

Pressure injury/pressure ulcer

ICD-10-CM

Clinical overview

Definition

The National Pressure Injury Advisory Panel (NPIAP) is an independent not-for-profit professional organization dedicated to the prevention and management of pressure injuries. The NPIAP advises as follows:

A pressure injury is localized damage to the skin and underlying soft tissue, usually over a bony prominence or related to a medical or other device. The injury can present as intact skin or an open ulcer and may be painful. The injury occurs as a result of intense and/or prolonged pressure or pressure in combination with shear. The tolerance of soft tissue for pressure and shear may also be affected by microclimate, nutrition, perfusion, comorbidities and condition of the soft tissue.

Causes and risk factors

- Immobility (being bedridden or requiring the use of a wheelchair; being unable to change position without help – e.g., post-surgery, due to coma or paralysis)
- Fragile skin
- Moisture (such as with incontinence of bowel or bladder or excessive perspiration)
- Poor nutrition
- Mental disability that interferes with ability to prevent or treat pressure ulcers
- Older age
- Poorly fitting prosthetic devices
- Chronic conditions that cause poor circulation or lack of pain perception
- Smoking (nicotine impairs circulation)

Complications

- Bone and joint infections
- Cellulitis
- Sepsis
- Skin cancer

Signs and symptoms

The NPIAP provides detailed descriptions and illustrations of the signs and symptoms associated with each stage of pressure injury:

- Stage 1: Nonblanchable erythema of intact skin
- Stage 2: Partial-thickness skin loss with exposed dermis

- Stage 3: Full-thickness skin loss
- Stage 4: Full-thickness skin and tissue loss
- Unstageable pressure injury: Obscured full-thickness skin and tissue loss
- Deep-tissue pressure injury: Persistent nonblanchable deep red, maroon or purple discoloration

Link to NPIAP pressure injury stages and illustrations

<https://npiap.com/page/PressureInjuryStages>

Diagnostic tools

- Medical history and physical exam
- Skin or wound culture if infection is suspected
- Skin biopsy
- Diagnostic testing related to underlying contributing conditions and to evaluate nutritional status

Prevention

- Regular and frequent skin inspection to monitor for early signs and symptoms of pressure injury
- Proper positioning with frequent position changes
- Proper skin care (keeping skin clean and moisturized, but avoiding too much moisture)
- Balanced nutrition
- Avoidance of sliding or dragging maneuvers
- Smoking cessation
- Exercise
- Individual and caregiver education

Treatment

- Implementation of preventive measures, such as those listed above
- Relieving pressure on the area (devices such as foam pads or air-filled mattresses may be used)
- Pain and infection management
- Management and treatment of contributing underlying conditions
- Other treatment based on the stage of the pressure ulcer and according to physician orders, which may include cleaning the ulcer, dressing changes, ointments, creams, medications, debridement procedures and surgery

Pressure injury/pressure ulcer

ICD-10-CM

Best documentation practices for physicians

Subjective

The subjective section of the office note should document any current patient or caregiver complaint related to pressure injury.

Objective

In the objective section, document the physical examination findings and detailed description of any current pressure injury, including the following:

- The specific site/location with laterality
- The specific stage (per NPIAP descriptions)
- Precise measurements (length, width, depth in centimeters)
- Undermining, sinus tracts or tunneling (recorded in centimeters)
- Wound-base description (granulation, necrotic tissue, eschar, slough, new epithelial tissue)
- Absence or presence of drainage (amount, color, consistency and odor, as appropriate)
- Wound edges – description of area up to 4 cm from edge of the wound; measure in centimeters and describe characteristics (light pink, deep red, purple, macerated, calloused, etc.)
- Odor – present or absent
- Associated pain and related interventions
- Current status (improved, worsening, no change, stable, etc.)

Assessment

Specificity: Describe each final pressure injury diagnosis to the highest level of specificity, including cause, appearance, stage, location with laterality.

Abbreviations: A good rule of thumb for any medical record is to limit – or avoid altogether – the use of abbreviations. **Best practice:**

- First mention in the office note of any medical diagnosis should be spelled out in full with the abbreviation in parentheses, for example: “Pressure ulcer (PU).”
- Subsequent mention can then be made using the abbreviation, except in the final assessment, where the diagnosis should again be spelled out in full.

Current versus historical:

- Do not describe a current pressure ulcer as “history of.” In diagnosis coding, the phrase “history of” means the condition is historical and no longer exists as a current problem.
- Do not document a past pressure ulcer that has resolved as if it were current.

