Smith+Nephew

PICO◊
Single Use Negative Pressure
Wound Therapy System

Reimbursement guide **2025**
Hospital Outpatient Department (HOPD)

Reimbursement Hotline Services
Phone: 866-988-3491
Fax: 866-304-6692
Alternate fax: 443-472-4274

Customer Support
Phone: 888-674-9551

Reimbursement Hotline Services

For assistance with reimbursement questions, contact Smith+Nephew Reimbursement Hotline Services Monday through Friday from 8:00 am - 7:00 pm EST at 1-866-988-3491.

Smith+Nephew Reimbursement Hotline Services staff can assist with the following:

- Patient-specific insurance verifications
- Payer policy and Medicare Local Coverage Determination (LCD) information
- Nurse Case Manager review of documentation and coding
- Prior authorization and pre-determination support

To initiate insurance verification support for your patients, please submit a complete Insurance Verification Request (IVR) Form with a signed practitioner authorization and fax to 866-304-6692. The provider is responsible for verifying individual contract or reimbursement rates with each payer. The Smith+Nephew Reimbursement Hotline Services are not able to confirm contracted or reimbursable rates on your behalf.

Reimbursement disclaimer

Information on reimbursement in the U.S. is provided as a courtesy. Due to the rapidly changing nature of the law and the Medicare payment policy, and reliance on information provided by outside sources, the information provided herein does not constitute a guarantee or warranty that reimbursement will be received or that the codes identified herein are or will remain applicable. This information is provided “AS IS” and without any other warranty or guarantee, expressed or implied, as to completeness or accuracy, or otherwise. This information has been compiled based on data gathered from many primary and secondary sources, including the American Medical Association, and certain Medicare contractors. Providers must confirm or clarify coding and coverage from their respective payers, as each payer may have differing formal or informal coding and coverage policies or decisions. Providers are responsible for accurate documentation of patient conditions and for reporting of products in accordance with particular payer requirements.

Advanced therapy pre-treatment checklist

Prior to requesting insurance verification or prior authorization from a payer, the provider should have documentation of the following in the patient's medical record:

- ☐ Prior conservative treatments that have failed to induce significant healing
- ☐ Exact location of ulcer
- ☐ Baseline measurements (LxWxD) immediately prior to initiation of treatment
- ☐ Ulcer is free of wound infection and osteomyelitis; past history of osteomyelitis has been treated successfully
- ☐ Adequate treatment of the underlying disease contributing to the ulcer
- ☐ Appropriate wound dressing changes, adequate wound debridement and patient compliance
- ☐ Appropriate off-loading / compression (if applicable), and patient compliance
- ☐ Adequate blood flow / perfusion; documentation of tests used to assess perfusion
- ☐ Patient's nutritional status is adequate for healing
- ☐ If patient is a smoker, cessation counseling and resources for smoking cessation are documented
- ☐ Measurement of the wound progression (length and width or circumference and depth)
- ☐ Be consistent in documenting etiology of wound – pressure ulcer, stasis, diabetic ulcer; measure and document progress
- ☐ Code diagnosis codes to the highest specificity

CPT Procedure Codes and Medicare Payments

Medicare has designated specific CPT codes (97607 - 97608) for qualified healthcare providers to report the purchase and application of Single Use Negative Pressure Wound Therapy (sNPWT). The selection of the code is based upon the size of the wound to be dressed. Ensure the medical record reflects the wound size for appropriate documentation.

CPT codes[1]	Code description	Status indicator	APC	Medicare National Average Payment (Facility rate)
97607	Negative pressure wound therapy (e.g. 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.	T	5052	$399.53
97608	Negative pressure wound therapy (e.g. 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.	T	5052	$399.53

References: 1. CPT Copyright 2024 American Medical Association. All rights reserved, CPT is a registered trademark of the American Medical Association. **2.** The Centers for Medicare and Medicaid Services, CY 2025 Hospital Outpatient PPS Final Rule, Addendum A and Addendum B Updates. Retrieved from https://www.cms.gov/medicare/payment/prospective-payment-systems/hospital-outpatient/regulations-notices/cms-1809-fc

Medicare has assigned CPT codes 97607 and 97608 (single-use negative pressure wound therapy) to Ambulatory Payment Classification (APC) Group 5052 Level II Debridement and Destruction with a status indicator or T (procedure or service subject to multiple reduction), provided that the NPWT service is medically necessary. HOPD's will bill 97607/08 on a CMS 1450 claim form.

