Anthem

Clinical UM Guideline

Subject: Chronic Wound Care in the Home or Outpatient Setting
Guideline #: CG-MED-71
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Description

This document addresses wound care in the home or outpatient setting (for example, an outpatient wound center or wound clinic) for a variety of chronic wounds, such as ulcers related to pressure sores, venous or arterial insufficiency, or neuropathy.

Note: Please see the following related documents for additional information:

- CG-DME-06 Compression Devices for Lymphedema
- CG-DME-16 Pressure Reducing Support Surfaces - Groups 1, 2 & 3
- CG-DME-48 Vacuum Assisted Wound Therapy in the Outpatient Setting
- CG-MED-19 Custodial Care
- CG-MED-23 Home Health
- CG-MED-73 Hyperbaric Oxygen Therapy (Systemic/Topical)
- CG-REHAB-07 Skilled Nursing and Skilled Rehabilitation Services (Outpatient)
- CG-REHAB-08 Private Duty Nursing in the Home Setting
- MED.00096 Low-Frequency Ultrasound Therapy for Wound Management
- MED.00110 Silver-based Products for Wound and Soft Tissue Applications
- SURG.00011 Allogeneic, Xenographic, Synthetic, Bioengineered, and Composite Products for Wound Healing and Soft Tissue Grafting

Clinical Indications

Medically Necessary:

Note: To be eligible for wound care in the home setting, the individual must be confined to the home as defined in CG-MED-23 Home Health**.**

Initial care for a chronic wound in the home or outpatient setting is considered**medically necessary** when:

A. The wound care is prescribed by the attending physician, health care provider practicing within the scope of license, or the primary care physician in coordination with the attending physician as part of a written plan of care; **and**
B. The wound care is so inherently complex that it can only be safely and effectively performed by or under the general supervision of a licensed medical professional (for example, but not limited to stage III or IV pressure ulcers, non-healing neuropathic ulcers, venous or arterial insufficiency related ulcers, persistent wounds); **and**
C. A complete, individualized wound care program appropriate to the type of wound being treated, which meets**all** of the requirements below, has been initiated:
    1. Initial documentation in the individual's medical record of evaluation, plan of care, wound care, wound characteristics, and wound measurements by a licensed medical professional; **and**
    2. Application of dressings according to manufacturer guidelines;**and**
    3. Debridement of necrotic tissue if present;**and**
    4. Evaluation of and provision for adequate nutritional status;**and**
    5. Underlying medical conditions (for example, venous insufficiency or diabetes) are being appropriately managed.

Continued care for a chronic wound in the home or outpatient setting is considered**medically necessary** when:

A. The wound care provided meets all the criteria under initial wound care;**and**
B. Weekly documentation by a licensed medical professional includes**all** of the following:
    1. The plan of care; **and**
    2. Wound care provided;**and**
    3. Assessment of the wound's dimensions and characteristics;**and**
C. The primary care physician, health care provider practicing within the scope of license, or attending physician in coordination with the primary care physician should review the plan of care at least once every 30 days to assess the continued need for wound care in the home or outpatient setting; **and**
D. Progressive wound healing is demonstrated through measurable changes in wound characteristics and wound measurements taken no more than 30 days apart.

Not Medically Necessary:

Care for a chronic wound in the home or outpatient setting is considered**not medically necessary** when:

A. The plan of care does not demonstrate the need for skilled intervention performed by or under the general supervision of a licensed medical professional; **or**
B. Criteria for initial wound care in the home or outpatient setting as defined above have not been met;**or**
C. Criteria for continuing wound care in the home or outpatient setting as defined above have not been met;**or**
D. The goals have been achieved per the plan of care;**or**
E. The wound care is custodial as defined in CG-MED-19 Custodial Care.

Coding

The following codes for treatments and procedures applicable to this guideline are included below for informational purposes. Inclusion or exclusion of a procedure, diagnosis or device code(s) does not constitute or imply member coverage or provider reimbursement policy. Please refer to the member's contract benefits in effect at the time of service to determine coverage or non-

coverage of these services as it applies to an individual member.

