



Cellulitis and Chronic/Complex Wound Care

I. Policy

University Health Alliance (UHA) will reimburse for the care and medications associated with the medically necessary treatment of skin cellulitis, chronic and complex ulcerations, and wounds when determined to be medically necessary and within the medical criteria guidelines (subject to limitations and exclusions) indicated below.

II. Background

Soft tissue infections of all types are the source of significant suffering and represent a large societal burden and cover a large share of healthcare resources. Acute and chronic wounds of the lower extremities are particularly vexing as a result of chronicity and the difficulties associated with achieving long-term healing. Diabetic ulcers and infections (neuropathic and other), chronic venous ulcers, wounds associated with arterial insufficiency and other systemic diseases (such as vasculitis) are all problematic in unique ways. The transfer of substantial portions of care to outpatient settings has proven to be problematic in the care of these wounds as a result of failures in local wound care, enforcement of limb elevation, smoking cessation, and medication compliance and frequent surveillance by knowledgeable specialists.

UHA seeks comprehensive, rational, and step-wise care in the management of complex and, in particular, diabetic and chronic venous wounds. UHA believes that patients with severe and/or refractory wounds and/or with comorbid conditions (including those related to behavioral health) require coordinated and comprehensive care and may sometimes benefit from hospitalization even when standard utilization management might “preclude” it. At the same time, fastidious outpatient care can be very successfully pursued when appropriate resources are utilized. UHA has witnessed increasingly fragmented and episodic care being applied to severe and chronic soft tissue wounds. This is anathema to the principles upon which UHA makes necessity determinations. Accordingly, this policy outlines core expectations for the management of these specified wounds. This policy is not meant to be an encyclopedic procedure manual but serves to outline basic expectations and principles; the expectation being that care is provided in a timely, safe, effective, efficacious, equitable, and patient centered manner, with the overlying principle that care provided meets requirements for medical necessity.

The following UHA policies may apply as appropriate adjuncts to wound healing in defined circumstances, but are not substitutes for standard treatment:

- Hyperbaric Oxygen Therapy (HBOT) Medical Payment Policy
- Negative Pressure Wound Therapy Medical Payment Policy
- Bio-Engineered Skin and Soft Tissue Substitutes Medical Payment Policy

III. Criteria/Guidelines

- A. UHA will reimburse for the evaluation and management of cellulitis and complex wounds in accordance with applicable standards of care. In determining medical necessity for care, members are expected to receive appropriate treatment; therefore, coverage of such is subject to the following criteria:
 1. A comprehensive plan of treatment must address systemic disease and goals for rehabilitation and prevention of recurrent infection and/or breakdown. Treatment of predisposing factors, such as edema or underlying cutaneous disorders, meets criteria for medical necessity and is an obligatory part of care.
 - a. In lower-extremity cellulitis, it is considered medically necessary for clinicians to carefully examine the interdigital toe spaces because treating fissuring, scaling, or

maceration may eradicate colonization with pathogens and reduce the incidence of recurrent infection.

- b. Failure to document adequate consideration and treatment of applicable comorbidities, etiologic conditions, and treatment goals may lead to request for information from UHA to determine if standard of care has been met.
 - c. Patients who present with recurrent cellulitis in whom adequate consideration of systemic disease, comorbid conditions, and goals of treatment have not been addressed may lead to request for information from UHA. Claims may be denied if standard of care is not met.
2. UHA will reimburse for the evaluation and management of chronic and complex wounds in accordance with applicable standards of care. Determination of medical necessity is subject to the following criteria:
- a. Appropriate wound care includes the proper attention the following:
 - i. Irrigation;
 - ii. Debridement: determination of adequacy of debridement is essential. Viability of bone, tendon and cartilage can often be best determined by very experienced surgeons;
 - iii. Topical therapy;
 - iv. Dressing;
 - v. Wound packing;
 - vi. Wound closure;
 - vii. Negative pressure wound therapy;
 - viii. Skin grafts;
 - ix. Adjunct therapy;
 - x. Hyperbaric oxygen therapy;
 - xi. Appropriate positioning and relief of mechanical and hydrostatic pressure;
 - xii. Biopsies will be considered in atypical and refractory lesions;
 - xiii. Adjuncts to wound healing such as “wound vacs” and bioengineered dressings are NOT substitutes for mechanical debridement and frequent wound inspection;
 - xiv. Decisions regarding amputation, closure, or open wounds; choice of antimicrobials; and extent and frequency of debridement are complicated and require very complete documentation and early consultation with appropriate specialists.
3. Determination of factors which will preclude healing or affect compliance must include attention to the following:
- a. Social and domestic factors;
 - b. Underlying disease (i.e., failure to evaluate and to manage underlying vascular disease may result in denial);
 - c. Comorbidities;
 - d. Diabetes:
 - i. Although there is no overwhelming clinical evidence in support of short-term glycemic control as directly affecting wound healing potential or preventing

infection, UHA considers adequate glycemic control a priority when treating wounds and infections;