Please be sure to check with your patient's individual health insurance provider to ensure coverage, coding and payment requirements are met for the site of care and provider.

The payment amounts referenced are based on Medicare national averages and do not include copayments/deductibles, sequestration, or wage index adjustments. Additionally, providers billing POS 19 (Outpatient Hospital – Off Campus) may receive reduced payment from Medicare.

Important reminders:

- ☐ Verify that sNPWT codes 97607 and 97608 are listed on your Charge Description Master (CDM)
- ☐ Verify the HOPD charges for sNPWT codes 97607 and 97608 include combined charges for the PICO device and for the work to assess the wound, to apply the PICO device and to provide instructions for ongoing use
- ☐ Verify that the charge for 97607 and 97608 are different than the charges for 97605 and 97606 (which should not include a charge for the NPWT durable medical equipment)

Indications and contraindications

PICO◊ is intended for use by or on the direction of a trained and licensed physician in accordance with these instructions for use.

Indications

PICO is indicated for patients who would benefit from a suction device (negative pressure wound therapy) as it may promote wound healing via removal of low to moderate levels of exudate and infectious materials. Appropriate wound types include:

- ☐ Chronic
- ☐ Acute
- ☐ Traumatic
- ☐ Subacute and dehisced wounds
- ☐ Partial-thickness burns
- ☐ Ulcers (such as diabetic or pressure)
- ☐ Flaps and grafts
- ☐ Closed surgical incisions

PICO single use negative pressure systems are suitable for use both in a hospital and homecare setting.

Contraindications

PICO is contraindicated for:

- ☐ Patients with malignancy in the wound bed or margins of the wound (except in palliative care to enhance quality of life)
- ☐ Previously confirmed and untreated osteomyelitis
- ☐ Non-enteric and unexplored fistulas
- ☐ Necrotic tissue with eschar present
- ☐ Exposed arteries, veins, nerves or organs
- ☐ Exposed anastomotic sites

PICO should not be used for the purpose of:

- ☐ Emergency airway aspiration.
- ☐ Pleural, mediastinal or chest tube drainage.
- ☐ Surgical suction

ICD-10 diagnosis code guidelines for wound care

PICO® coverage is based on medical necessity and subject to payer coverage guidelines. Providers should always follow payer coverage guidelines for covered indications.

PICO® Single Use Negative Pressure Wound Therapy is indicated for the following types of wounds:

- Chronic wounds
- Acute wounds
- Traumatic wounds
- Subacute & dehisced wounds
- Flaps & grafts
- Closed surgical incisions
- Ulcers (diabetic & pressure)
- Partial thickness burns

For chronic wounds, it is recommended that providers select the most specific primary and secondary diagnosis codes to accurately describe the reason the wound is not healing properly, and codes that indicate the wound is chronic and describe the location, severity, and laterality.

Some common types of chronic wounds include:

Example of specific DFU codes:

- Primary diagnosis: E11.621, type 2 diabetes mellitus with a foot ulcer
- Secondary diagnosis: L97.522, non-pressure chronic ulcer of other part of left foot with fat layer exposed

Example of specific VLU codes:

- Primary diagnosis: I87.312, chronic venous hypertension (idiopathic) with ulcer of left lower extremity
- Secondary diagnosis: L97.222, non-pressure chronic ulcer of left calf with fat ayer exposed

For traumatic, surgical and wounds of other origin (such as partial thickness burns, flaps & grafts and closed surgical incisions) it is recommended that providers select the most specific code related to the causation and location of the wound, as well as any 7th character indicating “type of encounter” (if required by ICD 10 Guidelines)

