Clinical Policy Title: Debridement of diabetic foot ulcers

Clinical Policy Number: CCP.1200

Effective Date: January 1, 2016
Initial Review Date: October 19, 2015
Most Recent Review Date: October 2, 2018
Next Review Date: October 2019

Related policies:
- CCP.1092 Negative pressure wound therapy for chronic ulcers
- CCP.1039 Full body hyperbaric oxygen therapy
- CCP.1014 Skin substitutes
- CCP.1129 Growth factors for wound healing-musculoskeletal uses

**Coverage policy**

AmeriHealth Caritas considers the use of debridement of diabetic foot ulcers to be clinically proven and, therefore, medically necessary when all of the following criteria are met (Elraiyah, 2016; Hingorani, 2016; Lipsky, 2012):

- **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.**

- **Types of debridement may include one or more of the following:**
  - Surgical/nonsurgical sharp wound debridement.
  - Mechanical (e.g., wet-to-dry gauze dressings, water jet, or ultrasonic irrigation).
  - Autolytic (e.g., moist occlusive or semioclusive dressings).
– Biochemical (e.g., enzyme collagenase).
– Biological using sterile maggots.

• The procedure is carried out by a qualified professional when his or her scope of practice and state and local laws allow it, and his or her professional training is sufficient to provide the beneficiary skills. A qualified professional includes the following (National Institute for Health and Care Excellence, 2015; Lipsky, 2012):
  – A physician, podiatrist, non-physician practitioner, physical therapist, or an occupational therapist who is licensed or certified by the state to furnish such services.
  – Physical therapist assistants and occupational therapy assistants when working under the supervision of a qualified therapist, within the scope of practice allowed by state law.
  – Educated and trained therapists (staff or auxiliary personnel) qualified to furnish therapy services under direct supervision, incident to a physician or non-physician practitioner. Personnel may or may not be licensed as therapists, but meet all of the requirements for therapists, with the exception of licensure.

Limitations:

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 medically necessary.

Documentation for each treatment visit must include all of the following:

- A detailed description of the procedure and the method (e.g., scalpel, scissors, 4x4 gauze, wet-to-dry, or enzyme).
- Frequent wound measurements.
- Description of the appearance of the wound (e.g., size, depth, stage, and/or bed characteristics).
- Type of tissue or material removed.
- The use of a qualified professional.

Debridement with topical enzymes is used when the necrotic substances to be removed from a wound are protein, fiber, and collagen. The manufacturer’s product insert contains indications, contraindications, precautions, dosage, and administration guidelines; it is the clinician’s responsibility to comply with those guidelines.

Autolytic debridement is contraindicated for infected wounds.

Severe ischemia is a relative contraindication to the use of sharp debridement for removing slough, necrotic tissue, and surrounding callus (Game, 2016).
Alternative covered services:

- Antibiotic therapy.
- Bioengineered skin substitutes.
- Granulocyte colony-stimulating factors.
- Hyperbaric oxygen therapy.
- Intensive wound therapy.
- Negative pressure wound therapy.
- Off-loading.

Background

One of the most common chronic complications of diabetes mellitus is diabetic foot ulcer. The most significant causative factors are neuropathy and peripheral arterial disease. Peripheral arterial disease, ulcer, and neuropathy are costly and disabling lower extremity conditions that can lead to amputation if not properly treated (Centers for Disease Control and Prevention, 2015).

Successful diagnosis and treatment of patients with diabetic foot ulcers involves a holistic approach of optimal diabetes control, effective local wound care, infection control, pressure relieving strategies, and restoring pulsatile blood flow. Chronic wounds have underlying pathogenic abnormalities that cause necrotic tissue to accumulate. To facilitate wound progression, repeated removal of necrotic tissue may be necessary throughout the lifespan of the chronic wound.

