

Newly Funded Selective and Non-Selective Debridement CPT Codes: Impact on Hospital-Owned Outpatient Wound Care Departments

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Each year in the US, healthcare insurers (including Medicare) process more than five billion claims for payment. Standard codes have been devised to ensure these claims are processed in an orderly and consistent manner. As a reference for providers, the American Medical Association (AMA) publishes a monthly guide, the *CPT Assistant*, that includes the correct definitions of all Current Procedural Terminology (CPT[®]) Codes*.

In an effort to promote proper utilization of established wound care management codes, the AMA revised the active wound management CPT codes and correlating descriptions as of January 1, 2006. In addition, the Centers for Medicare and Medicaid Services (CMS) assigned the CPT codes to three Ambulatory Payment Classification (APC) groups which have payment rates for Hospital-Owned Outpatient Wound Care Departments (HOPDs). These codes are to be used to indicate the removal of devitalized and/or necrotic tissue to promote healing in selective and non-selective debridement cases when a patient's wound does not require or cannot tolerate surgical debridement.

Also of note is that the increase in the number of Medicare claims submitted for the surgical debridement of wounds under CPT codes 11040–11044 has prompted a planned investigation by the Office of the Inspector General (OIG). The proper coding of wound care treatments should provide a decrease in inappropriately labeled claims from HOPDs.

The information from HOPD program directors that follows will answer some relevant questions.

[Is it true the OIG plans to monitor and investigate the number and types of surgically debrided wounds?](#)

The OIG has seen a dramatic increase in the number of Medicare claims submitted for the surgical debridement of wounds under CPT codes 11040–11044. Many wound care specialists appear to have forgotten that surgical debridement must be billed based on the level of tissue that is removed, not on the depth of the wound. For that reason, the OIG has included the surgical debridement of wounds in its Work Plan for 2006.

[Where can providers obtain guidance regarding the correct definitions for the surgical debridement codes?](#)

The AMA's monthly guidance document, the *CPT Assistant*, has been archived every year since its inception. A CD-ROM of these publications is available for purchase; it includes all of the AMA's guidance articles regarding the topics *surgical debridement*, *selective debridement*, and *non-selective debridement*. Additionally, many Medicare carriers (Carriers) and Fiscal Intermediaries (FIs) provide written guidance to MDs, DOs, and DPMs through specific manuals available on their websites. Most recently, Carriers and FIs started writing Local Coverage Determinations (LCDs) regarding wound care. These LCDs usually offer explicit guidance for surgical debridement, burn debridement, and selective and non-selective debridement.



One Medicare Carrier recently released a wound debridement guidance document and LCD. Among the key points in these directives:

- Surgical debridement codes 11040–11044 must be based on the type of tissue removed, not on the depth or grade of the ulcer or wound
- Surgical debridement will be considered as “not medically necessary” when documentation indicates the wound is without infection, necrosis, or nonviable tissues and has pink to red granulated tissue
- CPT code 11042 is defined as *debridement; skin and subcutaneous tissue*. Wound care providers are using this code incorrectly when they are removing fibrin, which is not skin. To bill the code 11042, the Carrier expects the provider to debride skin and subcutaneous tissue — eg, when only necrotic skin and subcutaneous tissue are debrided, even though the ulcer or wound might extend to bone
- The Carrier states that an individual wound would not be expected to be repeatedly debrided of skin and subcutaneous tissue because these tissues do not regrow very quickly.

Be sure to check your Carrier’s and/or your FI’s website for any LCDs that pertain to surgical debridement.

Several years ago, the AMA released active wound management codes to be used by nurses and physical therapists when they removed devitalized and/or necrotic tissue from wounds to promote healing. However, those codes did not have payment rates for HOPDs. Therefore, HOPDs had two choices: include this work into their clinic visit levels or request that physicians perform the debridements. Are the active wound management codes still unfunded for HOPDs?