Example of other types of wound codes:

- Primary diagnosis: S61.401A Unspecified open wound of right hand, initial encounter
- Primary diagnosis: T21.23XA Burn of second degree of upper back, initial encounter
- Primary diagnosis: T81.30XA Disruption of wound, unspecified, initial encounter
- Primary diagnosis: M72.6 Necrotizing fasciitis
- Primary diagnosis: T81.83XS Persistent postprocedural fistula, sequela
- Primary diagnosis: L76.32 Postprocedural hematoma of skin and subcutaneous tissue following other procedure
- Primary diagnosis: L89.152 Pressure ulcer of sacral region, stage 2

Dressing changes

While Medicare does not separately pay for dressing changes, they may reimburse services as part of a billable evaluation and management (E/M) or procedure that often occurs on the same date of service as the dressing change. If not included in another service, the costs associated with dressing changes may be reported as not separately payable.

Medicare states, “Providers must document the medical necessity for all services provided. If there is no documented evidence (e.g., objective measurements) of ongoing significant benefit, then the medical record documentation must provide other clear evidence of medical necessity for treatments. The medical record must also clearly and indicate the complexity of skills required by the treating practitioner/clinician.” We generally accept this to mean that the patient had a reason to receive sNPWT/advanced therapies.

Global surgical period and consolidated billing

Global surgical period

- ☐ Medicare has established a national definition of a global surgical period to ensure that Medicare Administrative Contractors (MACs) make payments for the same services consistently across all jurisdictions.
- ☐ While PICO (device or its application) is not associated with a global surgical period, other surgical procedures performed may.
- ☐ Medicare payment for a surgical procedure includes pre-operative, surgery and post-operative care after a procedure routinely performed by the surgeon or other physician associated with the same group.
- ☐ A global period begins day 1 prior to the procedure, day of the procedure and 90 days post-operatively (92 days).
- ☐ Medicare payment rules for global surgical packages apply to procedure codes with global surgery indicators of 000, 010, 090, and YYY. While codes with "ZZZ" are surgical codes, they are add-on codes that you must bill with another service. There is no post- operative work included in the MPFS payment for the "ZZZ" codes.
- ☐ If the administration of PICO sNPWT is by the surgeon who performed the original surgery and is related to a complication from the original surgery (that did not require a trip to the OR), Medicare may consider the administration of PICO sNPWT "related" to the underlying surgery.

Consolidated billing

- ☐ If a Traditional Medicare patient is enrolled under a Home Health (HH) Episode of Care, the Home Health Agency must purchase, apply and bill PICO using code A9272.
- ☐ If the HOPD applies and bills for PICO when the Medicare patient is under a HH Episode of Care, the HOPD will not receive payment.
- ☐ A conditional allowance may apply if the Home Health Agency is treating a different condition than that of the HOPD, the HOPD may still retain payment in these instances. Please inquire through the patients care coordinators.
- ☐ Consolidated billing does not apply for Medicare patients enrolled in a Medicare Advantage plan. Please check with the patient's applicable Medicare Advantage and Commercial plan to determine their specific policies and procedures.

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Smith+Nephew Reimbursement Hotline Services
PICO° Insurance Verification Request (IVR) Form
Phone: 866-988-3491 Fax: 866-304-6692

1. Type of Insurance Verification Requested: Prior Authorization support will be initiated if required by Payer, include clinical documentation to support PA

☐ **New Wound** ☐ **Subsequent Applications** ☐ **Re-Verification** ☐ **New Insurance** ☐ **IVR Lite** ☐ **I opt out of Prior Authorization/Pre-Determination support services**

☐ **Single Wound** ☐ **Multiple Wounds** **Procedure Date: _____/_____/_____**

2. Patient Information: ***Please list the patient's name on this form when attaching a face sheet***

First Name:	Last Name:			M.I.:
Address:	Apt./Suite#:	City:	State:	Zip:
Date of Birth:	Phone #:		Gender: ☐ Female ☐ Male	