Debridement:

Debridement is an important component of standard wound treatment for diabetic foot ulcers (Frykberg, 2015). It involves removal of necrotic tissue, foreign debris, bacterial growth, callus, wound edge, and wound bed tissue from chronic wounds in order to stimulate the wound healing process. Debridement may reduce pressure, help drain secretions, allow full inspection of the underlying tissues, and optimize the effectiveness of topical preparations. Several procedures may be required to accomplish adequate debridement.

Debridement procedures require different levels of skill and training (Fife, 2011). In some cases, only superficial slough needs removing. In other cases, deep layers of viable tissue (e.g., bone) may be removed. They are performed in-hospital and in specialty outpatient clinics.

Methods of debridement are classified as excisional, selective, or nonselective. Excisional debridement is the sharp removal of tissue using instruments such as scissors, scalpels, or curettes to remove viable as well as nonviable tissue. It requires anesthesia and/or the control of bleeding and is performed by a physician. Nonsurgical (or conservative) sharp debridement refers to removal of loose, nonviable tissue with the aid of scalpel, scissors, or curette above the level of viable tissue. It is less extensive and
aggressive than surgical debridement and requires no anesthesia. Physicians, non-physician practitioners or a therapist (but not an assistant, aide, or any other personnel) may provide this service within their scope of practice and consistent with state and local law.

Nonselective debridement is the gradual removal of nonviable tissue and is generally not performed by a physician. These methods include mechanical (e.g., wet-to-dry gauze dressings, water jet or ultrasonic irrigation), autolytic, biochemical (e.g., enzyme collagenase), and biological using sterile maggots.

**Searches**

AmeriHealth Caritas searched PubMed and the databases of:

- UK National Health Services Center for Reviews and Dissemination.
- Agency for Healthcare Research and Quality’s National Guideline Clearinghouse and other evidence-based practice centers.
- The Centers for Medicare & Medicaid Services.

We conducted searches on August 14, 2018. Search terms were: "Wound Healing" (MeSH), "Debridement" (MeSH), and "Diabetes Complications" (MeSH).

We included:

- **Systematic reviews**, which pool results from multiple studies to achieve larger sample sizes and greater precision of effect estimation than in smaller primary studies. Systematic reviews use predetermined transparent methods to minimize bias, effectively treating the review as a scientific endeavor, and are thus rated highest in evidence-grading hierarchies.
- **Guidelines based on systematic reviews**.
- **Economic analyses**, such as cost-effectiveness, and benefit or utility studies (but not simple cost studies), reporting both costs and outcomes — sometimes referred to as efficiency studies — which also rank near the top of evidence hierarchies.

**Findings**

We identified one systematic review (Edwards, 2010), one health technology assessment (Canadian Agency for Drugs and Technologies in Health, 2014), and four evidence-based guidelines (National Institute for Health and Care Excellence, 2015; Rodd-Nielsen, 2013; Wounds International, 2013; Lipsky, 2012) for this policy. There is currently a discrepancy between clinical practice and the scientific evidence for improved healing as a result of debridement. All guidelines recommend a multidisciplinary approach to diabetic wound care.

Debridement is effective for speeding up ulcer healing, but the most effective method is unclear. Surgical or non-surgical sharp debridement is the gold standard technique, despite conflicting evidence of clinical efficacy; the need for further surgical/sharp debridement should be determined at each
dressing change. Low-to-moderate quality evidence from randomized controlled trials suggests clostridial collagenase ointment (biochemical debridement) and hydrogels may offer improved clinical outcomes. Less robust evidence suggests other modern dressings and biological techniques may reduce pain and be more acceptable to patients.

The choice of debriding agent for difficult-to-heal surgical wounds should be based on impact on comfort, odor control and other aspects relevant to patient acceptability, type and location of wound, and total costs. Surgical/sharp debridement should be carried out by experienced practitioners with specialist training in wound care that includes sharp wound debridement. Practitioners must be able to distinguish tissue types, understand anatomy to avoid damage to blood vessels, nerves and tendons, and demonstrate high-level clinical decision-making skills in assessing a safe and effective level of debridement.