Plan

- Document a specific and concise treatment plan for pressure ulcers (e.g., devices such as foam pads or mattresses; wound care instructions; prescriptions for ointments, creams or other medications; planned debridement; etc.).
- If referrals are made or consultations requested, the office note should indicate to whom or where the referral or consultation is made or from whom consultation advice is requested.
- Document when the patient will be seen again.

Electronic medical record (EMR) issues

Some electronic medical records insert ICD-10-CM code descriptions into the medical record to represent the final diagnosis, for example:

“L89.899 Pressure ulcer of other site, unspecified stage”

This is a vague and nonspecific diagnosis that is not complete without clear documentation of the specific site and stage of the pressure ulcer.

ICD-10-CM Official Guidelines for Coding and Reporting, Section I.A.9.a – “Other and unspecified codes”:

Codes titled “other” or “other specified” are for use when the information in the medical record provides specific detail for which a specific code does not exist.

- Alphabetic Index entries in the coding manual with NEC (not elsewhere classified) in the line designate “other” codes in the Tabular List.
- These Alphabetic Index entries represent specific disease entities for which no specific code exists so the term is included within an “other” code.
- The “other” ICD-10-CM code with description should not be used, by itself, as a final diagnosis without clear documentation of the particular “other” condition – or in this case – the “other” pressure ulcer site that does not have its own code.

Pressure injury/pressure ulcer

ICD-10-CM

Best documentation practices for physicians

Another scenario that causes confusion is one in which the assessment section documents a provider-stated diagnosis *PLUS* an EMR-inserted diagnosis code with description that does not match or may even contradict the stated diagnosis. Example:

Final Assessment:

Stage 1 pressure ulcer right heel

L89.613 Pressure ulcer of right heel, stage 3

In this scenario, the provider's final diagnostic statement in bold does not match the diagnosis code with description.

To avoid confusion and ensure accurate diagnosis code assignment, the provider-stated final diagnosis must either

- a) match the code with description; OR
- b) it must classify in ICD-10-CM to the EMR-inserted diagnosis code with description.

Note: ICD-10-CM is a statistical classification; it is not a substitute for a provider's final diagnostic statement. It is the healthcare provider's responsibility to provide legible, clear, concise and complete documentation of the final diagnosis to the highest level of specificity, which is then translated to a code for reporting purposes. It is not appropriate for healthcare providers to simply list a code number or select a code number from a list of codes in place of a written final diagnosis. (See AHA Coding Clinic guideline Code number in lieu of a diagnosis, Fourth Quarter 2015, Pages 34-35).

Pressure injury/pressure ulcer

ICD-10-CM

Tips and resources for coders

Coding basics

For accurate and specific diagnosis code assignment, review the entire medical record to verify pressure ulcer/injury is a current condition. Next note the exact description of the pressure ulcer/injury documented in the medical record; and in accordance with ICD-10-CM official coding conventions and guidelines:

- a) Search the alphabetic index for that specific description.
- b) Verify the code in the tabular list, carefully following all instructional notes.

Coding pressure injury/ulcer

The NPIAP change from "pressure ulcer" to "pressure injury" was a change in terminology, not a change in the definition of pressure ulcer. The stages of pressure injury used in the NPIAP's updated terminology correspond to the pressure ulcer stages in ICD-10-CM. For pressure injury, there is an Alphabetic Index entry as follows:

Injury

pressure

injury – see Ulcer, pressure, by site

ICD-10-CM Official Guidelines for Coding and Reporting (Section I.C.12.a.1-7) advise as follows:

1) Pressure ulcer stages

- Codes in category L89, pressure ulcer, are combination codes that identify the site and stage of the pressure ulcer.

Fourth characters identify the specific site of the ulcer – e.g., elbow (L89.0-); back (L89.1-); hip (L89.2-); buttock (L89.3-); contiguous site of back, buttock and hip (L89.4-); ankle (L89.5-); heel (L89.6-); other site (L89.8-); and unspecified site (L89.9-).

A fifth character is added for laterality. Examples: unspecified ankle (L89.50-); right ankle (L89.51-); left ankle (L89.52-)

A sixth character indicates the severity of the ulcer by identifying the stage designated by stages 1-4, deep tissue damage, unspecified stage and unstageable.

- Assign as many codes from category L89 as needed to identify all the pressure ulcers the patient has, if applicable.

2) Unstageable pressure ulcers

- Assignment of the code for unstageable pressure ulcer (L89.--0) should be based on the clinical documentation. These codes are used for pressure ulcers of which the stage cannot be clinically determined (e.g., the ulcer is covered by eschar or has been treated with a skin or muscle graft).
- This code should not be confused with the codes for unspecified stage (L89.--9), which are used when there is no documentation regarding the stage of the pressure ulcer.
- When there is no documentation regarding the stage of the pressure ulcer, assign the appropriate code for unspecified stage (L89.--9)

3) Documented pressure ulcer stage

- Assignment of the code for the pressure ulcer stage should be guided by clinical documentation of the stage or documentation of the terms found in the alphabetic index.
- For clinical terms describing the stage that are not found in the alphabetic index, and for which there is no documentation of the stage, the provider should be queried.

