CPT ADVISOR

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Predictors of wound complications following major amputation for critical limb ischemia

In 2011, several coding changes occurred in the area of wound management. The commonly used CPT codes 11040 and 11041 were deleted, and replacing them for skin debridement are the active wound care management CPT codes 97597 and 97598. The second major change is the need to measure and report based on the surface area of wound(s) debrided. The first 20 square centimeters of area treated will be reported with a primary code, and any area beyond that will be billed using add-on CPT codes in 20 square centimeter increments or part thereof. As in the past, the debridements will still be reported based on depth of tissue removed. The first level involves only skin (either partial or full thickness), the second encompasses skin and subcutaneous tissue, the third comprises skin, subcutaneous tissue, and muscle and/or fascia, and the deepest level contains skin, subcutaneous tissue, muscle and/or fascia, and bone. The third major change is that all of the primary CPT debridement codes (97597, 11042, 11043, and 11044) now have a 0-day global period. Previously, CPT codes 11043 and 11044 were assigned a 10-day global period by the Centers for Medicare and Medicaid Services.

Debridement services may be reported for injuries, infections, wounds, and chronic ulcers. When performing debridement of a single wound, choose a CPT description that corresponds to the deepest level of tissue removed. In multiple wounds, calculate the surface area for all wounds which are at that same depth (regardless of location in the body), but do not combine sums from different depths. The new add-on codes 11045, 11046, and 11047 are used to report debridement of each additional 20 square centimeters at the three different depths: subcutaneous tissue, muscle/fascia, and bone, respectively. These three add-on codes can be reported multiple times as appropriate, but may be subject to frequency edits by the insurance carrier. The add-on CPT code descriptors all include the phrase "or part thereof," which means that one does not need to debride an entire additional 20 square centimeters to submit the add-on code. For example, if 30 square centimeters of skin is debrided, report the primary CPT code (97597) plus the add-on CPT code (97598) for that level of depth. Last, removing a collar of callus (hyperkeratotic tissue) around an ulcer is not considered a true debridement.

Documentation is required to justify the indication, the treatment plan, and the procedure itself. Private carriers have their own guidelines ,while regional Medicare carriers produce Local Coverage Determinations (LCDs). The regional Medicare carrier Trailblazer has LCD 4S-150AB-R9 (L26721) which requires the medical record contain clearly documented evidence of the progress of the wound's response to treatment at each physician visit, while the procedure notes must characterize the tissue removed and the method of excision. The local Medicare carrier NGS LCD L27373 (R9) has medical necessity edits that deny reimbursement for the debridement CPT codes detailed above when paired with the "cellulitis and abscess" diagnoses (ICD-9 codes 682.X) and other diagnoses that lack ulcer or wound in their description. All vascular providers should consult their regional Medicare carrier websites for active LCDs that govern debridement services in their area of practice.

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