



Missouri Care

WellCare (Nebraska)

Burn Surgery:
Policy Number: CP.MP.186

Last Review Date: 05/20

APPLICATION STATEMENT

The application of the Clinical Coverage Guideline is subject to the benefit determinations set forth by the Centers for Medicare and Medicaid Services (CMS) National and Local Coverage Determinations and state-specific Medicaid mandates, if any.

DISCLAIMER

The Clinical Coverage Guideline (CCG) is intended to supplement certain standard WellCare benefit plans and aid in administering benefits. Federal and state law, contract language, etc. take precedence over the CCG (e.g., Centers for Medicare and Medicaid Services [CMS] National Coverage Determinations [NCDs], Local Coverage Determinations [LCDs] or other published documents). The terms of a member's particular Benefit Plan, Evidence of Coverage, Certificate of Coverage, etc., may differ significantly from this Coverage Position. For example, a member's benefit plan may contain specific exclusions related to the topic addressed in this CCG. Additionally, CCGs relate exclusively to the administration of health benefit plans and are NOT recommendations for treatment, nor should they be used as treatment guidelines. Providers are responsible for the treatment and recommendations provided to the member. The application of the CCG is subject to the benefit determinations set forth by the Centers for Medicare and Medicaid Services (CMS) National and Local Coverage Determinations, and any state-specific Medicaid mandates. Links are current at time of approval by the Medical Policy Committee (MPC) and are subject to change. Lines of business are also subject to change without notice and are noted on www.wellcare.com. Guidelines are also available on the site by selecting the Provider tab, then "Tools" and "Clinical Guidelines".

BACKGROUND

Johns Hopkins Health Library defines burns as a type of painful wound caused by thermal, electrical, chemical, or electromagnetic energy. They cite smoking and open flame as the leading causes of burn injury for older adults and scalding as the leading cause of burn injury for children.¹ According to the American Burn Association, burn injuries result in more than 500,000 hospital emergency department visits and approximately 50,000 acute admissions per year in the United States. The most severe burn injuries require admission to a specialty hospital or burn center.²

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. Also considered severe are any burns involving over 20 percent of the total body surface area (TBSA), with the exception of first-degree burns. 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 a 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

Burns are classified in terms of degrees. First-degree burns, also called superficial partial thickness, only involve the outer layer of skin, the epidermis. These burns will be 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 2 to 3 weeks to heal. Third degree, or full thickness, burns have a white or leathery appearance and will be 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 are called fourth degree or

are classified as with extension to deep tissues. These burns will extend to the muscles, tendons and/or bone. Skin grafting and even more intensive surgeries or amputations may be required for healing.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. The goal of treating a burn wound 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. 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 be still be required to restore a normal appearance and function. 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

Skin Grafts

Skin grafting consists of taking tissue from another source and placing it over a wound. Sources include unaffected skin from another location on the burn victim's body, cadaveric skin grafts and amniotic chorion/membrane. The success of a skin graft relies on many factors. The graft bed must be suitable to sustain the graft during the imbibition phase of healing. Also, there must be sufficient perfusion to the graft, either from the graft bed or from another supply such as a flap repair. Skin grafts are used for coverage of exposed bone and tendons only if there is a vascularized layer of periosteum or the paratenon is intact.^{7,8}

POSITION STATEMENT

Early burn debridement is vital to the overall survivability and outcome of burn patients. Early grafting is also directly related to improved survival rates.¹² Grafts used to cover the wound bed include skin replacements (i.e., autograft and allograft) and skin substitutes. Autografts (split or full thickness skin grafts) are the current standard of care in burn surgery. When the total body surface area is larger than the available donor sites or tissues are too edematous to allow successful acceptance of autografts, allograft and skin substitutes are an alternative. Skin substitutes are tissue-engineered products designed to replace, either temporarily or permanently, the form and function of the skin. This policy addresses the medical necessity criteria for burn debridement and/or excision and the use of skin substitutes for burns during the acute phase of treatment.

Note: For skin substitutes for chronic wounds, refer to *CP.MP.185 Skin Substitutes for Chronic Wounds*.

Policy/Criteria

- I. 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.

- II. Burn treatment with skin replacement/substitutes (including the procedure, product, service) is **medically necessary** when meeting all of the following:
 - A. Sufficient autograft is not available at the time of excision or is not feasible due to the physiological condition of the patient;
 - B. No evidence of burn wound infection;
 - C. Treatment with any of the following skin replacement/substitutes:
 1. Allograft (human cadaver);

2. Xenograft (porcine);
3. Tissue engineered skin substitute (e.g., Biobrane®, Transcyte® Apligraf®, TheraSkin®, Integra® Wound Matrix, Integra® meshed Bilayer Wound Matrix, Integra® Dermal Regeneration Template, or Epicel,® if used per FDA HDE).

III. Burn treatment with debridement and/or skin substitutes (including the procedure, product, service) is **not medically necessary** when duplicating another provider's procedure, product, or service.

CODING

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)
15271	Application of skin substitute graft to trunk, arms, legs, total wound surface area up to 100 sq cm; first 25 sq cm or less wound surface area
15272	Application of skin substitute graft to trunk, arms, legs, total wound surface area up to 100 sq cm; each additional 25 sq cm wound surface area, or part thereof
15273	Application of skin substitute graft to trunk, arms, legs, total wound surface area greater than or equal to 100 sq cm; first 100 sq cm wound surface area, or 1% of body area of infants and children
15274	Application of skin substitute graft to trunk, arms, legs, total wound surface area greater than or equal to 100 sq cm; each additional 100 sq cm wound surface area, or part thereof, or each additional 1% of body area of infants and children, or part thereof
15275	Application of skin substitute graft to face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits, total wound surface area up to 100 sq cm; first 25 sq cm or less wound surface area
15276	Application of skin substitute graft to face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits, total wound surface area up to 100 sq cm; each additional 25 sq cm wound surface area, or part thereof (List separately in addition to code for primary procedure)
15277	Application of skin substitute graft to face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits, total wound surface area greater than or equal to 100 sq cm; first 100 sq cm wound surface area, or 1% of body area of infants and children
15278	Application of skin substitute graft to face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits, total wound surface area greater than or equal to 100 sq cm; each additional 100 sq cm wound surface area, or part thereof, or each additional 1% of body area of infants and children, or part thereof (List separately in addition to code for primary procedure)

HCPCS Codes that Support Coverage Criteria

HCPCS Codes	Description
N/A	

ICD-10-CM Diagnosis Codes that Support Coverage Criteria

ICD-10-CM Code	Description
T20.xxx	Burn and corrosion of head, face, and neck
T22.xxx	Burn and corrosion of shoulder and upper limb, except wrist and hand
T27.xxx	Burn and corrosion of respiratory tract
T28.xxx	Burn and corrosion of other internal organs

Coding information is provided for informational purposes only. The inclusion or omission of a CPT, HCPCS, or ICD-10 code does not imply member coverage or provider reimbursement. Consult the member's benefits that are in place at time of service to determine coverage (or non-coverage) as well as applicable federal / state laws.

REFERENCES

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REVIEWS, REVISIONS, AND APPROVALS

	Date	Approval Date
<p>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.</p>	05/20	05/20