Policy Number	**DME101.050**
Policy Effective Date	**05/01/2026**

Noncontact Normothermic Wound Therapy (NNWT)

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DME101.044 Noncontact Ultrasound Treatment for Wounds

Disclaimer

Carefully check state regulations and/or the member contract.
Each benefit plan, summary plan description or contract defines which services are covered, which services are excluded, and which services are subject to dollar caps or other limitations, conditions or exclusions. Members and their providers have the responsibility for consulting the member's benefit plan, summary plan description or contract to determine if there are any exclusions or other benefit limitations applicable to this service or supply. **If there is a discrepancy between a Medical Policy and a member's benefit plan, summary plan description or contract, the benefit plan, summary plan description or contract will govern.**

Legislative Mandates

EXCEPTION: For Illinois only: Illinois Public Act 103-0458 [Insurance Code 215 ILCS 5/356z.61] (HB3809 Impaired Children) states all group or individual fully insured PPO, HMO, POS plans amended, delivered, issued, or renewed on or after January 1, 2025 shall provide coverage for therapy, diagnostic testing, and equipment necessary to increase quality of life for children who have been clinically or genetically diagnosed with any disease, syndrome, or disorder that includes low tone neuromuscular impairment, neurological impairment, or cognitive impairment.

Coverage

Use of noncontact normothermic wound therapy (NNWT) **is considered experimental, investigational and/or unproven.**

Policy Guidelines

None.

Description

Noncontact normothermic wound therapy (NNWT) is a device reported to promote wound healing by warming a wound to a predetermined temperature. The device consists of a noncontact wound cover into which a flexible, battery powered, infrared heating card is inserted.

Rationale

This policy is based on a review of coverage guidance from the Centers for Medicare and Medicaid Services (CMS) specific to noncontact normothermic wound therapy (NNWT). (1)

The CMS National Coverage Determination states, “There is insufficient scientific or clinical evidence to consider this device as reasonable and necessary for the treatment of wounds within the meaning of §1862(a)(1)(A) of the Social Security Act and will not be covered by Medicare.” (1)

Coding

Procedure codes on Medical Policy documents are included **only** as a general reference tool for each policy. **They may not be all-inclusive.**

The presence or absence of procedure, service, supply, or device codes in a Medical Policy document has no relevance for determination of benefit coverage for members or reimbursement for providers. **Only the written coverage position in a Medical Policy should be used for such determinations.**

Benefit coverage determinations based on written Medical Policy coverage positions must include review of the member’s benefit contract or Summary Plan Description (SPD) for defined coverage vs. non-coverage, benefit exclusions, and benefit limitations such as dollar or duration caps.

CPT Codes	None
HCPCS Codes	A6000, E0231, E0232

*Current Procedural Terminology (CPT®) ©2025 American Medical Association: Chicago, IL.

References

1. Centers for Medicare and Medicaid Services. National Coverage Determination for Noncontact Normothermic Wound Therapy (NNWT) (270.2) (July 1, 2002) (Version 1). Available at <https://www.cms.gov> (accessed March 31, 2026).

Centers for Medicare and Medicaid Services (CMS)

The information contained in this section is for informational purposes only. HCSC makes no representation as to the accuracy of this information. It is not to be used for claims adjudication for HCSC Plans.

The Centers for Medicare and Medicaid Services (CMS) does have a national Medicare coverage position. Coverage may be subject to local carrier discretion.

A national coverage position for Medicare may have been changed since this medical policy document was written. See Medicare's National Coverage at <https://www.cms.hhs.gov>.

Policy History/Revision	
Date	**Description of Change**
05/01/2026	Document updated. Coverage unchanged. No new references added.
01/01/2026	Document updated with literature review. The following changes were made to Coverage: 1) Revised language in experimental, investigational and/or unproven statement without change to intent; and 2) Removed content on noncontact real-time fluorescence wound imaging. One new reference added; others removed. Title changed from: Noncontact Warming Therapy and Fluorescence Imaging for Wounds.
08/15/2024	Document updated with literature review. The following change was made to Coverage: Added: Noncontact real-time fluorescence wound imaging (e.g., MolecuLight) for bacterial presence is considered experimental, investigational and/or unproven for all indications. References 1-3, 14-19 added; others revised. Title changed from Noncontact Normothermic Wound Therapy.
06/01/2023	Reviewed. No changes.
12/01/2022	Document updated with literature review. Coverage unchanged. No new references added.
02/01/2022	Reviewed. No changes.
03/01/2021	Document updated with literature review. Coverage unchanged. No new references added.
10/15/2020	Reviewed. No changes.
01/01/2020	Document updated with literature review. Coverage unchanged. The following references were added/updated: 4 and 10.
06/01/2017	Reviewed. No changes.
07/01/2016	New medical document originating from medical policy DME101.044. The following change was made to Coverage: Added “or noncontact wound warming device” to the following coverage statement: Use of noncontact normothermic wound therapy or noncontact wound warming device, either as a primary intervention or as an adjunct to other wound therapies, is considered experimental, investigational and/or unproven. Title changed from Noncontact Wound Therapy.