4. Step-wise approach to surgical management:

- a. When appropriately utilized by qualified providers, UHA considers the following step-wise approach to surgical interventions to be medically necessary for complex wounds such as diabetic foot infections:
 - i. Incision:
 - All but the simplest infections may require staged procedures; thus, the initial skin incision and dissection should take into account future surgical plans.
 - ii. Wound investigation, to include the size and extent of soft tissue involvement and the presence of any foreign bodies, abscesses, or sinus tracts. Surgical exploration should then follow when appropriate.
 - iii. Debridement should be completed regardless of size and quantity.
 - iv. Wound irrigation and lavage following surgical debridement of infected tissue has been reported as a good complement to systemic antibiotics and appears to be safe in reducing the incidence of continued infection.
 - v. Definitive wound closure:
 - Decisions regarding closure are ultimately dependent on the volume of viable soft tissue remaining after surgery, the amount of drainage, and the presence of any residual infection.

5. Antibiotics:

- a. UHA will not routinely cover the use of antibiotics to treat bilateral swelling and redness of the lower leg unless there is clear evidence of infection.
 - i. To ensure appropriate treatment, clinicians must consider the likelihood of diagnoses other than cellulitis when evaluating swelling and redness of the lower legs. Misdiagnosis of bilateral cellulitis can lead to overuse of antibiotics and subject patients to potentially unnecessary hospital stays.
- b. For cellulitis with systemic signs of infection, parenteral antibiotics are considered medically necessary. The choice of antibiotic therapy is expected to conform to community standard of care.
 - i. Parenteral antibiotic therapy is considered NOT medically necessary for typical cases of cellulitis *without* systemic signs of infection in most instances (standard algorithms exist and are widely available).
 - ii. Consultation with a pharmacist and/or infectious disease specialist may be medically necessary for determining appropriate antibiotic therapy for patients with atypical presentations, significant comorbidities, or recurrent disease.

6. Laboratory Testing:

- a. Laboratory testing may not be considered medically necessary for patients with uncomplicated infections in the absence of comorbidities or complications.
 - i. Cultures of blood or cutaneous aspirates, biopsies, or swabs are not routinely recommended (current guidelines from Infectious Diseases Society of America). Therefore, coverage may be denied in the absence of clear documentation of necessity.

- ii. Cultures of blood and microscopic examination of cutaneous aspirates, biopsies, or swabs may be considered medically necessary in patients with complicating circumstances, such as the following:
 - Malignancy on chemotherapy, neutropenia, or severe cell-mediated immunodeficiency
 - Severe local infection (e.g., extensive cellulitis)
 - Systemic signs of infection (e.g., fever)
 - History of recurrent or multiple abscesses
 - Failure of initial antibiotic therapy
 - Extremes of age (e.g., young infants or older adults)
 - Presence of underlying comorbidities (e.g., lymphedema, malignancy, neutropenia, immunodeficiency, splenectomy, diabetes, vasculitis, venous insufficiency, atrial inflow problem)
 - Special exposures (e.g., animal bite, water-associated injury)
 - Presence of indication for prophylaxis against infective endocarditis
 - Community patterns of *S. aureus* or other organism susceptibility are unknown or rapidly changing

7. Consultations:

- a. A comprehensive and collaborative approach is essential to favorable outcomes in chronic and complex wounds. Dermatology, radiology, surgery, and infectious disease specialists can elucidate uncommon etiologies and guide therapy or refractory disease.
 - i. UHA considers consultation with appropriate specialists medically necessary on a case-by-case basis for patients with complex wounds or comorbidities that place those patients at high risk for poor outcomes.
 - ii. Early consultation may be considered medically necessary and is encouraged in unusual, complex, or recurrent soft tissue infections.
 - Outpatient wound care must be coordinated among providers. Attention must be given to ensure that all providers responsible for the care of members with complex wounds are informed of the applicable assessments and recommendations of consulting providers.

8. Radiography:

- a. Radiographic examination may be medically necessary to determine whether a skin abscess is present (via ultrasonography) and for distinguishing cellulitis from osteomyelitis (via magnetic resonance imaging).
 - i. Radiographic evaluation may be warranted in patients with underlying immunosuppression, diabetes, venous insufficiency, or lymphedema; in patients with persistent systemic symptoms; and in patients suspected to have a radio dense foreign body.
 - ii. Radiographic examination cannot reliably distinguish cellulitis from necrotizing fasciitis or gas gangrene; if there is clinical suspicion for these entities, radiographic imaging should not delay surgical intervention.

