

Wound Debridement Vs Active Wound Care Management

This article is written to clarify which set of Current Procedural Terminology (CPT®) codes should be used when reporting procedures related to various types of wound treatment. There has been some concern that wound debridement codes and wound care management codes are being misused. Therefore, these sets of codes need to be compared and contrasted to illustrate which set of codes would be the appropriate choice based on the actual service provided. In most cases, wound debridement is intended for debriding acute wounds of devitalized tissue, while active wound care management is intended for cleansing and promoting healing of chronic wounds.

It is important to note that the intent of the CPT guidelines is to assist the user in reporting services and procedures as accurately as possible. Therefore, the purpose of this article is also to provide guidelines for choosing the appropriate codes to report based on the procedure or service performed, and *not* on the health professional's choice of instruments or devices.

Debridement Codes 11042-11047

Debridement is the process of removing dead tissue from wounds. It can be accomplished by invasive methods such as scissors, scalpel, and/or forceps. Debridement codes 11042-11047 are reported based on depth of tissue that is removed and total surface area of the wound(s). *Depth* is defined progressively from the skin level down through to the bone. For the debridement codes, *surface area* is defined as each section of 20 sq cm, or additional part thereof. To report debridement codes 11042-11047, both criteria of depth and surface area should be met. The degree to which they are met determines the code reported. The operative note or procedure report should document all pertinent information that is required to determine to what depth and how much total surface area is being debrided from a given wound. This code series is for the debridement of wounds when no direct primary closure, such as grafting, is anticipated.

11042 Debridement, subcutaneous tissue (includes epidermis and dermis, if performed); first 20 sq cm or less

(For debridement of skin [ie, epidermis and/or dermis only], see 97597, 97598)

#+11045 each additional 20 sq cm, or part thereof (List separately in addition to code for primary procedure)

(Use 11045 in conjunction with 11042)

11043 Debridement, muscle and/or fascia (includes epidermis, dermis, and subcutaneous tissue, if performed); first 20 sq cm or less

#+11046 each additional 20 sq cm, or part thereof (List separately in addition to code for primary procedure)

(Use 11046 in conjunction with 11043)

11044 Debridement, bone (includes epidermis, dermis, subcutaneous tissue, muscle and/or fascia, if performed); first 20 sq cm or less

+11047 each additional 20 sq cm, or part thereof (List separately in addition to code for primary procedure)

(Do not report 11042-11047 in conjunction with 97597-97602 for the same wound)

(Use 11047 in conjunction with 11044)

As explained in the parenthetical note following code 11047, wound care management codes 97597-97602 should not be reported in conjunction with codes 11042-11047 for the same wound.

Clinical Example (11042)

A 66-year-old male with insulin-dependent diabetes presents with a 4.0 cm x 3.5 cm x 0.8 cm noninfected ulceration involving the skin and subcutaneous tissue of the plantar lateral aspect of the right heel. The decision is made to debride the wound.

Description of Procedure (11042)

Inspect and document the ulceration for size, location, depth; classification/staging; and any interval changes, if appropriate, from any previous inspections. Anesthesia, if necessary, is utilized. The ulcer bed is debrided with forceps, scalpel, scissors, or tissue nippers excising the necrotic

skin, if present, and subcutaneous tissues to the level of viable tissue. The wound is irrigated and hemostasis is obtained. Upon completion, the ulcer is re-measured and the size recorded.

Clinical Example (11043)

A 74-year-old diabetic female with limited mobility presents with a 4.0 cm x 3.5 cm posterior heel ulceration involving the skin and subcutaneous tissues and Achilles tendon/muscle. She requires debridement of the wound, including debridement of the tendon/muscle.

Description of Procedure (11043)

Inspect and document the ulceration for size, location, depth; classification/staging; and any interval changes, if appropriate, from any previous inspections. Anesthesia, as necessary, is utilized. The posterior heel ulcer bed is debrided, excising nonviable skin and subcutaneous tissue, if present, and tendon/muscle tissues with forceps, scissors, scalpel, or tissue nippers to the level of viable tissue. Hemostasis is obtained. The wound is inspected and irrigated. Upon completion, the ulcer is remeasured and the size recorded.