When services may be Medically Necessary when criteria are met:

CPT	
99600	Unlisted home visit service or procedure [when specified as home visit for wound care]
HCPCS	
	For the following services **when specified as visit for wound care**:
G0299	Direct skilled nursing services of a registered nurse (RN) in the home health or hospice setting, each 15 minutes
G0300	Direct skilled nursing services of a licensed practical nurse (LPN) in the home health or hospice setting, each 15 minutes
S9097	Home visit for wound care
S9123	Nursing care in the home; by registered nurse, per hour
S9124	Nursing care in the home; by licensed practical nurse, per hour
T1030	Nursing care, in the home, by registered nurse, per diem
T1031	Nursing care, in the home, by licensed practical nurse, per diem
ICD-10 Diagnosis	
	All diagnoses

When services are Not Medically Necessary:
For the procedure codes listed above when criteria are not met or for situations designated in the Clinical Indications section as not medically necessary.

Discussion/General Information

Wound care is a general term for the treatment of a variety of wounds such as ulcers related to pressure sores, venous or arterial insufficiency, or neuropathy, and is often provided in the home or outpatient setting. The treatment of these wounds is determined by a detailed assessment that includes, but is not limited to underlying medical conditions, wound measurements, wound characteristics, and nutritional status. Due to the complexities of the types of wounds, underlying medical conditions, and other factors, treatment strategies typically vary for each individual. The plan of care should be a multimodal approach that includes managing underlying medical conditions. An evaluation of the plan of care should occur at least once a week. Wound healing normally progresses at a sustained, measurable rate. Although there is no specific time frame that clearly differentiates an acute from a chronic wound, a lack of approximately fifty percent reduction of the surface area of the wound over a one-month period may indicate a chronic state (Sheehan, 2006). If the wound shows no measurable improvement within 30 days, the plan of care should be evaluated and changed.

Neuropathic ulcers

Neuropathic ulcers can be caused by various disease processes, including diabetes. The Society for Vascular Surgery published a clinical practice guideline on the management of the diabetic foot, which includes recommendations for diabetic foot ulcers. The guideline recommends off-loading diabetic foot ulcers stating, “most plantar ulcers result from repetitive or high plantar pressures… therefore…such pressures must be ameliorated or reduced to allow healing to occur” (Hingorani, 2016). Regarding wound dressings, the guideline states there is little evidence to support the use of one product over another and recommends basing dressing selection on the characteristics of the wound and ease of use of the product.

Ulcers related to pressure sores

Pressure ulcers, also known as pressure sores or pressure injuries, result from decreased blood supply to the tissue due to friction or prolonged pressure on a part of the body. Both the National Pressure Injury Advisory Panel, European Pressure Ulcer Advisory Panel and Pan Pacific Pressure Injury Alliance (Haesler, 2019) and the Wound, Ostomy and Continence Nurses Society-Wound Guidelines Task Force (2017) released guidelines on the management of pressure ulcers recommending the use of a multi-faceted approach to meet the individual’s needs that includes strategies to minimize mechanical risk, assess and stage the injury, address factors that impact healing locally and systemically, and monitor the progress of the treatment plan.

Venous or arterial insufficiency

Venous or arterial insufficiency results from impairment of blood flow and can lead to tissue ischemia creating an ulcer. The Society for Vascular Surgery published a clinical practice guideline on the management of venous leg ulcers. Compression therapy is recommended for venous leg ulcers to help increase the healing rate (O’Donnell, 2014). In 2016, the Wound Ostomy and Continence Nurses Society published guidelines on the management of wounds caused by lower-extremity arterial disease (Bonham, 2016). Two treatments that the Wound Ostomy and Continence Nurses Society recommends are compression therapy and offloading foot ulcers.

In 2016, the Wound Healing Society published updates to their 2006 wound care guidelines related to diabetic foot ulcers (Lavery, 2016), pressure ulcers (Gould, 2016), and venous ulcers (Marston, 2016). The authors noted that due to the lack of high-quality data from human clinical studies, they included well-controlled animal studies in their assessment of evidence to demonstrate proof of principle, especially when a clinical series corroborated the results. All three guidelines recommended ongoing and consistent documentation of history, characteristics, and rate of wound healing. The following guidance was also included.

