Priority Health	BILLING POLICY No. 072
NEGATIVE PRESSURE WOUND THERAPY PUMPS	
Effective date: Aug. 25, 2025 **Date of origin: Jan. 3, 2025**	**Review dates: 2/2025, 6/2025, 8/2026**

POLICY OVERVIEW

This policy identifies billing and payment requirements associated with Negative pressure wound therapy. This policy provides guidelines for billing, coding, and documentation, ensuring claims are processed according to contractual and industry standards.

DEFINITION

Negative Pressure Wound Therapy (NPWT) is the application of sub-atmospheric pressure to a wound to remove exudate and debris from wounds. NPWT is delivered through a system that consists of a suction pump, separate exudate collection chamber, and dressing sets to a qualified wound. Using this system ensures that exudate is completely removed from the wound site and collected by the collection chamber.

MEDICAL POLICY

- Durable Medical Equipment (#91110)
- Rehabilitative & Habilitative Medicine Services (#91318-R16)

FOR MEDICARE

For indications that do not meet criteria of NCD, local LCD or specific medical policy, a Pre-Service Organization Determination (PSOD) will need to be completed. Get more information on PSOD in our Provider Manual.

POLICY SPECIFIC INFORMATION

Coding specifics

NPWT is a system that contains a pump (E2402), dressing sets (A6550) and a separate collection canister (A7000). Wound suction systems that do not contain all of the required components are not classified as NPWT.

Code	Description
97605	Negative pressure wound therapy (eg, 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
97606	Negative pressure wound therapy (eg, 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 greater than 50 square centimeters
97607	Negative pressure wound therapy, (eg, 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
97608	Negative pressure wound therapy, (eg, 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 greater than 50 square centimeters
E2402	Negative pressure wound therapy electrical pump, stationary or portable
A6550	Wound care set, for negative pressure wound therapy electrical pump, includes all supplies and accessories (maximum of 15 dressing kits per wound per month)
A7000	Canister, disposable, used with suction pump, each (maximum of 10 canister sets per month unless there is documentation evidencing a large volume of drainage; greater than 90 ml of exudate per day).
These codes may also be used when removing exudate from a wound	
K0743	Suction pump, home model, portable, for use on wounds
K0744	Absorptive wound dressing for use with suction pump, home model, portable, pad size 16 sq in or less
K0745	Absorptive wound dressing for use with suction pump, home model, portable, pad size more than 16 sq in but less than or equal to 48 sq in
K0746	Absorptive wound dressing for use with suction pump, home model, portable, pad size greater than 48 sq in

A diagnosis code describing the wound being treated must be included on each claim for the equipment and related supplies.

Modifiers

- **EY** - No physician or other health care provider order for this item or service.
- **KX** - Requirements specified in the medical policy have been met.
- **GA**- Waiver of liability statement issued as required by Medicare policy; member notified that the service may not be covered and accepted financial responsibility.
- **GZ** - Item or service expected to be denied as not reasonable and necessary; member was not issued a waiver of liability statement and cannot be held financially responsible.

Place of service

- 12 – Home
- 21 – Inpatient

Documentation requirements

- History, previous treatment regimens (if applicable) and current wound management for which a NPWT pump is being billed must be present and include length of sessions of use, dressing types and frequency of change, changes in wound conditions, precise measurements, quantity of exudates, presence of granulation and necrotic tissue and measures being addressed relevant to treatment.
- Wound evaluation and treatment must indicate regular evaluation and treatment of wounds.
- Documentation of quantitative measurements of wound characteristics including wound length, width, depth and amount of drainage, indicating progress of healing must be entered at least monthly. Month-to-month comparisons of wound size must compare measurements.
- Statement from the provider describing the initial condition of the wound (including measurements) and the efforts to address all aspects of wound care

- If the initiation of NPWT occurs during an inpatient stay, to accurately account for the duration of treatment, the initial inpatient date of service must be documented.

For NPWT that exceeds four months, consideration for one additional month at a time may be granted through an appeal.

Reimbursement specifics

Code	Limit
A6550	15 per wound per month
A7000	10 per month
E2402	1 per month

FAQ

Not applicable

RESOURCES

- LCD - Negative Pressure Wound Therapy Pumps (L33821) (CMS)
- Article - Negative Pressure Wound Therapy Pumps - Policy Article (A52511) (CMS)
- Always Sometimes Therapy Billing Policy

DISCLAIMER

CMS and/or MDHHS guidelines apply unless otherwise specified in this policy or provider manual. Where such guidance is absent, this policy applies. Priority Health's billing policies outline our guidelines to assist providers in accurate claim submissions and define reimbursement or coding requirements if the service is covered by a Priority Health member's benefit plan. The determination of visits, procedures, DME, supplies and other services or items for coverage under a member's benefit plan or authorization isn't being determined for reimbursement. Authorization requirements and medical necessity requirements appropriate to procedure, diagnosis and frequency are still required. We use Current Procedural Terminology (CPT), Centers for Medicare and Medicaid Services (CMS), Michigan Department of Health and Human Services (MDHHS), and other defined medical coding guidelines for coding accuracy.

An authorization isn't a guarantee of payment when proper billing and coding requirements or adherence to our policies aren't followed. Proper billing and submission guidelines must be followed. We require industry standard, compliant codes defined by CPT, HCPCS, and revenue codes for all claim submissions. CPT, HCPCPS, revenue codes, etc., can be reported only when the service has been performed and fully documented in the medical record to the highest level of specificity. Failure to document services rendered or items supplied will result in a denial. To validate billing and coding accuracy, payment integrity pre- or post-claim reviews may be performed to prevent fraud, waste and abuse. Unless otherwise detailed in the policy, our billing policies apply to both participating and non-participating providers and facilities.

If guidelines detailed in government program regulations, defined in policies and contractual requirements aren't followed, Priority Health may:

- Reject or deny the claim
- Recover or recoup claim payment

An authorization on file for an item or services doesn't supersede coding, billing or reimbursement requirements.

These policies may be superseded by mandates defined in provider contracts or state, federal or CMS contracts or requirements. We make every effort to update our policies in a timely manner to align these requirements or contracts. If there's a delay in implementation of a policy or requirement defined by state or federal law, as well as contract language, we reserve the right to recoup and/or recover claim

payments to the effective dates per our policy. We reserve the right to update policies when necessary. Our most current policy will be made available in our Provider Manual.

CHANGE / REVIEW HISTORY

Date	Revisions made
Feb. 14, 2025	Added “Disclaimer” section
June 19, 2025	Added Frequency Limits for A6550, A7000 and E2402 that will go into effect Aug. 25, 2025
August 2026	Added GA, GZ modifiers. Added medical and billing policy for reference.