Effective January 1, 2006, the AMA revised the active wound management CPT codes and descriptions. Simultaneously, the CMS assigned the CPT codes to APC groups which have payment rates for HOPDs. The new/revised active wound management CPT codes are:

97597: Removal of devitalized tissue from wound(s), selective debridement, without anesthesia (eg, high pressure waterjet with/without suction, sharp selective debridement with scissors,

scalpel, and forceps), with or without topical application(s), wound assessment, and instruction(s) for ongoing care, may include use of a whirlpool, per session; total wound(s) surface area ≤20 cm².

97598: Removal of devitalized tissue from wound(s), selective debridement, without anesthesia (eg, high pressure waterjet with/without suction, sharp selective debridement, with scissors, scalpel and forceps), with or without topical application(s), wound assessment, and instruction(s) for ongoing care, may include use of a whirlpool, per session; total wound(s) surface area >20 cm².

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

The 2006 APC group assignments and national unadjusted payment rates are shown in **Table 1**.

When should an HOPD use these new codes?

The active wound management procedures are performed to remove devitalized and/or necrotic tissue and to promote healing. These selective and non-selective debridement codes are used when a patient’s wound does not require surgical debridement or if a patient cannot tolerate surgical debridement. The provider also is required to have direct (one-on-one) patient contact.

Many HOPDs include selective and non-selective debridements into their clinic visit level mapping system. What should the HOPD do now that these procedures have uniquely defined and funded CPT codes?

The HOPD program director should remove all selective and non-selective debridement services from the clinic visit level mapping system. Simultaneously, the program director should add codes 97597, 97598, and 97602 to the chargemaster and the charge sheets. To ensure compliance, the program director should in-service staff regarding the various procedures and products included in each of the newly funded active wound management codes.

To clarify: if the patient’s wound needs to be debrided or the patient cannot tolerate surgical debridement and the physician

TABLE 1

CPT Code	APC Group	National Unadjusted Medicare Payment Rate	National Unadjusted Medicare Copayment	Minimum Unadjusted Medicare Copayment
97597	0012 Level I Debridement and Destruction	\$50.45	\$11.18	\$10.09
97598	0013 Level II Debridement and Destruction	\$63.10	\$13.07	\$12.52
97602	0340 Minor Ancillary Procedures	\$36.52	—	\$7.30

TABLE 2

CPT Code	In-Office National Average Medicare Payment Rate	In-Office National Average Medicare Copayment Rate	In-Facility National Average Medicare Payment Rate	In-Facility National Average Medicare Copayment Rate
97597	\$48.89	\$9.78	NA	NA
97598	\$62.15	\$12.43	NA	NA
97602	0	0	0	0

orders the application of an enzymatic debrider, the HOPD should bill for 97602 rather than a clinic visit.

Must the HOPD purchase the enzymatic debrider used on the patient or can the patient bring the enzymatic debrider from home?

Like all APC procedures, dressings and drugs are bundled into the payment for the procedure. Therefore, the HOPD is required to purchase the enzymatic debrider and the dressings used on the day of HOPD care. The drugs and dressings patients acquire for home use should be left at home. NOTE: the enzymatic debriders and dressings should not be samples.

How does the HOPD bill when the wound specialist applies an enzymatic debrider to more than one wound?

The code 97602 should be billed only once per HOPD visit, even if an enzymatic debrider is applied to multiple wounds on a patient.

Some HOPDs are staffed only by wound care nurses. Can the HOPD bill 97602 if a wound care nurse applies an enzymatic debrider ordered by the physician?

Yes. The HOPD can bill for 97602 when a wound care nurse applies an enzymatic debrider.

Is it acceptable for an HOPD to bill a clinic visit and the selective/non-selective debridement codes on the same day? What about surgical debridement and selective/non-selective debridement codes on the same day?

No. Neither of these scenarios is allowed under the current system. The HOPD can bill one or the other but not both.

Is it true that the selective and non-selective debridement codes are not funded by Medicare for physicians?

Yes and no. On one hand, the 2006 Medicare Physician Fee Schedule lists in-office payment rates for the selective debridement codes 97597 and 97598 but does not list rates for the same work performed in facilities such as HOPDs. On the other hand, the 2006 Medicare Physician Fee Schedule does not list any payment rates for the non-selective debridement code 97602 (see Table 2).

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