

Pressure injury (formerly pressure ulcer) ICD-10-CM

Clinical overview

Background and NPUAP terminology/definition

In April 2016, the National Pressure Ulcer Advisory Panel (NPUAP) announced a change in terminology from “pressure ulcer” to “pressure injury” and also updated the stages of pressure injury. The change in terminology more accurately describes pressure injuries to both intact and ulcerated skin.

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

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

Signs and symptoms

The NPUAP 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**

<http://www.npuap.org/resources/educational-and-clinical-resources/npuap-pressure-injury-stages/>

Pressure injury staging illustrations

<http://www.npuap.org/resources/educational-and-clinical-resources/pressure-injury-staging-illustrations/>

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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Documentation tips for physicians

Abbreviations

A good rule of thumb for any medical record is to limit – or avoid altogether – the use of abbreviations. Best practice is to spell out “pressure ulcer” or “pressure injury” in full, along with a detailed description.

Subjective

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

Objective

The objective section of the office note should document the physical examination findings and detailed description of any current pressure ulcer, including the following:

- The specific site/location, including laterality
- The specific stage (per NPUAP 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
- Any associated pain and related intervention
- Current status (improved, no change, stable, etc.)

Final assessment/impression

- 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.
- Document the current status of pressure ulcers (stable, no change, improved, worsening, etc.), and refer the reader back to the physical exam description.

Treatment 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.

Documentation and 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 codes	I96 Gangrene, not elsewhere classified L89.614 Pressure ulcer of right heel, stage 4

Example 3

Final diagnosis	Pressure ulcer left lower back, not staged since covered with dressing and patient refused to have it removed and redressed.
ICD-10-CM code	L89.14Ø Pressure ulcer of left lower back, unstageable

Example 4

Final diagnosis	Stage 1 right foot ulcer
ICD-10-CM code	L97.519 Nonpressure chronic ulcer of other part of right foot with unspecified severity

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ICD-10-CM tips and resources for coders

Coding basics

For accurate and specific diagnosis code assignment, the coder must:

- Review the entire medical record to verify pressure ulcer/pressure injury is a current condition.
- Note the exact description of the pressure injury documented in the medical record; then, according to 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 ulcers

The ICD-10-CM Official Guidelines for Coding and Reporting (Section I.C.12.a.1-6) provides detailed information regarding coding of pressure ulcer stages.

1) Pressure ulcer stages

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

Fifth 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-).

The sixth character indicates the severity of the ulcer by identifying the stage. ICD-10-CM classifies pressure ulcer stages based on severity designated by stages 1-4, 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)

- Pressure ulcers that are documented as deep-tissue injury but not documented as due to trauma
- 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.

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 physician or other health care provider should be queried.

4) Pressure ulcers documented as healed

- No code is assigned if the documentation states the pressure ulcer is completely healed.

5) Pressure ulcers documented as healing

- For pressure ulcers described as healing, assign 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 physician or other health care provider.
- For ulcers that were present on (inpatient) 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 with a pressure ulcer at one stage and it progresses to a higher stage, two separate codes should be assigned:
 - a) One code for the site and stage of the ulcer on admission; and
 - b) A second code for the same ulcer site and the highest stage reported during the stay.

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ICD-10-CM tips and resources for coders

Coding pressure injury

As noted in the clinical overview section, in April 2016, the National Pressure Ulcer Advisory Panel (NPUAP) announced a change in terminology from “pressure ulcer” to “pressure injury” and also updated the stages of pressure injury. The change in terminology more accurately describes pressure injuries to both intact and ulcerated skin.

Please note: This is a change in terminology, not a change in the definition of pressure ulcer.

- For pressure injury meaning pressure ulcer, code as a pressure ulcer by the site and stage or unstageable, as appropriate.
- The stages of pressure injury used in the NPUAP’s updated terminology correspond to the pressure ulcer stages in ICD-10-CM. Therefore, code a non-traumatic pressure injury the same as a pressure ulcer by site with stages 1 through 4 and unstageable.
 - For example, pressure injury, stages 1-4, is coded as pressure ulcer, stages 1-4.
 - A deep-tissue injury is coded as an unstageable pressure ulcer. In ICD-10-CM, there is an existing index entry under deep-tissue injury:

Injury

deep tissue

meaning pressure ulcer – see Ulcer pressure, unstageable, by site

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.).

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 Ulcer Advisory Panel

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. A staged diabetic foot ulcer is not coded as a pressure ulcer unless the medical record clearly states the diabetic foot ulcer is a pressure ulcer.