

Wound Treatments

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Related Medicare Advantage Policy Guideline
• Porcine Skin and Gradient Pressure Dressings

Coverage Guidelines

Wound and ulcer treatments are covered when Medicare coverage criteria are met.

Note: The guidelines in this Coverage Summary are for specific procedures only. For procedures not addressed in this Coverage Summary, refer to the [Medicare Coverage Database](#) to search for applicable coverage policies (National Coverage Determinations, Local Coverage Determinations and Local Coverage Articles).

Skin Substitutes (Non-Porcine Based)

Medicare does not have a National Coverage Determination (NCD) for non-porcine based skin substitutes. Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) may exist and compliance with these policies is required where applicable.

For state specific LCDs/LCAs, refer to the following LCDs/LCAs:

- For the states of **KY** and **OH**, use the CGS LCD for [Wound Application of Cellular and/or Tissue Based Products \(CTPs\), Lower Extremities \(L36690\)](#).
- For the states of **AR, CO, DC, DE, LA, MD, MS, NJ, NM, OK, PA,** and **TX**, use the Novitas LCD for [Application of Bioengineered Skin Substitutes to Lower Extremity Chronic Non-Healing Wounds \(L35041\)](#).
- For the states and territories of **FL, PR,** and **VI**, use the First Coast LCD for [Application of Skin Substitute Grafts for Treatment of DFU and VLU of Lower Extremities \(L36377\)](#).

(Accessed March 4, 2024)

For coverage guidelines for states/territories with no LCDs/LCAs, refer to the UnitedHealthcare Commercial Medical Policy titled [Skin and Soft Tissue Substitutes](#).

Note: After searching the [Medicare Coverage Database](#), if no LCD/LCA is found, then use the UnitedHealthcare Commercial Medical Policy referenced above for coverage guidelines.

Skin Substitutes (Porcine Based)

Porcine based skin substitutes may be covered when criteria are met. Refer to the [NCD for Porcine Skin and Gradient Pressure Dressings \(270.5\)](#).

Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) exist and compliance with these policies is required where applicable. These LCDs/LCAs are available at <https://www.cms.gov/medicare-coverage-database/search.aspx>. (Accessed March 4, 2024)

Ablative Laser Treatment for Wounds (CPT Code 17999)

Medicare does not have a National Coverage Determination (NCD) for ablative laser treatment for wounds. Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) do not exist at this time.

For coverage guidelines, refer to the UnitedHealthcare Medical Policy titled [Omnibus Codes](#).

Note: After searching the [Medicare Coverage Database](#), if no LCD/LCA is found, then use the policy referenced above for coverage guidelines. (Accessed March 4, 2024)

Electrical Stimulation (ES) or Electromagnetic Therapy

Electrical stimulation is the application of electrical current through the electrodes placed directly on the skin in close proximity to the wound. Electrical stimulation uses electrical current applied through electrodes, which are placed directly on the skin close to the wound. Electromagnetic therapy is the application of pulsed magnetic field to induce current.

The use of ES and electromagnetic therapy for the treatment of wounds are considered adjunctive therapies and will only be covered for chronic Stage III or Stage IV pressure ulcers, arterial ulcers, diabetic ulcers, and venous stasis ulcers. For coverage guidelines; refer to the [National Coverage Determination \(NCD\) for Electrical Stimulation \(ES\) and Electromagnetic Therapy for the Treatment of Wounds \(270.1\)](#). (Accessed March 4, 2024)

Topical Application of Oxygen (HCPCS Code E0446)

Topical application of oxygen for wound healing will be denied as not reasonable and necessary. Refer to the DME MAC for [LCD for Oxygen and Oxygen Equipment \(L33797\)](#). (Accessed March 4, 2024)

Non-Contact Normothermic Wound Therapy

Non-contact normothermic wound therapy uses a device reported to promote wound healing by warming a wound to a predetermined temperature. The device consists of a non-contact wound cover into which a flexible, battery powered, infrared heating card is inserted.

Non-contact normothermic wound therapy is not covered. There is insufficient scientific or clinical evidence to consider this device as reasonable and necessary for the treatment of wounds.

Refer to the [NCD for Noncontact Normothermic Wound Therapy \(NNWT\) \(270.2\)](#). (Accessed March 4, 2024)

Policy History/Revision Information

Date	Summary of Changes
03/13/2024	<p>Coverage Guideline</p> <p>Ablative Laser Treatment for Wounds (CPT Code 17999)</p> <ul style="list-style-type: none">Replaced instruction to “refer to the UnitedHealthcare Medical Policy titled <i>Omnibus Codes</i> for coverage guidelines <i>for states/territories with no Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs)</i>” with “refer to the UnitedHealthcare Medical Policy titled <i>Omnibus Codes</i> for coverage guidelines” <p>Administrative</p> <ul style="list-style-type: none">Archived previous policy version MCS105.10

Instructions for Use

This information is being distributed to you for personal reference. The information belongs to UnitedHealthcare and unauthorized copying, use, and distribution are prohibited. This information is intended to serve only as a general reference resource and is not intended to address every aspect of a clinical situation. Physicians and patients should not rely on this information in making health care decisions. Physicians and patients must exercise their independent clinical discretion and judgment in determining care. Each benefit plan contains its own specific provisions for coverage, limitations, and exclusions as stated in the Member's Evidence of Coverage (EOC)/Summary of Benefits (SB). If there is a discrepancy between this policy and the member's EOC/SB, the member's EOC/SB provision will govern. The information contained in this document is believed to be current as of the date noted.

The benefit information in this Coverage Summary is based on existing national coverage policy; however, Local Coverage Determinations (LCDs) may exist and compliance with these policies are required where applicable.

UnitedHealthcare follows Medicare coverage guidelines found in statutes, regulations, NCDs, and LCDs to determine coverage. The clinical coverage criteria governing the items or services in this coverage summary have not been fully established in applicable Medicare guidelines because there is an absence of any applicable Medicare statutes, regulations, NCDs, or LCDs setting forth coverage criteria and/or the applicable NCDs or LCDs include flexibility that explicitly allows for coverage in circumstances beyond the specific indications that are listed in an NCD or LCD. As a result, UnitedHealthcare applies internal coverage criteria in the UnitedHealthcare commercial policies referenced in this coverage summary. The coverage criteria in these commercial policies was developed through an evaluation of the current relevant clinical evidence in acceptable clinical literature and/or widely used treatment guidelines. UnitedHealthcare evaluated the evidence to determine whether it was of sufficient quality to support a finding that the items or services discussed in the policy might, under certain circumstances, be reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member.

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