3. Insurance Information: ***Please attach a copy (front & back) of patient's insurance card(s)***

Cardholder Name:	DOB:	Relationship to patient:
Primary Payer:	SSN:	Plan Type:
Policy #:	Group #:	Card Phone #:
Secondary Payer:		Plan Type:
Policy #:	Group #:	Card Phone #:

4. Healthcare Provider (HCP) & Facility/Agency Information: *Please note, we do not verify inpatient benefits*

Place of Service: ☐ Physician Office (POS11) ☐ Hospital Outpatient Department (POS19/22) ☐ Unskilled Nursing Bed (POS32) ☐ Home Visit (POS12) ☐ Home Health Agency (POS12) ☐ Other POS: _____

Skilled Nursing Facility: Provider is responsible for confirming skilled/unskilled status. Is the patient expected to be in a skilled bed on the date of service? ☐ Yes ☐ No

HCP First Name:	HCP Last Name:	M.I.:
HCP NPI:	HCP Tax ID#:	
Specialty: ☐ MD ☐ DO ☐ DPM ☐ PA ☐ NP/FNP ☐ Other: _____		
Contact Name:	Phone #:	
Facility Name:	Facility NPI:	
Facility Address:	Facility Tax ID:	
City, State, Zip:	Phone #:	Fax #:

5. Treatment & Wound Information: *Please note, wound diagnoses codes are required and should be listed to include the specific anatomical site, type of wound, and etiology whenever possible. Missing information will result in processing delays.**

ICD-10-CM Diagnosis Codes*:

Primary: _____; _____

Secondary: _____; _____

Other: _____; _____

Select One: ☐ PICO 7 ☐ PICO 7Y ☐ PICO 14

Wound Information:

☐ CPT 97607 - Total Wound(s) surface area < to 50 square centimeters
☐ CPT 97608 - Total Wound(s) surface area > than 50 square centimeters
☐ CPT A9272 - Home Health Agency, Device Only
☐ Procedure Date: _____ / _____ / _____ Number of Anticipated Applications: _____

6. Wound Information & Diagnosis Code(s): ***Please include ICD-10 codes that indicate Primary diagnosis, ulcer type, AND location. MUST include the full alpha-numeric ICD-10 Code. Ex: E11.621; L97.512; If treating more than one wound, please provide diagnosis codes for each additional wound***

ICD-10 Codes: #1 Wound (Required)

Primary (Etiology): _____

Secondary (Ulcer/Location): _____

Tertiary (Optional): _____

Wound Dimensions: L_____W_____D_____

ICD-10 Codes: #2 Wound

Primary (Etiology): _____

Secondary (Ulcer/Location): _____

Tertiary (Optional): _____

Wound Dimensions: L_____W_____D_____

7. Prior Authorization: ***For PA support please attach all clinical notes related to the wound treatment episode***

# of Anticipated Applications/Visits _____ Anticipated Units _____

8. Authorized Signature: ***Please include all required information and sign below***

By signing below, I certify that I have obtained a valid authorization from the patient listed on this form permitting me to release the patient's protected health information (PHI) to the Smith+Nephew Reimbursement Hotline Services, Smith & Nephew, Inc., its contractors, and the patient's health insurance company as necessary to research insurance coverage and payment information to determine benefits related to PICO° products on behalf of the patient. I further understand that completing this form does not guarantee that insurance coverage or reimbursement will be provided to the patient. I certify that the information provided on this form is current, complete, and accurate to the best of my knowledge.

If **prior authorization** is required, I authorize Smith and Nephew to initiate the authorization.
For typed or stamped signatures below: I agree that this typed or stamped signature has the same validity and meaning as my handwritten signature.

Authorized Signature: _____ **Date:** _____

Disclaimer: The Smith+Nephew Reimbursement Hotline is an information service only. Benefits information is provided by the insurer or third-party payer. Results of this research are not a guarantee of coverage or reimbursement now or in the future, and Smith & Nephew disclaims liability for payment of any claims, benefits or costs.