Clinical Practice Guideline: **Incision and Drainage Below Fascia**

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Product: **Specialty**

GUIDELINES

American Specialty Health – Specialty (ASH) considers services consisting of CPT® Codes 28002 or 28003 to be medically necessary when indicated for the drainage of abscess, cyst, or bursa. Examples of appropriate diagnoses include the following and would be considered an emergent situation:

ICD-10 Code	ICD-10 Code Description
I70.233, I70.243	Atherosclerosis of native arteries of leg with ulceration of ankle
I70.333, I70.343, I70.433, I70.443, I70.533, I70.543, I70.633, I70.643, I70.733, I70.743	Atherosclerosis of bypass graft(s) of the leg with ulceration of ankle
I70.234, I70.244	Atherosclerosis of native arteries of leg with ulceration of heel and midfoot
I70.334, I70.344, I70.434, I70.444, I70.534, I70.544, I70.634, I70.644, I70.734, I70.744	Atherosclerosis of bypass graft(s) of the leg with ulceration of heel and midfoot
I70.235, I70.245	Atherosclerosis of native arteries of leg with ulceration of other part of foot
I70.335, I70.345, I70.435, I70.445, I70.535, I70.545, I70.635, I70.645, I70.735, I70.745	Atherosclerosis of bypass graft(s) of the leg with ulceration of other part of foot
L02.611 - L02.619, L03.115 - L03.119, L03.125 - L03.129	Cutaneous abscess of foot - Cellulitis and acute lymphangitis of lower and unspecified part of limb
L02.818, L03.818, L03.898	Cutaneous abscess, cellulitis, and acute lymphangitis of other sites
L89.500 - L89.529	Pressure ulcer of ankle

L89.600 - L89.629	Pressure ulcer of heel
L97.301 - L97.329	Non-pressure chronic ulcer of ankle
L97.401 - L97.429	Non-pressure chronic ulcer of heel and midfoot
L97.501 - L97.529	Non-pressure chronic ulcer of other part of foot

CPT® Code	CPT® Code Description
28002	Incision and drainage below fascia, with or without tendon sheath involvement, foot; single bursal space
28003	Incision and drainage below fascia, with or without tendon sheath involvement, foot; multiple areas

BACKGROUND

Incision and drainage is a minor surgical procedure to release pus or pressure buildup under the skin. For the CPT® codes covered in this practice guideline, an incision is made through skin and fascia to expose and remove the infected tissues. The bursal sac may also be removed or simply incised and drained. Wounds encompassing a large area, may be irrigated and then treated using an antibiotic, followed by packing with gauze. The incision may also be left open to facilitate the wound healing. According to current procedural terminology (American Medical Association), one or multiple incisions may be necessary depending on the extent of the involved tissues.

When clinically indicated, uncomplicated Skin and Soft Tissue Infections (SSTIs), such as abscesses, with no symptoms or signs of systemic involvement respond well to incision and drainage and appropriate wound care. The extent of the abscess must be confirmed, and complete drainage performed (Ramakrishnan et al., 2015).

Most successful incision and drainage procedures on healthy patients do not require subsequent treatment with antibiotics. For a simple abscess, the open draining incision site permits the body's defenses to purge the infection without having to expose patients to potential adverse effects of antibiotic treatment. However, patients with extensive cellulitis beyond the region of the abscess or who have material comorbidities may require supplemental antimicrobial therapy (Fitch et al., 2007).

According to the Infectious Disease Society of America (IDSA) guidelines, incision and drainage is the recommended treatment for inflamed epidermoid cysts, carbuncles, abscesses, and large furuncles (Stevens et al., 2014). The decision to initiate antibiotic therapy to target *S. aureus* as an adjunct to incision and drainage should be based upon whether or not systemic inflammatory response syndrome (SIRS) is present. In addition, use of an antibiotic for methicillin resistant staphylococcus aureus (MRSA) is recommended for patients with carbuncles or abscesses who have failed initial antibiotic treatment or have markedly impaired host defenses or who have SIRS and hypotension (Stevens et al., 2014).

Pressure injuries are areas of necrosis and often ulceration (also called pressure ulcers) where soft tissues are compressed between bony prominences and external hard surfaces. They are caused by unrelieved mechanical pressure in combination with friction, shearing forces, and moisture. Pressure injuries can also occur from poorly fitting casts or appliances. They can also be found in soft tissues due to the effects of pressure from a foreign object such as a medical device (Grada and Phillips, 2021). 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 (Edsberg et al., 2016; Kottner et al., 2019).

Potential complications of incision and drainage procedures include bacteremic spread (e.g., due to inadequate drainage), damage or rupture into adjacent tissue(s), and bleeding from vessels eroded by inflammation (Tunkel, 2012).

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)* clinical practice guideline for information.

References

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