Other methods may be appropriate in certain situations:
- As an interim measure (e.g., by practitioners without the necessary skill sets to carry out sharp debridement; methods include the use of a monofilament pad or larval therapy).
- For patients in whom sharp debridement is contraindicated or unacceptably painful.
- When another debridement technique may be more beneficial for the patient.
- For patients who have expressed another preference.

Policy updates:

In 2016, we identified one new systematic review/meta-analysis (Elraiyah, 2016), one new guideline (Hingorani, 2016), and no new economic studies for this policy. The results of the new analysis and recommendations from The Society for Vascular Surgery, in collaboration with the American Podiatric Medical Association and the Society for Vascular Medicine, are consistent with previous findings. Several effective debridement methods are available for use. Initial sharp debridement of the diabetic foot ulcer is preferred with choice of subsequent debridement method based on available expertise, patient preferences, the clinical context, and cost. No changes to the policy are warranted.

A new cross-sectional study analyzed the magnitude and impact of diabetic foot ulcers presenting to emergency departments in the United States from 2006 to 2010 (Skrepnek, 2015). Using data of more than 1 million cases from the Agency for Healthcare Research and Quality Healthcare Cost and Utilization Project National Emergency Department Sample discharge records, multivariable analysis found significant clinical and economic burden of diabetic foot ulcers, particularly among the rural and working poor. Those living in rural areas were at a significantly higher risk of major amputation, minor amputation, and inpatient death than those living in urban locales \((P < .05)\). Medicaid beneficiaries were at significantly higher risk for major or minor amputations than Medicare patients \((P < .05)\). Finally, low income was associated with a significantly higher risk of major amputation \((P < .05)\). While this study does not change previous findings, it further establishes the need for effective screening, prevention,
and coordinated care among AmeriHealth Caritas members who are at elevated risk of diabetic foot complications.

In 2017, we added an evidence-based guideline by International Working Group on the Diabetic Foot (Game, 2016). Their general recommendations are consistent with previous guidelines in this policy. Their statement on severe ischemia as a relative contraindication to sharp debridement was added to this policy’s limitations.

In 2018, we added no new information to the policy. Policy ID changed from CP# 06.02.04 to CCP.1200.

Summary of clinical evidence:

<table>
<thead>
<tr>
<th>Citation</th>
<th>Content, Methods, Recommendations</th>
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<tbody>
<tr>
<td>Elraiyah (2016)</td>
<td><strong>Key points:</strong></td>
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| Debridement methods for chronic diabetic foot ulcers | - Systematic review and meta-analysis of 11 randomized controlled trials and three nonrandomized studies (n = 800 total patients).  
- Overall quality: low to moderate with a moderate risk of bias.  
- Results presented as relative risk [RR], 95% confidence interval [CI].  
- Autolytic debridement significantly increased healing rate (1.89, 1.35 - 2.64, three randomized controlled trials).  
- Larval debridement reduced amputation (0.43, 0.21 - 0.88, one randomized controlled trial and three nonrandomized studies) but did not increase complete healing (1.27, 0.84 - 1.91).  
- Surgical debridement: shorter healing time v. conventional wound care (one randomized controlled trial).  
- Relative effectiveness is unclear and insufficient evidence for other methods.  
- Choice of method should be based on available expertise, patient preferences, the clinical context, and cost. |
| Game (2016) | **Key points:** |
| for the International Working Group on the Diabetic Foot Guideline: prevention and management of foot problems in diabetes | - Clean ulcers regularly with clean water or saline, debride when possible to remove debris from the wound surface, and dress them with a sterile, inert dressing to control excessive exudate and maintain a warm, moist environment to promote healing. (GRADE strength of recommendation: Strong; Quality of Evidence: Low).  
- In general remove slough, necrotic tissue, and surrounding callus with sharp debridement in preference to other methods, taking relative contra-indications such as severe ischemia into account. (Strong; Low). |
| Hingorani (2016) | **Key points:** |
| for the Society for Vascular Surgery in collaboration with the American Podiatric Medical Association and the Society for Vascular Medicine | - Initial sharp debridement of all infected diabetic foot ulcers and urgent surgical intervention for foot infections involving abscess, gas, or necrotizing fasciitis (grade 1B, strong recommendation, moderate-quality evidence).  
- Follow current Infectious Diseases Society of America guidelines (ungraded).  
- Sharp debridement of all devitalized tissue and surrounding callus material from diabetic foot ulcers at one- to four-week intervals (grade 1B, strong recommendation, moderate-quality evidence). |
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<tr>
<th>Citation</th>
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<tr>
<td>National Institute for Health and Care Excellence (2015) Guideline: treatment of diabetic foot ulcers</td>
<td>Key points: • In-hospital debridement should only be done by a multidisciplinary foot care service, using the technique that best matches clinical expertise and experience, ulcer site, and patient preference. • Debridement in the community should only be done by health care professionals with the relevant training and skills, continuing the care described in the person's treatment plan.</td>
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<tr>
<td>Canadian Agency for Drugs and Technologies in Health (2014) Comparative effectiveness, cost-effectiveness and guidelines for debridement procedures</td>
<td>Key points: • Analysis included one systematic review, one meta-analysis, two randomized controlled trials, one randomized controlled trial with a cost-effectiveness analysis, and seven relevant guidelines. • Overall quality: low to moderate with high risk of bias. • Despite contrasting evidence of clinical efficacy, surgical debridement is often part of standard care for diabetic foot ulcers. • Clostridial collagenase ointment (biochemical debridement) and hydrogels may offer improved clinical outcomes, although the evidence is from randomized controlled trials with methodological limitations. • Callus debridement is recommended to reduce focal plantar pressure, but no specific technique for removal was recommended.</td>
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<td>Rodd-Nielsen for the Canadian Association for Enterostomal Therapy (2013) Guideline: conservative sharp wound debridement</td>
<td>Key points: • Conservative sharp wound debridement requires specific knowledge and training (i.e., advanced preparation beyond the basic entry to nursing practice) and a supervised regulatory process for assessing clinician skills. • Optimal conservative sharp wound debridement uses an interdisciplinary approach to wound management and is critical to high-acuity wound care. • Ensure safe practice regardless of the client care setting: acute/primary care, clinic, community/home care, or long-term care.</td>
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<td>Wounds International (2013) Guideline: wound management in diabetic foot ulcers</td>
<td>Key points: • Debridement may be a one-off procedure or ongoing for wound maintenance. • Gold standard technique for tissue management in diabetic foot ulcers is regular, local, sharp debridement carried out by experienced practitioners (e.g., a specialist podiatrist or nurse) with specialist training: − Ability to distinguish tissue types and understand anatomy to avoid damage to blood vessels, nerves, and tendons. − Skilled in assessing the most safe and effective debridement level. − Performed in the clinic or at the bedside. • Further debridement should be determined at each dressing change. Relative effectiveness of methods was not determined.</td>
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Other methods may be appropriate as interim measures when sharp debridement is contraindicated or unacceptably painful, when other techniques are more effective, or when patients express another preference.

**Key points:**
- “Standard/good wound care” includes sharp debridement of callus and other wound debris or eschar, moist wound healing, and pressure or weight displacement of the affected foot area. Other considerations include ensuring adequate arterial perfusion to the site and controlling any concomitant infection. (Strong recommendation, level of evidence expert opinion.)
- Debridement aimed at removing debris, eschar, and surrounding callus (strong, moderate). Sharp (or surgical) methods are generally best (strong, low), but mechanical, autolytic, or larval debridement techniques may be appropriate for some wounds (weak, low).
- Selection of dressing should be based on the size, depth, and nature of the ulcer (e.g., dry, exudative, purulent) (strong, low).
- Clinicians without adequate training in wound debridement should seek consultation from more qualified clinicians for this task, especially when extensive procedures are required (strong, low).

