UM-CDG-083 Debridement Services	Approved By: Director, Health Services	Effective Date: 10/20/2025

This Policy applies to all SECUR affiliates, associates, and subsidiaries.

Approved by Courtney Gonzales, Director of Health Services on behalf of the Utilization Management Committee.

PURPOSE

This coverage determination guideline serves to address debridement services. Debridement is the removal of infected, contaminated, damaged, devitalized, necrotic, or foreign tissue from a wound. This guideline will 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. Prior to debridement, determination of the extent of an ulcer/wound may be aided by the use of blunt probes to determine wound/ulcer depth and to disclose abscess and sinus tracts.

This guideline does not apply to debridement of burned surfaces. It also does not apply to debridement of nails. This guideline does not apply to debridement services performed by physical or occupational therapists.

For SECUR Health Plan members, National Coverage Determinations (NCD) and Local Coverage Determinations (LCD) will be applied to requests when applicable. SECUR Health Plan Coverage Determination Guidelines (CDG) will be utilized in the absence of an appropriate NCD and/or LCD.

DEFINITIONS

None

POLICY

SECUR Health Plan recognizes the following as indications for debridement:

Debridement is indicated for any wound requiring removal of deep seated foreign material, devitalized or nonviable tissue at the level of skin, subcutaneous tissue, fascia, muscle or bone, to promote optimal wound healing or to prepare the site of appropriate surgical intervention.

CPT codes 11000 and 11001 describe removal of extensive eczematous or infected skin. A key word is extensive. Conditions that may require debridement of large amounts of skin include: rapidly spreading necrotizing process (sometimes seen with 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).

CPT codes 11042-11047 should be used for debridement of relatively localized areas depending upon the involvement of contiguous underlying structures. These codes are appropriate for treatment of skin ulcers, circumscribed dermal infections, conditions affecting contiguous deeper structures, and debridement of deep-seated debris from any number of injury types.

The number of debridement services required is variable and depends on numerous intrinsic and extrinsic factors. Debridement services are covered provided all significant relevant comorbid conditions are addressed that could interfere with optimal wound healing.

Debridements of the wound(s) if indicated must be performed judiciously and at appropriate intervals. It is expected that, with appropriate care, and no extenuating medical or surgical complications or setbacks, wound volume or surface dimension should decrease over time. It is also expected the wound care treatment plan is modified in the event that appropriate healing is not achieved. It is expected that co-morbid conditions that may interfere with normal wound healing have been addressed; the etiology of the wound has been determined and addressed as well as addressing member compliance issues. This may include, for example, evaluation of pulses, ABI and/or possible consultation with a vascular surgeon.

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 considered medically necessary by SECUR Health Plan. The presence or absence of such tissue or foreign matter must be documented in the supporting documentation.

The following procedures are considered part of active wound care management and are not considered as debridement and are not included in this Coverage Determination Guideline: 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.

CPT codes 11000 and 11001 are not appropriate for debridement of a localized amount of tissue normally associated with a circumscribed lesion. Examples of this are ulcers, furuncles, and localized skin infections.

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.

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.

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

Local infiltration, metacarpal/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.

Requests must contain appropriate supporting documentation that fully supports the medical necessity for services described in this Coverage Determination Guideline.

An operative note or procedure note for the debridement service. This note should describe the anatomical location treated, the instruments used, anesthesia used if required, the type of tissue removed from the wound, the depth and area of the wound and the immediate post procedure care and follow-up instructions.

Identification of the wound location, size, depth and stage either by description and/or a drawing or photograph.

A description of the type(s) of tissue involvement, the severity of tissue destruction, undermining or tunneling, necrosis, infection or evidence of reduced circulation. If infection has developed, the member's response to this infection should be described.

The member's comorbid medical and mental condition, and all health factors that may influence the member's ability to heal tissue, such as, but not limited to the following: mental status, mobility, infection, tissue oxygenation, chronic pressure, arterial insufficiency/small vessel ischemia, venous stasis, edema, type of dressing, chronic illness such as diabetes mellitus, uremia, COPD, malnutrition, CHF, anemia, iron deficiency, and immune deficiency disorders.

A determination of the initial treatment plan to include the expected frequency and duration of the skilled treatment and the potential to heal. Continuation of treatment plan with ongoing evidence of the effectiveness of that plan, including diminishing area and depth of the ulceration, resolution of surrounding erythema and /or wound exudates, decreasing symptomatology, and overall assessment of wound status (such as stable, improved, worsening, etc). Appropriate changes in the ongoing treatment plan to reflect the clinical presentation must be present in the record.
The documentation must include that if indicated, ongoing pressure relief has been prescribed, for example, shoe inserts, modifications, padding, frequent position changes, etc. and monitoring is occurring.

In cases of excessive frequency or prolonged duration of treatment, documentation should include an evaluation for possible infection (e.g. culture and sensitivity), osteomyelitis (e.g. x-ray), and treatment of any infection by antibiotics. Any other conditions that may significantly affect wound healing should also be appropriately addressed in the medical record.

Photographic documentation of wounds either immediately before or immediately after debridement is recommended for prolonged or repetitive debridement services (especially those that exceed five extensive debridements per wound (CPT code 11043 and/or 11044)). If the provider is unable to use photographs for documentation purposes, the medical record should contain sufficient detail to determine the extent of the wound and the result of the treatment.

Cornerstones of chronic foot ulcer management include relief of pressure, control of infection and appropriate debridement. While there is some consensus that repeated debridement may promote more rapid healing of diabetic foot ulcers, the appropriate interval and frequency of debridement depends on the individual clinical characteristics of members and ulcers. Reduction of pressure and/or control of infection will facilitate healing and may reduce the need for repeated debridement services. The treatment plan for a member who requires frequent

repeated debridement should be reevaluated, to ensure that pressure reduction and infection control have been adequately addressed. Frequent repeated debridement is not considered reasonable and necessary; pressure reduction and infection control are insufficient to allow for healing of the ulcer. In the presence of documented significant ischemic disease with necrotic ulceration, extensive and definitive debridement may be required.

When the member has required more debridement services per wound than defined below, the medical record must include documentation reflecting neuropathic, vascular, metabolic, or other comorbid conditions.

Debridement of diabetic foot ulcers more frequently than once every seven (7) days, for a period longer than three (3) months may not be reasonable and necessary. Services exceeding this intensity and duration of treatment will be considered not medically necessary.

Debridement services are now defined by body surface area of the debrided tissue and not by individual ulcers or wounds. For example, debridement of two ulcers on the foot to the level of subcutaneous tissue, total area of 6 sq cm should be billed as CPT code 11042 with unit of service of "1".

For members with chronic wounds being treated in an outpatient setting, services beyond the fifth surgical debridement, CPT code 11043, 11046 and/or 11044, 11047, per member, per year, per wound may require a medical review of records demonstrating the medical reasonableness and necessity. Providers are reminded that the CPT code used to report the debridement must represent the level of debridement and not the depth of the ulcer.

References:

1. Local Coverage Determination Guideline (LCD) L34032, Debridement Services, https://www.cms.gov/medicare-coverage-database/view/lcd.aspx?lcdid=34032&ver=31&