4) Pressure ulcers documented as healed

No code is assigned if the documentation states the pressure ulcer is completely healed at the time of the admission.

5) Pressure ulcers documented as healing

- Pressure ulcers described as healing should be assigned the appropriate pressure ulcer stage code based on the documentation in the medical record. If the documentation does not provide information about the stage of the healing pressure ulcer, assign the appropriate code for unspecified stage.
- If the documentation is unclear as to whether the patient has a current (new) pressure ulcer or if the patient is being treated for a healing pressure ulcer, query the provider.
- For ulcers that were present on admission but healed at the time of discharge, assign the code for the site and stage of the pressure ulcer at the time of admission.

Pressure injury/pressure ulcer

ICD-10-CM

Tips and resources for coders

6) Patient admitted with pressure ulcer evolving into another stage during the admission

If a patient is admitted to an inpatient hospital with a pressure ulcer at one stage and it progresses to a higher stage, two separate codes should be assigned:

- One code for the site and stage of the ulcer on admission; and
- A second code for the same ulcer site and the highest stage reported during the stay.

7) Pressure-induced deep tissue damage

For pressure-induced deep tissue damage or deep tissue pressure injury, assign only the appropriate code for pressure-induced deep tissue damage (L89.--6).

Note: In ICD-10-CM, there is an alphabetic index entry for deep tissue injury as follows:

Injury

deep tissue

meaning pressure ulcer – see Ulcer pressure
L89 with final character .6

Here are some examples of codes found at category L89 for pressure-induced deep tissue damage:

- L89.006 Pressure-induced deep tissue damage of unspecified elbow
- L89.016 Pressure-induced deep tissue damage of right elbow
- L89.026 Pressure-induced deep tissue damage of left elbow
- L89.206 Pressure-induced deep tissue damage of unspecified hip
- L89.216 Pressure-induced deep tissue damage of right hip
- L89.226 Pressure-induced deep tissue damage of left hip

See the ICD-10-CM coding manual for a complete list of pressure-induced deep tissue damage code options under category L89 with final character .6.

Classifications and staging of diabetic foot ulcers

There are classification systems that grade or stage diabetic foot ulcers from no ulcer to superficial ulcer to deep/infected/ischemic or gangrenous ulcers. Examples include the Wagner system or the University of Texas system. These classification systems should not be confused with pressure ulcer staging.

Staged ulcers not described as pressure ulcers

The fact that an ulcer is staged does not, by itself, support coding as a pressure ulcer. For a staged ulcer to be coded as a pressure ulcer, the staged ulcer must be described with terms that classify to pressure ulcer (e.g., pressure ulcer, pressure injury, decubitus ulcer, bed sore, etc.)

Pressure injury/pressure ulcer

ICD-10-CM

Tips and resources for coders

Coding examples

| Example 1 | |
|-----------------|---|
| Final diagnosis | 1.0 cm decubitus ulcer sacral region |
| ICD-10-CM code | L89.159 Pressure ulcer of sacral region, unspecified stage |

| Example 2 | |
|-----------------|---|
| Final diagnosis | Stage 4 gangrenous pressure ulcer right heel |
| ICD-10-CM code | I96 Gangrene, not elsewhere classified L89.614 Pressure ulcer of right heel, stage 4 |

| Example 3 | |
|-----------------|--|
| Final diagnosis | Left heel pressure ulcer covered with dry eschar so unable to assess stage |
| ICD-10-CM code | L89.62Ø Pressure ulcer left heel, unstageable |

| Example 4 | |
|-----------------|--|
| Final diagnosis | Stage 2 chronic pressure ulcer left hip, improving |
| ICD-10-CM code | L89.222 Pressure ulcer of left hip, stage 2 |

| Example 5 | |
|-----------------|---|
| Final diagnosis | Stage 1 right foot ulcer |
| ICD-10-CM code | L97.519 Non-pressure chronic ulcer of other part of right foot with unspecified severity |
| Comments | A staged foot ulcer is not coded as a pressure ulcer unless the medical record specifically describes it as such. |

References: American Hospital Association Coding Clinic; ICD-10-CM and ICD-10-PCS Coding Handbook; ICD-10-CM Official Guidelines for Coding and Reporting; Mayo Clinic; MedlinePlus; Merck Manual; National Pressure Injury Advisory Panel.