Clinical Practice Guideline: **Debridement of Skin, Muscle and/or Fascia, or Bone in the Lower Extremities**

Date of Implementation: **August 18, 2016**

Product: **Specialty**

GUIDELINES

A. American Specialty Health – Specialty (ASH) considers services consisting of CPT Code 11000 and 11001 to be medically necessary for the treatment of extensive eczematous or infected skin **upon meeting ALL of the following criteria:**

1. Presence of condition(s) that may require debridement of large amounts of skin (at least one of the following):
   - Rapidly spreading necrotizing process (e.g., aggressive streptococcal infections);
   - Severe eczema;
   - Bullous skin diseases;
   - Extensive skin trauma (including large, abraded areas with ground-in dirt); OR
   - Autoimmune skin diseases (such as pemphigus).

2. All significant relevant comorbid conditions are addressed that could interfere with optimal wound healing.

3. If there is no necrotic, devitalized, fibrotic, or other tissue or foreign matter present that would interfere with wound healing, the debridement service is not medically necessary. The presence or absence of such tissue or foreign matter must be documented in the medical record.

The number of debridement services required is variable and depends on numerous intrinsic and extrinsic factors.

Local infiltration, metatarsal/digital block or topical anesthesia are included in the reimbursement for debridement services and are not separately payable. Anesthesia administered by or incident to the provider performing the debridement procedure is not separately payable.

Exclusion criteria: CPT code 11000 and 11001 is **NOT** appropriate for the following conditions:

- Debridement of a localized amount of tissue normally associated with a circumscribed lesion. Examples of this are ulcers, furuncles, and localized skin infections.

- Skin breakdown under a dorsal corn is not considered an ulcer and generally does not require debridement. These lesions typically heal without significant surgical intervention beyond removal of the corn and shoe modification.
- Removing a collar of callus (hyperkeratotic tissue) around an ulcer is not debridement of skin or necrotic tissue.

ASH considers **CPT code 17250** (Chemical cauterization of granulation tissue [i.e., proud flesh]) an integral service as part of a health care provider's medical or surgical care and not separately billable with surgical debridement CPT codes listed in the table below.

CPT CODES AND DESCRIPTIONS

CPT® Code	**CPT® Code** Description
11000	Debridement of extensive eczematous or infected skin; up to 10% of body surface
11001	Debridement of extensive eczematous or infected skin; each additional 10% of the body surface, or part thereof (List separately in addition to code for primary procedure)
17250	Chemical cauterization of granulation tissue (i.e., proud flesh)

BACKGROUND

Debridement is the removal of infected, contaminated, damaged, devitalized, necrotic, or foreign tissue from a wound. The services described in this clinical practice guideline cover debridement of skin, subcutaneous tissue, fascia, muscle, bone and removal of foreign material. Debridement promotes wound healing by reducing sources of infection and other mechanical impediments to healing. Its goal is to cleanse the wound, reduce bacterial contamination and provide an optimal environment for wound healing or possible surgical intervention. The usual end point of debridement is removal of pathological tissue and/or foreign material until healthy tissue is exposed. Debridement techniques include, among others, sharp and blunt dissection, curettement, scrubbing, and forceful irrigation. Surgical instruments may include a scrub brush, irrigation device, electrocautery, laser, sharp curette, forceps, scissors, burr or scalpel.

Conditions that may require debridement of large amounts of skin are aggressive infections, severe eczema, and certain autoimmune skin diseases. The Infectious Disease Society of America (IDSA) recommends surgical debridement as a component of a multimodal treatment plan including broad-spectrum antibiotics and empirical therapy for patients with complicated deeper soft-tissue infections, surgical/traumatic wound infection, major abscesses, cellulitis, and infected ulcers and burns (Liu et al., 2011).

Foot infections are a common and serious problem in persons with diabetes. Diabetic foot infections (DFIs) typically begin in a wound, most often a neuropathic ulceration. While all wounds are colonized with microorganisms, the presence of infection is defined by ≥2 classic findings of inflammation or purulence. The IDSA (Lipsky et al., 2012) recommends debridement within a multimodal care plan. Debridement, aimed at removing debris, eschar, and surrounding callus. Sharp (or surgical) methods were generally considered best, but mechanical, autolytic, or larval debridement techniques were recommended as appropriate for some wounds. The specific course of care for the patient needs to be determined on a case-by-case basis.

Bullous Disorders

Bullous disorders are characterized by blisters or erosions of the skin and mucous membranes. The type of disease depends upon the level in the skin in which the blisters form and where they are located on the body. Bullous skin disorders may be acquired or induced, or they may be autoimmune in origin. These disorders are not contagious.