9. Place of Service:

- a. UHA recognizes the necessity of acute hospitalization and/or Skilled Nursing Facility (SNF) admissions (with authorization) when circumstances exist that may compromise optimal care if standard medical necessity for place of service criteria are strictly enforced.
- i. Hospitalization:
- Inpatient care may be considered medically necessary if there is concern for a deeper or necrotizing infection, for patients with poor adherence to therapy, for infection in a severely immunocompromised patient, or if outpatient treatment is failing.
 - Documentation of the clinician's medical reasoning for hospitalization for cellulitis or complex wound care must meet criteria for medical necessity and should be available to UHA upon request.
 - UHA is open to hospitalization for the purpose of overcoming therapeutic roadblocks. Direct communication with UHA clinical staff (808-532-4006) is required when admitting providers suspect member will benefit from admission but may not meet standard admission requirements.
- ii. Inpatient/SNF:
- UHA considers inpatient treatment medically necessary on a case-by-case basis for patients who otherwise would not meet criteria for inpatient or SNF admission, but because of comorbidities (social or medical), the patient is at high risk for noncompliance, poor outcome, or regression of progress.
- iii. Wound Care Center:
- Care at dedicated wound clinics can be advantageous. UHA considers referral to a certified wound care center medically necessary for complex patients with conditions that include:
 - Arterial ulcers
 - Diabetic foot ulcers
 - Refractory lower extremity cellulitis and edema
 - Neuropathic ulcers
 - Non-healing wounds resulting from:
 - Diabetes
 - Post-radiation injury to soft tissue
 - Surgery
 - Osteoradionecrosis
 - Podiatry-related wounds
 - Pressure ulcers
 - Necrotizing infections and polymicrobial deep infections
 - Venous ulcers
 - Chemical injuries

- Other chronic, non-healing wounds
 - i. Outpatient wound care must be coordinated among providers, and patient compliance must be established.
- B. Special Wounds:
 1. UHA recognizes the importance of appropriate consideration of wounds that lack a typical presentation or that are associated with critical outcomes or poor prognosis. In these situations, UHA may request additional information to document that proper care has been provided. Such wounds include the following:
 - a. Meleney ulcer
 - b. Pyoderma gangrenosum (PG):
 - i. PG is neither in an infectious nor gangrenous condition
 - ii. Association with an underlying systemic disease
 - iii. Consultations to appropriate specialty services may be considered medically necessary in wounds that may present a diagnostic challenge due to an atypical presentation
 - c. Necrotizing soft tissue infections:
 - i. These infections are characterized clinically by fulminant tissue destruction, systemic signs of toxicity, and high mortality. Accurate diagnosis and appropriate treatment must include early surgical intervention and antibiotic therapy.
 - ii. Fournier gangrene
 - iii. Prompt surgery referral is considered medically necessary for all necrotizing soft tissue infections.
 - d. Burns:
 - i. Surgical consultation is considered medically necessary for all burns meeting criteria for admission.
- C. Adequate tetanus toxoid immunization is medically necessary for all open wounds, indolent or acute. Appropriate tetanus prophylaxis should be administered as soon as possible following a wound but is medically necessary even to patients who present late for medical attention.

NOTE:

This UHA payment policy is a guide to coverage, the need for prior authorization and other administrative directives. It is not meant to provide instruction in the practice of medicine, and it should not deter a provider from expressing his/her judgment.

Even though this payment policy may indicate that a particular service or supply is considered covered, specific provider contract terms and/or members' individual benefit plans may apply, and this policy is not a guarantee of payment. UHA reserves the right to apply this payment policy to all UHA companies and subsidiaries.

UHA understands that opinions about and approaches to clinical problems may vary. Questions concerning medical necessity (see Hawaii Revised Statutes §432E-1.4) are welcome. A provider may request that UHA reconsider the application of the medical necessity criteria in light of any supporting documentation.

IV. Limitations/Exclusions

- A. Treatment of cellulitis and chronic or complex wounds without appropriate consideration of applicable comorbidities and without a treatment plan that meets standard of care guidelines does not meet criteria for medical necessity and therefore is not covered.
- B. Claims for patients with recurrent cellulitis may be pended for review for medical necessity by UHA. The following standards of care should be documented:
 - 1. Identification and treatment of predisposing conditions such as edema, obesity, diabetes, arterial and small vessel disease, dermatitis, eczema, venous insufficiency, and toe web abnormalities. These practices should be performed as part of routine patient care and certainly during the acute stage of cellulitis;
 - 2. Consideration of prophylactic antibiotics when appropriate in patients who have 3 to 4 episodes of cellulitis per year despite attempts to treat or control predisposing factors;
 - 3. Consultation with infectious disease, vascular surgery, and/or other specialties as applicable and appropriate;
 - 4. Identification of social/domestic causes must be undertaken (e.g., recurrent insect bites, poor hygiene, inaccessibility to prescribed treatment);
 - 5. Examination and documentation at outpatient visits must allow for the assessment of degree of improvement or disease progression. Photographs are very helpful but do not replace documentation of measurements, examination of dressings, evaluation of edema, erythema, drainage, circulation, etc.

V. Administrative Guidelines

- A. Prior authorization is not required.

VI. Policy History

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