Clinical Example (11044)

A 67-year-old diabetic male with limited mobility presents with a 4.0 cm x 3.5 cm posterior heel ulceration involving the skin and subcutaneous tissues, Achilles tendon/muscle, and calcaneus. He requires debridement of the wound, including debridement of the tendon/muscle and calcaneus.

Description of Procedure (11044)

Inspect and palpate the surrounding skin, wound edge, and exposed soft tissue and bone. Document the size, location, drainage, and depth of the wound. Inspect for and document sinus tracts, undermining, odor, and the quality of the wound bed tissue. Anesthesia, as necessary, is utilized. Remove, with scalpel and forceps, scissors, rongeur, or tissue nippers, the overhanging skin at the wound margins, the nonviable fatty tissue, and the exposed bone using the rongeur, cutting it back to bleeding bone and deeper than the soft tissue. Send samples of the debrided bone for culture and/or histopathology. Copiously irrigate the wound bed. Ensure hemostasis of the wound bed.

Clinical Example (11045)

An 82-year-old male presents with a nonhealing abdominal wound. The original surgical procedure was an exploratory laparotomy. The wound is 9 cm x 4 cm x 3.5 cm and has granulation tissue along the side walls of the wound but dry

fatty tissue in the base of the wound. After review, a decision is made to perform a debridement.

Description of Procedure (11045)

Intraservice work includes additional assessment and debridement after the first 20 sq cm. This may include additional dressing removal after induction of anesthesia; additional sharp debridement with additional excision of devitalized, traumatized, nonviable, infected, or colonized subcutaneous tissue (including epidermis and dermis, as necessary) to obtain clean, viable wound edges; additional irrigation; additional hemostasis; and additional dressing and padding.

Note: If multiple, separate site (additive) wounds are involved (eg, trauma), additional and separate documentation for size, location, depth, classification/staging, and ongoing treatment plan will be required, along with additional prep/drape.

Clinical Example (11046)

A 45-year-old paraplegic male presents with a nonhealing pressure ulcer. After a fall 5 years ago, the patient suffered a spinal cord injury at T10. This stage 3 full-thickness pressure ulcer is located over the right ischial tuberosity and measures 5.5 cm x 6 cm x 4.5 cm. Despite the use of seat cushions and local dressings, the wound has increased in size over time. After review, a decision is made to perform a debridement.

Description of Procedure (11046)

Intraservice work includes additional assessment and debridement after the first 20 sq cm. This may include additional dressing removal after induction of anesthesia; additional sharp debridement with additional excision of devitalized, traumatized, nonviable, infected, or colonized muscle and/or fascia (including epidermis, dermis, and subcutaneous tissue, as necessary) to obtain clean, viable wound edges; additional irrigation; additional hemostasis; and additional dressing and padding.

Note: If multiple, separate site (additive) wounds are involved (eg, trauma), additional and separate documentation for size, location, depth, classification/staging, and ongoing treatment plan will be required, along with additional prep/drape.

Clinical Example (11047)

A 34-year-old paraplegic male presents with a stage 4 sacral decubitus ulcer. The eschar has been debrided, but the sacral bone is exposed and bleeds and he has an elevated temperature. There is serous drainage from the ulcer base. The ulcer measures 6.5 cm x 6.0 cm x 4.5 cm.

After review, a decision is made to perform a debridement of the bone.

Description of Procedure (11047)

Intraservice work includes additional assessment and debridement after the first 20 sq cm. This may include additional dressing removal after induction of anesthesia; additional sharp debridement with additional excision of devitalized, traumatized, nonviable, infected, or colonized bone (including epidermis, dermis, subcutaneous tissue, muscle, and/or fascia, as necessary) to obtain clean, viable wound edges; additional irrigation; additional hemostasis; and additional dressing and padding.

Note: If multiple, separate site (additive) wounds are involved (eg, trauma), additional and separate documentation for size, location, depth, classification/staging, and ongoing treatment plan will be required, along with additional prep/drape.

Active Wound Care Management Codes 97597-97602

Active wound care management refers to procedures performed to remove devitalized and/or necrotic tissue to promote healing, and may require multiple visits. Code 97597 involves debridement of open wound(s) and includes topical application(s); wound assessment; use of a whirlpool, when performed; and instruction(s) for the ongoing care of a wound that has a total surface area of 20 sq cm or less. Add-on code 97598 is reported for each additional 20 sq cm or part thereof. Methods include high-pressure water jet and sharp selective debridement techniques using scissors, scalpel, and/or forceps.

