

**WOUND CARE AND DEBRIDEMENT**

Date of origin: June 2024

Review dates: 9/2024, 2/2025, 6/2025, 6/2026

**DEFINITION**

Priority Health follows Medicare policy for NCCI edits where applicable.

It's the provider's responsibility to review coding rules and apply modifiers where appropriate and supported by documentation.

When *any* of the following debridement services are performed, the casting/splinting/strapping is included in the surgical procedure.

In alignment with CMS, we won't reimburse a dressing change when performed as part of debridement or other wound care. This will process the claim as a not separately payable service if billed along with and will be considered a component of an E/M service or procedure that may be coded on the same date of service.

These services can be found on the CMS NCCI PTP edits.

*This isn't an all-inclusive listing.*

**POLICY SPECIFIC INFORMATION****Debridement codes**

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

**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)

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

**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)

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

**11047** – Debridement, bone (includes epidermis, dermis, subcutaneous tissue, muscle and/or fascia, if performed); each additional 20 sq cm, or part thereof (List separately in addition to code for primary procedure)

**Selective debridement**

Documentation must clearly describe the instruments utilized for debridement. Examples may include forceps, scissors, scalpel or high-pressure waterjet.

Wound details should be documented to include the size of area to be debrided, drainage, condition of surrounding tissue, texture, temperature, and any additional specific elements identified during the assessment.

**97597** – Debridement (e.g., high pressure waterjet with/without suction, sharp selective debridement with scissors, scalpel and forceps), open wound, (e.g., 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** – Debridement (e.g., high pressure waterjet with/without suction, sharp selective debridement with scissors, scalpel and forceps), open wound, (e.g., 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)

### **Nonselective debridement (97602)**

Documentation must clearly describe techniques utilized for non-selective debridement (e.g., Abrasion, enzymatic, etc.).

Wound details should be documented to include the size of area to be debrided, drainage, condition of surrounding tissue, texture, temperature, and any additional specific elements identified during the assessment.

### **Whirlpool**

Whirlpool services may be separately reimbursed when performed on the same date of service as non-selective debridement or services unrelated to wound care. The appropriate modifier should be appended for distinct services when applicable.

Whirlpool services aren't separately reimbursed when selective debridement is performed on the same date of service unless two separate wounds are treated utilizing separate modalities for treatment. Appropriate modifier(s) should be appended to reflect separate wounds and modality.

Documentation must support the use of distinct service modifiers.

### **Casting / splinting / strapping codes**

**29580** - Strapping; Unna boot

**29581** - Application of multi-layer compression system; leg (below knee), including ankle and foot

All supplies utilized for Unna boot or compression bandages are considered inclusive to the procedure outlined above.

Per CMS NCCI manual chapter 4:

- Casting/splinting/strapping CPT codes shall not be reported for application of a dressing after a therapeutic procedure.
- Modifier application is **only** appropriate if performed at a separate location and supported by documentation as guided by CMS. Modifiers XE, XS, XP and XU give greater reporting specificity – use these modifiers instead of modifier 59 whenever possible. Only use modifier 59 if no other specific modifier is appropriate. [Get more information.](#)

- Documentation will be requested when Unna boot or multi-layer compression dressing are coded with a wound debridement on the same date of service as wound debridement.

See additional modifier information [in our Provider Manual](#).

## DISCLAIMER

CMS and/or MDHHS guidelines apply unless otherwise specified in this policy or provider manual. Where such guidance is absent, this policy applies. Priority Health’s billing policies outline our guidelines to assist providers in accurate claim submissions and define reimbursement or coding requirements if the service is covered by a Priority Health member’s benefit plan. The determination of visits, procedures, DME, supplies, and other services or items for coverage under a member’s benefit plan or authorization isn’t being determined for reimbursement. Authorization requirements and medical necessity requirements appropriate to procedure, diagnosis, and frequency are still required. We use Current Procedural Terminology (CPT), Centers for Medicare and Medicaid Services (CMS), Michigan Department of Health and Human Services (MDHHS), and other defined medical coding guidelines for coding accuracy.

An authorization isn’t a guarantee of payment when proper billing and coding requirements or adherence to our policies aren’t followed. Proper billing and submission guidelines must be followed. We require industry standard, compliant codes defined by CPT, HCPCS, and revenue codes for all claim submissions. CPT, HCPCS, revenue codes, etc., can be reported only when the service has been performed and fully documented in the medical record to the highest level of specificity. Failure to document services rendered or items supplied will result in a denial. To validate billing and coding accuracy, payment integrity pre- or post-claim reviews may be performed to prevent fraud, waste, and abuse. Unless otherwise detailed in the policy, our billing policies apply to both participating and non-participating providers and facilities.

If guidelines detailed in government program regulations, defined in policies and contractual requirements aren’t followed, Priority Health may:

- Reject or deny the claim
- Recover or recoup claim payment

An authorization on file for an item or services doesn’t supersede coding, billing or reimbursement requirements.

These policies may be superseded by mandates defined in provider contracts or state, federal, or CMS contracts or requirements. We make every effort to update our policies in a timely manner to align with these requirements or contracts. If there’s a delay in implementation of a policy or requirement defined by state or federal law, as well as contract language, we reserve the right to recoup and/or recover claim payments to the effective dates per our policy. We reserve the right to update policies when necessary. Our most current policy will be made available [in our Provider Manual](#).

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## CHANGE / REVIEW HISTORY

Date	Update(s) made
Sept. 10, 2024	Effective Nov. 11, 2024:  “Casting / splinting / strapping codes” section: <ul style="list-style-type: none"> <li>• In alignment with CMS, separate and distinct modifier applications (59, XE, XS, SP, and XU) will only be appropriate when performed at a separate location. These modifiers will no longer be appropriate when performed in a separate session.</li> </ul>
Feb. 13, 2025	Added “Disclaimer” section

June 4, 2025	No changes made
May 28, 2026	No changes made