Regarding diabetic foot ulcers (Lavery, 2016):

> Guideline 4.5: Patients who fail to show a reduction in ulcer size by 50% or more after 4 weeks of therapy should be reevaluated and other treatments should be considered.

Regarding pressure ulcers (Gould, 2016):

> Guideline 2.1: Nutritional assessment should be performed on entry to a new healthcare setting and whenever there is a change in an individual’s condition that may increase the risk of under-nutrition.
>
> Guideline 4.4: Initial debridement is required to remove the obvious necrotic tissue, excessive bacterial burden, and cellular burden of dead and senescent cells. Maintenance debridement is needed to maintain the appearance and readiness of the wound bed for healing. The healthcare provider can choose from a number of debridement methods including sharp, mechanical, enzymatic, and autolytic. More than one debridement method may be appropriate.

Definitions

Acute Wound: A wound with normal wound physiology anticipated to heal through the normal stages of wound healing; examples include lacerations, minor burns, and postoperative surgical incisions.

Chronic Wound: A wound that is physiologically impaired due to a disruption of the wound healing cycle, such as from impaired angiogenesis, innervation, or cellular migration; examples include nonhealing or infected surgical or traumatic wounds, venous ulcers, pressure ulcers, diabetic foot ulcers, and ischemic ulcers.

Initial wound care in the home setting: The first wound care service provided in the individual's place of residence.

Neuropathic ulcer: An ulcer resulting from the loss of sensation (for instance, pain, touch, stretch) as well as protective reflexes, due to loss of nerve supply to a body part.

Pressure ulcer (National Pressure Ulcer Advisory Panel, 2016): A pressure injury is localized damage to the skin and/or underlying soft tissue usually over a bony prominence or related to a medical or other device. The injury can present as intact skin or an open ulcer and may be painful. The injury occurs as a result of intense and/or prolonged pressure or pressure in combination with shear. The tolerance of soft tissue for pressure and shear may also be affected by microclimate, nutrition, perfusion, co-morbidities and condition of the soft tissue.

Pressure ulcer stages:

Pressure Injury:
A pressure injury is localized damage to the skin and/or underlying soft tissue usually over a bony prominence or related to a medical or other device. The injury can present as intact skin or an open ulcer and may be painful. The injury occurs as a result of intense and/or prolonged pressure or pressure in combination with shear. The tolerance of soft tissue for pressure and shear may also be affected by microclimate, nutrition, perfusion, co-morbidities and condition of the soft tissue.

Stage 1 Pressure Injury: Non-blanchable erythema of intact skin
Intact skin with a localized area of non-blanchable erythema, which may appear differently in darkly pigmented skin. Presence of blanchable erythema or changes in sensation, temperature, or firmness may precede visual changes. Color changes do not include purple or maroon discoloration; these may indicate deep tissue pressure injury.

Stage 2 Pressure Injury: Partial-thickness skin loss with exposed dermis
Partial-thickness loss of skin with exposed dermis. The wound bed is viable, pink or red, moist, and may also present as an intact or ruptured serum-filled blister. Adipose (fat) is not visible and deeper tissues are not visible. Granulation tissue, slough and eschar are not present. These injuries commonly result from adverse microclimate and shear in the skin over the pelvis and shear in the heel. This stage should not be used to describe moisture associated skin damage (MASD) including incontinence associated dermatitis (IAD), intertriginous dermatitis (ITD), medical adhesive related skin injury (MARSI), or traumatic wounds (skin tears, burns, abrasions).

Stage 3 Pressure Injury: Full-thickness skin loss
Full-thickness loss of skin, in which adipose (fat) is visible in the ulcer and granulation tissue and epibole (rolled wound edges) are often present. Slough and/or eschar may be visible. The depth of tissue damage varies by anatomical location; areas of significant adiposity can develop deep wounds. Undermining and tunneling may occur. Fascia, muscle, tendon, ligament, cartilage and/or bone are not exposed. If slough or eschar obscures the extent of tissue loss this is an Unstageable Pressure Injury.

