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Excisional Debridement

Physicians/providers must document "excisional debridement of bone, fascia or muscle." Otherwise, the procedure will be coded as non-excisional.

The following information must also be documented by the provider:

- Description of the **area debrided.**
- The **exact instruments used** (scalpel, scissors, forceps, etc.).
- The deepest tissue depth reached during the debridement in terms of **skin, fascia, muscle, tendon, or bone**. (Units of measurement, such as centimeters or inches, are not useable for coding purposes.
- Documentation of **removal or cutting away** of devitalized tissue**,** necrosis, or slough.

Terms such as "sharp debridement" or statement of use of scalpel alone are not considered sufficient for code assignment of excisional debridement.

Trauma registrars may not assume that debridement of bone, fascia or muscle is excisional. Nor may they assume that sharp debridement is excisional. The exact wording of "excisional debridement" with the supporting documentation must be present.

Failure to document appropriately may result in problems with physician reimbursement and/or denials.