Code 97602 involves the nonselective removal of devitalized tissue from wound(s), without anesthesia, and includes topical applications and dressings, wound assessment, and instruction(s) for ongoing care, per session. Note that there is no surface area specified with code 97602. This procedure can be a gradual removal of devitalized tissue and may require more than one visit, especially if the devitalized tissue needs to be gradually softened and loosened using pulsed lavage, irrigation, or other hydrotherapy techniques. Typical agents used are enzymatic, wet, wet-to-dry, and wet-to-moist.

One additional factor to consider is the surgical preparation code set (15002-15005). These are size-based procedure codes intended to describe burn and wound preparation or incisional or excisional release of scar contracture resulting in an open wound requiring skin grafts. Surgical preparation codes relate to healing wounds by primary intention, whereas debridement and wound management codes

relate to healing wounds by secondary intention. This is why CPT guidelines instruct the user to consider wound management codes (97597, 97598) and debridement codes (11042-11047) in cases in which nonviable tissue is removed from a chronic wound and it is left to heal by secondary intention, and to not report surgical preparation codes 15002-15005.

To summarize, both the wound care management and debridement CPT codes sets are meant for cases in which the healing of the wound is by secondary intention. Wound debridement codes are intended for acute wounds that are debrided of devitalized tissue, while active wound care management codes are intended for cleansing and promoting healing in chronic wounds. Debridement is measured in total depth and surface area, going from skin level down to the bone, while wound care management is limited to surface area only, generally does not go below skin level, and can be performed repeatedly as needed.

97597 Debridement (eg, high pressure waterjet with/without suction, sharp selective debridement with scissors, scalpel and forceps), open wound, (eg, fibrin, devitalized epidermis and/or dermis, exudate, debris, biofilm), including topical application(s), wound assessment, use of a whirlpool, when performed and instruction(s) for ongoing care, per session, total wound(s) surface area; first 20 sq cm or less

#+97598 each additional 20 sq cm, or part thereof (List separately in addition to code for primary procedure)

(Use 97598 in conjunction with 97597)

97602 Removal of devitalized tissue from wound(s), nonselective debridement, without anesthesia (eg, wet-to-moist dressings, enzymatic, abrasion, larval therapy), including topical application(s), wound assessment, and instruction(s) for ongoing care, per session

Clinical Example (97597)

A 58-year-old woman presents for follow-up care with a pressure ulcer on the left plantar heel. The wound measures 3.5 cm x 3.0 cm x 1.0 cm. She previously underwent extensive debridement. It is determined that the wound edges and the wound bed are viable with granulations but covered with an adherent proteinaceous slough, fibrin, and debris. After review, it is determined that the patient's wound would benefit from selective active wound care management.

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Wound Debridement, continued from page 5

Description of Procedure (97597)

The wound status, classification, size, location, drainage, and depth are documented. Inspect for and document sinus tracts, undermining, odor, and the quality of the wound bed tissue. Inspect and palpate the surrounding skin, wound edge, and exposed soft tissue. Topical or local anesthesia is administered, as needed. Cleanse the wound thoroughly, utilizing high-pressure water jet. Remove the proteinaceous slough, fibrin, and debris covering the wound bed with curette, scalpel, and forceps or scissors until healthy tissue is visualized. Ensure hemostasis.

Clinical Example (97598)

A 28-year-old man presents with a chronic open wound on the right lower leg 3 cm above the medial malleolus. The patient previously underwent extensive debridement

of the necrotic soft tissue at the site. The wound currently measures 6.3 cm x 5.2 cm x 2.2 cm. The wound bed is granulating but covered with adherent, yellow proteinaceous slough and fibrous tissue. A moderate amount of serosanguineous drainage is noted. X-rays are unremarkable for bone changes. After examining the wound, it is determined that selective active wound care management would be appropriate.

Description of Procedure (97598)

Additional topical or local anesthesia is administered, as needed. Additional wound cleansing is performed, including additional removal of proteinaceous slough, fibrin, and debris covering the wound bed with curette, scalpel, and forceps or scissors until healthy tissue is visualized.◆