

Self-Adherent Bandages

A6453	Self-adherent bandage, elastic, non-knitted/non-woven, width less than three inches, per yard
A6454	Self-adherent bandage, elastic, non-knitted/non-woven, width greater than or equal to three inches and less than five inches, per yard
A6455	Self-adherent bandage, elastic, non-knitted/non-woven, width greater than or equal to five inches, per yard

Zinc Paste Impregnated Bandage

A6456	Zinc paste impregnated bandage, non-elastic, knitted/woven, width greater than or equal to three inches and less than five inches, per yard

Tubular Dressing

A6457	Tubular dressing with or without elastic, any width, per linear yard

Gradient Compression Stockings

A6531	Gradient compression stocking, below knee, 30-40 mm Hg, used as a surgical dressing, each
A6532	Gradient compression stocking, below knee, 40-50 mm Hg, used as a surgical dressing, each

Gradient Compression Wrap

A6545	Gradient compression wrap, non-elastic, below-knee, 30-50 mm hg, each

Not Medically Necessary

A6025	Gel sheet for dermal or epidermal application, (e.g., silicone, hydrogel, other), each
A6228	Gauze, impregnated, water or normal saline, sterile, pad size 16 sq. in. or less, without adhesive border, each dressing
A6229	Gauze, impregnated, water or normal saline, sterile, pad size more than 16 sq. in. but less than or equal to 48 sq. In., without adhesive border, each dressing
A6230	Gauze, impregnated, water or normal saline, sterile, pad size more than 48 sq. in., without adhesive border, each dressing
A6250	Skin sealants, protectants, moisturizers, ointments, any type, any size
A6260	Wound cleansers, any type, any size
A6413	Adhesive bandage, first-aid
0640T	Noncontact near-infrared spectroscopy studies of flap or wound (eg, for measurement of deoxyhemoglobin, oxyhemoglobin, and ratio of tissue oxygenation [StO2]); image acquisition, interpretation and report, each flap or wound
0642T	Noncontact near-infrared spectroscopy studies of flap or wound (e.g., for measurement of deoxyhemoglobin, oxyhemoglobin, and ratio of tissue oxygenation [StO2]); interpretation and report only, each flap or wound

VII. MEDICAL NECESSITY REVIEW

Prior authorization for certain drugs, devices, services and procedures may or may not be required. In cases where prior authorization is required, providers will submit a request demonstrating that a drug, service or procedure is medically necessary. For more information, refer to the Priority Health Provider Manual.

Individual case review may allow coverage for care or treatment that is investigational yet promising for the conditions described. Requests for individual consideration require prior plan approval. All determinations of coverage for experimental, investigational, or

unproven treatment will be made by a Priority Health medical director or clinical pharmacist. The exclusion of coverage for experimental, investigational, or unproven treatment may be reviewed for exception if the condition is either a terminal illness, or a chronic, life threatening, severely disabling disease that is causing serious clinical deterioration.

VIII. APPLICATION TO PRODUCTS

Coverage is subject to the member's specific benefits. Group-specific policy will supersede this policy when applicable.

- **HMO/EPO**: This policy applies to insured HMO/EPO plans.
- **POS**: This policy applies to insured POS plans.
- **PPO**: This policy applies to insured PPO plans. Consult individual plan documents as state mandated benefits may apply. If there is a conflict between this policy and a plan document, the provisions of the plan document will govern.
- **ASO**: For self-funded plans, consult individual plan documents. If there is a conflict between this policy and a self-funded plan document, the provisions of the plan document will govern.
- **INDIVIDUAL**: For individual policies, consult the individual insurance policy. If there is a conflict between this medical policy and the individual insurance policy document, the provisions of the individual insurance policy will govern.
- **MEDICARE**: Coverage is determined by the Centers for Medicare and Medicaid Services (CMS); if a coverage determination has not been adopted by CMS, this policy applies.
- **MEDICAID/HEALTHY MICHIGAN PLAN**: For Medicaid/Healthy Michigan Plan members, this policy will apply. Coverage is based on medical necessity criteria being met and the appropriate code(s) from the coding section of this policy being included on the Michigan Medicaid Fee Schedule. If there is a discrepancy between this policy and the Michigan Medicaid Provider Manual, the Michigan Medicaid Provider Manual will govern. If there is a discrepancy or lack of guidance in the Michigan Medicaid Provider Manual, the Priority Health contract with Michigan Medicaid will govern. For Medical Supplies/DME/Prosthetics and Orthotics, please refer to the Michigan Medicaid Fee Schedule to verify coverage.

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SUMMARY OF CHANGES

- New Medical Policy

Past committee review dates: 05/2026