Clinical Policy: Burn Surgery

Reference Number: CP.MP.186
Date of Last Revision: 09/26

Coding Implications
Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Description

This policy addresses the medical necessity criteria for burn debridement and/or excision during the acute phase of treatment.

Note: For skin substitutes for burn treatment, refer to *CP.MP.185 Skin and Soft Tissue Substitutes.*

Policy/Criteria

I. It is the policy of health plans affiliated with Centene Corporation® that burn treatment with debridement and/or excision is **medically necessary** for either of the following:
   A. Deep partial-thickness burn;
   B. Full-thickness burn or deeper.

Background

A burn is defined as a traumatic injury to the skin or other organic tissue primarily caused by heat or exposure to electrical discharge, friction, chemicals, and radiation.[15] According to the American Burn Association, burn injuries result in 29,165 inpatient admissions per year in the United States and are a leading cause of accidental injury and death.[2,15] The most severe burn injuries require admission to a specialty hospital or burn center.[2,15]

Burns are classified in terms or degrees. First-degree burns, also called superficial partial thickness, only involve the outer layer of skin, the epidermis. These burns are red and painful but remain dry and without blisters. First-degree burns typically heal within about one week. Second degree, or partial thickness burns, extend deeper into the dermis, include blisters, and have a wet appearance. Second-degree burns are extremely painful and can take two to three weeks to heal. Third-degree, or full thickness, burns have a white or leather appearance and are dry to the touch. These burns are often without sensation due to nerve damage. They extend the full depth of the skin. Skin grafts are typically required for healing third-degree burns. The most severe burns extend into deeper tissues, including subcutaneous tissue, fascia, muscle, tendon, or bone, and are sometimes referred to as fourth-degree burns. Skin grafting and even more intensive surgeries or amputations may be required for healing.[4]

A severe or major burn is classified as any burn that is accompanied by a major trauma, inhalation injury, or a chemical or high-voltage electrical burn, and, generally, any burns involving over 20 percent of the total body surface area (TBSA), excluding first-degree burns.[3] Burns to high-risk individuals such as older adults, young children and anyone with a major comorbidity may be considered severe even if less than 20 percent of their TBSA is involved. Burns to areas like the eyes, ears, face, hands, feet or perineum may require specialized burn center care due to the high risk of functional impairment.[3] In addition, circumferential burns of the extremities or thorax require consultation with a burn center as they are an indicator of

decreased blood flow. Deep circumferential burns of the chest may impair or prevent mechanical ventilation of the burn victim.[4]

In the past, burns were treated with painful debridement of blisters, daily soaking and scrubbing, and frequent bandage changes with topical medications. Today, tissue regeneration and grafting is rapidly becoming the new standard of care in burn injuries.[3,5,6] The goal of burn treatment is to replace damaged or missing tissue with similar, healthy tissue and restore full function to the involved area with minimal to no scar tissue formation.[9,13] Second-, third- and fourth-degree burns most often require a surgical procedure to allow for healing. Although some of the most severe burns may require multisystem surgeries or amputations, most burn injuries are treated with the application of skin grafts.[3,5,6]

One of the greatest advances in burn treatment has been early excision of necrotic tissue and closure of thermal burn wounds. Early excision and grafting provide a skin substitute for the wound, but further reconstructive surgeries may still be required to restore a normal appearance and function.[7] According to the International Society for Burn Injury, management of major burns by debridement with dressings and subsequent delayed grafting may be the safest approach when resources are limited. By waiting until sloughing of the eschar, minimal surgery is needed, with harvest of the skin grafts being the key surgical intervention.[13]

Hydrosurgery describes the use of high-pressure water jets to debride necrotic tissue. This technique can aid in dermal skin preservation and scar reduction. In a 137-person within-patient trial, twice as many patients reported the hydrosurgically debrided area to be better or much better compared to conventional debridement at 12 months, but one-fourth of patients saw no difference. Although encouraging, additional larger trials are necessary prior to recommendations for routine use.[9]

By performing early excision and grafting, the patient's length of stay in the hospital is significantly reduced, as is the risk for hypertrophic scarring, joint contracture, infection and stiffness. Early closure also allows for quicker rehabilitation and lower mortality rates. As with any surgical procedure, there are also risks and challenges. Major challenges associated with burn surgery include extensive tissue loss and limited availability of tissue, exposure of other structures, scarring and limited tissue pliability.[7]

Coding Implications

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CPT Codes that Support Medical Necessity Criteria

CPT® Codes	Description
11000	Debridement of extensive eczematous or infected skin; up to 10% of body surface
11042	Debridement, subcutaneous tissue (includes epidermis and dermis, if performed); first 20 sq cm or less
11043	Debridement, muscle and/or fascia (includes epidermis, dermis, and subcutaneous tissue, if performed); first 20 sq cm or less
11044	Debridement, bone (includes epidermis, dermis, subcutaneous tissue, muscle and/or fascia, 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)
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)

Reviews, Revisions, and Approvals	Revision Date	Approval Date
New Policy adapted from WellCare's HS321. Updated description of the policy. Specified in medical necessity statement that the criteria applies to debridement and skin substitutes and their application. Removed criteria that treatment is individualized, specific, and consistent with symptoms/diagnosis, and not in excess of need. Removed criteria that treatment can be safely furnished and no equally effective or more conservative or less costly treatment is available. Removed criteria that treatment is not furnished only for convenience. Added medical necessity criteria for debridement/excision and skin substitutes. Added acceptable tissue engineered products i.e., Apligraf, TheraSkin and Integra wound matrix, Biobrane, Transcyte. Added Epicel acceptable (if used in accordance to the FDA HDE approval requirements). Removed statement that investigational products or procedures are not medically necessary.	05/20	05/20
Annual review completed. Background updated and minor rewording with no clinical significance. References reviewed, reformatted and updated.	11/22	11/22
Annual review. Added criteria II.C. that burn must be deep partial-thickness or full-thickness. Added used according to FDA indications to II.D.3. References reviewed and updated. Reviewed by internal specialist.	11/23	11/23
Annual review. References reviewed and updated. Reviewed by external specialist.	11/24	11/24
Annual review. Description and background updated with no clinical significance. Updated II.D.3. to clarify HDE abbreviation with no clinical significance. Coding reviewed and updated. Replaced	11/25	11/25

Reviews, Revisions, and Approvals	Revision Date	Approval Date
"coverage" to "medical necessity" in the code table titles. References reviewed and updated.		
Description revised to exclude skin grafting. Updated "Note" section. Moved all of criteria section II to CP.MP.185 Skin and Soft Tissue Substitutes. Removed CPT codes 15271 to 15278 from CPT code table. Removed HCPCS code table. Removed skin graft information from the background.	05/26	
Annual review. Background updated with no impact to criteria. Codes and descriptions reviewed. References reviewed and updated. Reviewed by external specialist.	09/26	09/26

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Important Reminder

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. "Health Plan" means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan's affiliates, as applicable.

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Note: For Medicare members/enrollees, to ensure consistency with the Medicare National Coverage Determinations (NCD) and Local Coverage Determinations (LCD), all applicable NCDs, LCDs, and Medicare Coverage Articles should be reviewed prior to applying the criteria set forth in this clinical policy. Refer to the CMS website at http://www.cms.gov for additional information.

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