CareSource

REIMBURSEMENT POLICY STATEMENT
INDIANA MEDICAID

Original Issue Date	Next Annual Review	Effective Date
01/01/2017	01/01/2018	01/01/2017
Policy Name		**Policy Number**
Debridement Services		PY-0250
Policy Type		
Medical / Administrative / Pharmacy		REIMBURSEMENT

Reimbursement Policies prepared by CSMG Co. and its affiliates (including CareSource) are intended to provide a general reference regarding billing, coding and documentation guidelines. Coding methodology, regulatory requirements, industry-standard claims editing logic, benefits design and other factors are considered in developing Reimbursement Policies.

In addition to this Policy, Reimbursement of services is subject to member benefits and eligibility on the date of service, medical necessity, adherence to plan policies and procedures, claims editing logic, provider contractual agreement, and applicable referral, authorization, notification and utilization management guidelines. Medically necessary services include, but are not limited to, those health care services or supplies that are proper and necessary for the diagnosis or treatment of disease, illness, or injury and without which the patient can be expected to suffer prolonged, increased or new morbidity, impairment of function, dysfunction of a body organ or part, or significant pain and discomfort. These services meet the standards of good medical practice in the local area, are the lowest cost alternative, and are not provided mainly for the convenience of the member or provider. Medically necessary services also include those services defined in any federal or state coverage mandate, Evidence of Coverage documents, Medical Policy Statements, Provider Manuals, Member Handbooks, and/or other policies and procedures.

This Policy does not ensure an authorization or Reimbursement of services. Please refer to the plan contract (often referred to as the Evidence of Coverage) for the service(s) referenced herein. If there is a conflict between this Policy and the plan contract (i.e., Evidence of Coverage), then the plan contract (i.e., Evidence of Coverage) will be the controlling document used to make the determination.

CSMG Co. and its affiliates may use reasonable discretion in interpreting and applying this Policy to services provided in a particular case and may modify this Policy at any time.

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A. SUBJECT

Debridement Services

B. BACKGROUND

Debridement Services are indicated in select cases to assist in promoting wound healing where removal of deep seated foreign material or nonviable tissue at the level of the skin, subcutaneous tissue, fascia, muscle or bone is required. The intent of debridement is to reduce infection and bacterial contaminates, cleaning the wound and removing any mechanical impediments in order to provide a favorable environment for wound healing or surgical intervention as necessary. Prior to initiating debridement blunt probes may be used to evaluate the extent of the wound and assess for abscesses or sinus tracts. Co-morbid conditions that would impede normal wound healing, along with identifying the etiology of the wound and educating the patient on compliance should be addressed prior to beginning treatment.

In the instance that debridement services are indicated, it is expected that they will be performed within reason and at appropriate treatment intervals. The expected outcome of wound debridement, with appropriate care and barring extenuating medical or surgical obstacles, is decreased wound size and volume. Should appropriate healing not occur, it is expected and reasonable for the plan of care for the wound to be modified.

C. DEFINITIONS

- **Debridement** is the removal of infected, contaminated, damaged, devitalized, necrotic, or foreign tissue from a wound.

D. POLICY

I. No Prior Auth

NOTE: Although the debridement covered by this policy do not require a prior authorization, CareSource may request documentation to support medical necessity. Appropriate and complete documentation must be presented at the time of review to validate medical necessity

II. Covered Areas of Debridement

A. CPT codes 11000 and 11001 describe removal of extensive eczematous or infected skin.

1. CPT codes 11000 and 11001 are not appropriate for debridement of a localized amount of tissue normally associated with a circumscribed lesion.
2. CPT code 11001 is limited to those practitioners who are licensed to perform surgery above the ankle, since the amount of skin required by the code is more than that contained on both feet.

B. CPT codes 11042-11047 should be used for debridement of relatively localized areas depending upon the involvement of contiguous underlying structures.

III. Osteomyelitis

A. Debridement for osteomyelitis is covered for chronic osteomyelitis and osteomyelitis associated with an open wound.

IV. Chronic Foot Ulcer Management

A. Debridement of diabetic foot ulcers more frequently than once every seven (7) days, for longer than three (3) consecutive calendar months, is not indicative of an effective plan of treatment. Should a patient require more debridement services per wound than noted above, the medical record must include careful documentation reflecting neuropathic, vascular, metabolic, or other co-morbid conditions.

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B. Removing a collar of callus (hyperkeratotic tissue) around an ulcer is not considered debridement of skin or necrotic tissue and should be billed under CPT code 11055 or 11056.

V. Limitations of Coverage
   A. Debridement services are not covered in the absence of necrotic, devitalized, fibrotic, or other tissue or foreign matter present that would interfere with the normal wound healing process and must be documented in the medical record.
   B. Removal of devitalized tissue from wound(s), non - selective debridement, without anesthesia (e.g., wet-to-moist dressings, enzymatic, abrasion), including topical application(s), wound assessment, and instruction(s) for ongoing care and is not addressed in this policy.
   C. The Debridement Services policy does not apply to CPT codes 97597, 97598 and 97602, as these services are provided by physical and occupational therapist.
   D. Anesthesia services are not separately reimbursable for these services.
   E. In the outpatient treatment setting, services beyond the fifth surgical debridement, billed with CPT code 11043, 11046 and/ or 11044, 11047; per patient, per year, per wound will require a medical review of records to determine medical necessity.

E. CONDITIONS OF COVERAGE

HCPCS
CPT

Adobe Acrobat
PDFXML Document

F. RELATED POLICIES/RULES

N/A

G. REVIEW/REVISION HISTORY

	DATE	ACTION
Date Issued	01/01/2017	New Policy.
Date Revised		
Date Effective	01/01/2017	

H. REFERENCES

1. Current Procedural Terminology (CPT) and National Uniform Billing Committee (NUBC) Licenses. (2016, September 1). Retrieved March 31, 2017, from https://www.cms.gov/medicare-coverage-database/details/lcd-details.aspx?LCDId=34032&ContrId=240&ver=16&ContrVer=1&CntrctrSelected=240*1&Cntrctr=240&name=CGS+Administrators%2c+LLC+(15201%2c+MAC+-+Part+A)&DocType=Active&LCntrctr=240*1&bc=AgACAAQAAAAAAA%3d%3d&
2. Lawriter - OAC - 5160-1-01 Medicaid medical necessity: definitions and principles. (2015, March 22). Retrieved March 31, 2017, from http://codes.ohio.gov/oac/5160-1-01

The Reimbursement Policy Statement detailed above has received due consideration as defined in the Reimbursement Policy Statement Policy and is approved.

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