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

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Best documentation practices for physicians

Subjective

The subjective section of the office note should document any current patient or caregiver complaints or symptoms 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.

Treatment plan

- Document a clear 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.).
- Include orders for diagnostic testing.
- Document to whom/where referral or consultation requests are made.
- Note the date or timeframe for the patient's next appointment.

Electronic health record (EHR) issues

"Other" and unspecified codes with descriptions:

Some electronic health records (EHRs) insert ICD-10-CM codes with corresponding descriptions into the medical record to represent the final diagnosis. For example:

L89.899 Pressure ulcer of other site, unspecified stage

L89.5Ø9 Pressure ulcer of unspecified ankle, unspecified stage

These are vague descriptions and incomplete diagnoses.

- Codes titled "other" or "other specified" are for use when the medical record documents a specific diagnosis description for which a specific diagnosis code does not exist.
- The "other" ICD-10-CM code with description should not be used, by itself, as a final diagnosis without clear documentation that specifies the particular "other" condition or site.
- Unspecified diagnosis descriptions should be used only when sufficient clinical information is not known or available to the provider at the time of the encounter.

Mismatch between final diagnostic statement and EHR-inserted diagnosis code with description:
Another scenario that causes confusion is when the assessment section documents a provider-stated diagnosis *PLUS* an EHR-inserted diagnosis code with description that does not match – or may even be contradictory.

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. This can lead to confusion regarding which diagnostic statement is correct and which diagnosis code should be reported. Documentation elsewhere in the record does not always provide clarity.

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 EHR-inserted diagnosis code with description.

Note: ICD-10-CM is a statistical classification; it is not a substitute for a healthcare provider's final diagnostic statement. It is the provider's responsibility to provide legible, clear, concise and complete documentation of each final diagnosis described 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.

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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.Ø-); 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 (L89.5Ø-); 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.--Ø) 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). When there is no documentation regarding the stage of the pressure ulcer, assign the appropriate code for unspecified stage (L89.--9)
- If during an encounter, the stage of an unstageable pressure ulcer is revealed after debridement, assign only the code for the stage revealed following debridement.

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.

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.ØØ6	Pressure-induced deep tissue damage of unspecified elbow
L89.Ø16	Pressure-induced deep tissue damage of right elbow
L89.Ø26	Pressure-induced deep tissue damage of left elbow
L89.2Ø6	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.).

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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 of 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. Right foot ulcer is specified as stage 1 but does not state which classification system is being used or what stage 1 means in this particular case.

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.