Wound Care Commonly Asked Questions

Question: When performing wound debridement of pressure ulcers without excision of the ulcer and without sutures and depending on the depth of debridement, should these be codes with the wound debridement codes, 97597-97598 or 11042-11047, or with the pressure ulcer codes, 15920-15999?

Answer: The 15920-15999 codes are specific to excision of pressure ulceration and require tissue removal to a clean base for suture, flap or graft closure. Debridement of these ulcers should be coded with the 97597-97598 or 11042-11047 code series, depending on ulcer depth.

Question: Would muscle debridement utilizing Versajet be coded with active wound care management codes, 97597-97598 or the debridement codes, (eg, 11043)?

Answer: The wound depth debrided determines the appropriate code. If just the biofilm on the surface of a muscular ulceration were debrided, then codes 97597-97598 would be appropriate. But if muscle substance was debrided, the 11043-11046 series would be appropriate, depending on the area debrided.

Question: The new guidelines for the debridement codes (11042-11047) state that the codes should be based on the “surface area of the wound.” Is this the surface area before or after the debridement? Also, if a wound was only partially cleaned and partially needed debridement, how would you report the measurement, ie, would you report the total surface area of the wound or the surface area of the wound that you debrided?

Answer: This question has a two-part answer. If the entire wound surface is debrided, then the measurement of the wound should be taken after the debridement procedure. For example, the initial wound appearance is frequently dramatically different from the final wound area in the foot. Therefore, coding is based on the wound measurement taken after the actual debridement is performed.

In the event that only a portion of a wound surface is debrided, report the measurement of the area that was actually debrided. The remainder of the wound would be irrelevant from a coding standpoint because it would not be appropriate to report a code with a larger measurement than what was actually debrided. If the surface area, depth, and measurement listed in the code descriptor were not performed, then it would not be appropriate to report that code.

Codes 11040 and 11041 have been deleted. Debridement performed on only the skin, epidermis, and/or dermis is now reported with the active wound care management codes 97597 and 97598
Coding Example

A patient with bilateral iliac crest Stage IV pressure ulcers requires debridement of necrotic subcutaneous tissue and muscle (code 11043).

Prior to debridement, the ulcers measure: left iliac crest: 3.4 cm x 3 cm (10.2 sq cm), and right iliac crest: 3.2 cm x 3 cm (9.6 sq cm)—for a total of 19.8 sq cm.

After debridement, the ulcers respectively measure 3.4 cm x 4 cm (13.6 sq cm) and 4 cm x 4.2 cm (16.8 sq cm)—for a total of 30.4 sq cm.

How To Code

In multiple wounds, combine the surface area of those wounds that are of the same depth. Because both wounds, albeit in different anatomic sites, required debridement of necrotic subcutaneous tissue and muscle, it is the norm to combine the surface area to get a total of 30.4 sq cm and report both code 11043, Debridement, muscle and/or fascia (includes epidermis, dermis, and subcutaneous tissue, if performed); first 20 sq cm or less, and the add-on code +11046, Debridement, muscle and/or fascia (includes epidermis, dermis, and subcutaneous tissue, if performed); each additional 20 sq cm, or part thereof (List separately in addition to code for primary procedure).

Question: A chronic ulcer of the calf measures 10 cm x 11 cm (110 sq cm). Approximately 30% (33 sq cm) of the ulcer requires debridement of slough and eschar at the dermis (code 97597). The physician manages the entire wound, debrides 33 sq cm, dresses the entire wound appropriately, and applies a multilayer of high-compression bandage system to the entire wound. How is this reported?

Answer: Because the depth of the debridement was to the level of the dermis and only 33 sq cm of the wound was debrided, the procedure is reported using the two debridement codes: code 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, and add-on code 97598, 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; each additional 20 sq cm, or part thereof (List separately in addition to code for primary procedure).
In this case, codes 97597 and 97498 are each reported only **once**. Code 97597 for the first 20 sq cm and code 97598 for the next 13 sq cm. the application of the wound dressing is not separately reported. However, the application of the multilayer high-compression bandage system is reported using code 29581, *Application of multi-layer venous wound compression system, below knee.*

**Question:** Since codes 11040 and 11041 have been deleted, how should the debridement of full-thickness skin be reported? For example, a patient with 2.8 cm x 2.5 cm (7 sq cm) diabetic foot ulcer requires the debridement of full-thickness skin from the plantar surface of a foot ulcer. Subcutaneous tissue is not debrided.

**Answer:** Because the debridement involved levels of the “skin” (eg, epidermis and/or dermis) and did not extend to the depth of the subcutaneous tissue, the procedure may be reported using code(s) 97597 and 97598 based on the size of the debrided wound surface.

**Question:** A patient is seen 4 weeks after the spontaneous rupture of a methicillin-resistant Staphylococcus aureus (MRSA) infected abscess of the leg. He has three chronic ulcerations on the anterior shin measuring 4 cm x 3 cm (12 sq cm), 1 cm x 1 cm (1 sq cm), and 2 cm x 2 cm (4 sq cm)—all with a depth of subcutaneous tissue—for a total surface area of 17 sq cm. All of these wounds have extensive undermining, and are actually connected together in the subcutaneous tissue where the abscess cavity was originally formed. There is also one large ulcer that has a depth of subcutaneous tissue, which measure 14 cm x 12 cm (168 sq cm). All the wounds are debrided and the final surface area totals 185 sq cm at the subcutaneous level. How is this reported?

**Answer:** The debridement of skin and subcutaneous tissue for a total surface area of 185 sq cm is reported with code 11042, *Debridement, subcutaneous tissue (includes epidermis and dermis, if performed); first 20 sq cm or less,* and nine units of add-on code 11045, *Debridement, subcutaneous tissue (includes epidermis and dermis, if performed); each additional 20 sq cm, or part thereof (List separately in addition to code for primary procedure).*

Note that third-party payers may have different reporting requirements for reporting such a procedure (ie, list the nine units of 11045 on nine separate claim lines or list code 11045 on one claim line with 9 units). Please check with the third-party payers on specific reporting requirements.

References