Stage 4 Pressure Injury: Full-thickness skin and tissue loss
Full-thickness skin and tissue loss with exposed or directly palpable fascia, muscle, tendon, ligament, cartilage or bone in the ulcer. Slough and/or eschar may be visible. Epibole (rolled edges), undermining and/or tunneling often occur. Depth varies by anatomical location. If slough or eschar obscures the extent of tissue loss this is an Unstageable Pressure Injury.

Unstageable Pressure Injury: Obscured full-thickness skin and tissue loss
Full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because it is obscured by slough or eschar. If slough or eschar is removed, a Stage 3 or Stage 4 pressure injury will be revealed. Stable eschar (for example, dry, adherent, intact without erythema or fluctuance) on an ischemic limb or the heel(s) should not be removed.

Deep Tissue Pressure Injury:
Persistent non-blanchable deep red, maroon or purple discoloration. Intact or non-intact skin with localized area of persistent non-blanchable deep red, maroon, purple discoloration or epidermal separation revealing a dark wound bed or blood filled blister. Pain and temperature change often precede skin color changes. Discoloration may appear differently in darkly pigmented skin. This injury results from intense and/or prolonged pressure and shear forces at the bone-muscle interface. The wound may evolve rapidly to reveal the actual extent of tissue injury, or may resolve without tissue loss. If necrotic tissue, subcutaneous tissue, granulation tissue, fascia, muscle or other underlying structures are visible, this indicates a full thickness pressure injury (Unstageable, Stage 3 or Stage 4). Do not use DTPI to describe vascular, traumatic, neuropathic, or dermatologic conditions.

Medical Device Related Pressure Injury:
This describes an etiology. Medical device related pressure injuries result from the use of devices designed and applied for diagnostic or therapeutic purposes. The resultant pressure injury generally conforms to the pattern or shape of the device. The injury should be staged using the staging system.

Mucosal Membrane Pressure Injury:
Mucosal membrane pressure injury is found on mucous membranes with a history of a medical device in use at the location of the injury. Due to the anatomy of the tissue these injuries cannot be staged.

Wound Care Center: An outpatient medical facility that treats wounds that are typically difficult to heal.

References

Peer Reviewed Publications:

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Government Agency, Medical Society, and Other Authoritative Publications:

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2. Gould L, Stuntz M, Giovannelli M, et al. Wound Healing Society 2015 update on guidelines for pressure ulcers. Wound Repair Regen. 2016; 24(1):145-162.
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4. Hingorani A, LaMuraglia GM, Henke P, et al. The management of diabetic foot: a clinical practice guideline by the Society for Vascular Surgery in collaboration with the American Podiatric Medical Association and the Society for Vascular Medicine. J Vasc Surg. 2016; 63(2 Suppl):3S-21S.
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11. Wound, Ostomy and Continence Nurses Society-Wound Guidelines Task Force. WOCN 2016 guideline for prevention and management of pressure injuries (ulcers): An executive summary. J Wound Ostomy Continence Nurs. 2017; 44(3):241-246.

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History

Status	Date	Action
Revised	11/09/2023	Medical Policy & Technology Assessment Committee (MPTAC) review. Reformatted Description and Clinical Indications sections. Updated References section.
Reviewed	11/10/2022	MPTAC review. Updated Discussion and References sections.
Reviewed	11/11/2021	MPTAC review. Updated Discussion/General Information and References sections.
Reviewed	11/05/2020	MPTAC review. Updated References section. Reformatted Coding section.
Revised	11/07/2019	MPTAC review. Expanded scope to include outpatient settings. Description, Clinical Indications, Discussion/General Information, Definitions and References sections updates. Coding section updated; added codes 99600, G0299, G0300, S9123, S9124, T1030, T1031.
Reviewed	06/06/2019	MPTAC review. Updated References section.
Revised	07/26/2018	MPTAC review. Revised Description section to clarify setting. Revised medically necessary criteria regarding initial wound care and continued wound care in the Clinical Indications section. Added additional criteria to the not medically necessary statement in the Clinical Indications section. Updated Discussion/General Information and References sections.
New	05/03/2018	MPTAC review. Initial document development.