Bullous disease of diabetes (bullosis diabeticorum) is a distinct, spontaneous, noninflammatory, blistering condition of acral skin that is unique to patients with diabetes mellitus. Specific treatment of bullous disease of diabetes (bullosis diabeticorum) is unnecessary because the condition is self-limiting. The blister should be left intact whenever possible to serve as a sterile dressing and to avoid secondary infection. However, secondary tissue necrosis may require debridement and possible tissue grafting (Poh-Fitzpatrick et al., 2013).

Pressure Injury

A pressure injury is defined as localized damage to the skin and/or underlying tissue as a result of pressure or pressure in combination with shear. These injuries usually occur over a bony prominence but may also occur due to injury from a medical device or other object (National Pressure Injury Advisory Panel, 2019). Because muscle and subcutaneous tissue are more susceptible to pressure induced injury than dermis and epidermis, pressure injuries are often worse than their initial presentation. Pressure injuries are assessed and staged at the bedside as a clinical description of the depth of observable tissue destruction.

For the purpose of this clinical practice guideline, the staging of pressure injuries can be classified according to the National Pressure Injury Advisory Panel as follows (Berlowitz, 2023):

Pressure Injury Stage	Description
(Suspected) Deep Tissue Injury	Deep tissue pressure injury is characterized as intact or non-intact skin with a localized area of persistent non-blanchable deep red, maroon, purple discoloration, or

Pressure Injury Stage	Description
	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.
Stage 1	Intact skin with a localized area of non-blanchable erythema, which may appear differently in darkly pigmented skin. The 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	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 tissue 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.
Stage 3	Full-thickness loss of skin, in which adipose tissue is visible in the ulcer and granulation tissue and epibole 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	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, 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.

Pressure Injury Stage	Description
Unstageable	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 (i.e., dry, adherent, intact without erythema or fluctuance) on the heel or ischemic limb should not be softened or removed.

The National Pressure Injury Advisory Panel (2019) recommends debridement of non-viable, necrotic, or infected tissue within the wound bed or edge of pressure injuries when appropriate to the individual's condition and consistent with the overall goals of care.

Necrotizing Fasciitis

Necrotizing Fasciitis (NF) is a necrotizing soft tissue infection involving the fascia and subcutaneous tissue that can cause rapid local tissue necrosis and life-threatening severe sepsis. Accurate assessment and timely intervention are critical in the treatment of patients affected with NF. Understanding the history and unique characteristics of this disease is crucial to achieve early recognition, effective treatment and a favorable outcome. Classic symptoms include severe pain out of proportion to local findings, erythema, mottling, crepitus, skin anesthesia, warmth, tenderness, hemorrhagic bullous formation, edema in the affected area and fever. Machado et al. (2011) reviewed the management of patients with necrotizing fasciitis. Radical surgical debridement, broad spectrum antibiotics, negative pressure wound dressings, and hyperbaric oxygen therapy are considered to be the cornerstone of treatment. The mortality rate ranges widely from 10% to 75% and is related to delay in initial debridement, and other factors such as patient age of more than 60 years, associated hypotension, acidosis, bacteremia, renal failure, hyponatremia, peripheral vascular disease, myonecrosis and myositis. The authors concluded that delay in recognition and effective treatment of necrotizing fasciitis increases the mortality. Therefore, prompt radical surgical debridement, appropriate antibiotics and adjuvant therapy contribute to an improved outcome.

PRACTITIONER SCOPE AND TRAINING

Practitioners should practice only in the areas in which they are competent based on their education, training and experience. Levels of education, experience, and proficiency may vary among individual practitioners. It is ethically and legally incumbent on a practitioner to determine where they have the knowledge and skills necessary to perform such services and whether the services are within their scope of practice.

It is best practice for the practitioner to appropriately render services to a member only if they are trained, equally skilled, and adequately competent to deliver a service compared

to others trained to perform the same procedure. If the service would be most competently delivered by another health care practitioner who has more skill and training, it would be best practice to refer the member to the more expert practitioner.

Best practice can be defined as a clinical, scientific, or professional technique, method, or process that is typically evidence-based and consensus driven and is recognized by a majority of professionals in a particular field as more effective at delivering a particular outcome than any other practice (Joint Commission International Accreditation Standards for Hospitals, 2020).

Depending on the practitioner's scope of practice, training, and experience, a member's condition and/or symptoms during examination or the course of treatment may indicate the need for referral to another practitioner or even emergency care. In such cases it is prudent for the practitioner to refer the member for appropriate co-management (e.g., to their primary care physician) or if immediate emergency care is warranted, to contact 911 as appropriate. See the *Managing Medical Emergencies (CPG 159 – S)* policy for information.

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