**Key points:**
- Systematic review of four randomized controlled trials of hydrogel versus gauze or standard care, one randomized controlled trial of surgical debridement versus standard care, and one small randomized controlled trial of larvae versus hydrogel.
- Overall quality: low with high risk of bias.
- Hydrogels are significantly more effective in healing diabetic foot ulcers than gauze or standard care (RR 1.84, 95% CI 1.3 to 2.61).
- No significant benefit of surgical debridement over standard treatment.
- Insufficient evidence of the effects of larval therapy on diabetic foot ulcers.
- More research is needed.

**References**

**Professional society guidelines/other:**


**Peer-reviewed references:**


Centers for Medicare & Medicaid Services National Coverage Determinations:

No National Coverage Determinations identified as of the writing of this policy.

Local Coverage Determinations:

A53001 Wound care.

A55767 Wound care.

A55757 Wound care (L37166): Medicare Part A/B local coverage determination (LCD) comment summary.

A55818 Wound care coding guidelines.

L33413 Therapy and Rehabilitation Services.

L34049 Outpatient Physical and Occupational Therapy Services.

L34427 Outpatient Occupational Therapy.

L34428 Outpatient Physical Therapy.

L35125 Wound Care.

L37166 Wound Care.

**Commonly submitted codes**

Below are the most commonly submitted codes for the service(s)/item(s) subject to this policy. This is not an exhaustive list of codes. Providers are expected to consult the appropriate coding manuals and bill accordingly.

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Description</th>
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<tr>
<td>11000</td>
<td>Debridement of extensive eczematous or infected skin; up to 10 percent of body surface</td>
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<tr>
<td>11042</td>
<td>Debridement, subcutaneous tissue (includes epidermis and dermis, if performed)</td>
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<tr>
<td>CPT Code</td>
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<tr>
<td>11043</td>
<td>Debridement, muscle and/or fascia (includes epidermis, dermis and subcutaneous tissue, if performed); first 20 sq cm or less</td>
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<tr>
<td>11044</td>
<td>Debridement, bone (includes epidermis, dermis, subcutaneous tissue, muscle and/or fascia, if performed), first 20 sq cm or less</td>
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<tr>
<td>97597</td>
<td>Debridement (e.g., high pressure waterjet with/without suction, sharp selective debridement with scissors, scalpel and forceps), one wound, (e.g., fibrin, devitalized epidermis and/or dermis, debris, biofilm) including topical application(s), wound assessment, use of whirlpool, when performed and instruction(s) for ongoing care, per session, total wound(s) surface area; first 20 sq cm or less</td>
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<tr>
<td>+97598</td>
<td>Each additional 20 sq cm or part thereof, list additionally to primary code</td>
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<tr>
<td>97602</td>
<td>Removal of devitalized tissue from wound(s), nonselective debridement, without anesthesia (e.g., wet-to-moist dressings, enzymatic, abrasion) including topical application(s), wound assessment, and instruction(s) for ongoing care per session</td>
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<thead>
<tr>
<th>ICD-10 Code</th>
<th>Description</th>
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<tr>
<td>E09.621</td>
<td>Drug or chemical induced diabetic foot ulcer</td>
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<tr>
<td>E10.621</td>
<td>Diabetic foot ulcer (Type I diabetes)</td>
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<tr>
<td>E11.621</td>
<td>Diabetic foot ulcer (Type II diabetes)</td>
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<tr>
<td>L97.401-L97.429</td>
<td>Chronic ulcer, unspecified heal and mid-foot</td>
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<thead>
<tr>
<th>HCPCS Level II Code</th>
<th>Description</th>
<th>Comment</th>
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<tr>
<td>No codes</td>
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