

Dermatology Coding Alert

Pressure Ulcers: Ease the Pressure of Pressure Ulcer Claims With the Right Dx and Procedure Codes

Tip: Each character of the ICD-10 code makes the diagnosis more specific.

Common among patients with limited movement, pressure ulcers (also known as decubitus ulcers) are certainly worrisome for those afflicted with them. But they can also be vexing to dermatology coders, especially now that ICD-10 is in effect. Read on to see if one of your frequently asked questions about pressure ulcer coding is tackled by our experts.

Question: What are the diagnosis codes for pressure ulcers?

Answer: Start with the L89 (Pressure ulcer) series in ICD-10. You will then have to select three further characters to fully describe the ulcer.

Fourth character: After L89 (and the decimal point), the fourth character describes the location of the pressure ulcer. For the different bodily areas, those characters are:

- 0: Elbow
- 1: Back
- 2: Hip
- 3: Buttock
- 4: Contiguous site of back, buttock, and hip
- 5: Ankle
- 6: Heel
- 7: Other site
- 8: Unspecified site

Fifth character: The fifth character narrows down the site of the ulcer even further. For example, for a pressure ulcer on the elbow, you have three choices for a fifth character:

- 0: Unspecified elbow
- 1: Right elbow
- 2: Left elbow

For a pressure ulcer on the back, you have six options:

- 0: Unspecified part of back
- 1: Right upper back
- 2: Left upper back
- 3: Right lower back
- 4: Left lower back
- 5: Sacral region

Sixth character: The sixth and final character describes the stage of the ulcer:

- 0: Unstageable
- 1: Stage 1
- 2: Stage 2
- 3: Stage 3
- 4: Stage 4
- 5: Unspecified

Put it together: Once you have all the information about location and staging, you can come up with the correct ICD-10 code. For example, you would code a stage 3 ulcer on the right elbow as L89.013. A stage 1 ulcer of the right upper back would be L89.111.

Question: How do I know what stage an ulcer is?

Answer: Always check with the dermatologist to confirm the stage. You can find hints, however, in how ICD-10 describes the different stages:

Stage 1: Pressure pre-ulcer skin changes limited to persistent focal edema

Stage 2: Pressure ulcer with abrasion, blister, partial thickness skin loss involving epidermis and/or dermis

Stage 3: Pressure ulcer with full thickness skin loss involving damage or necrosis of subcutaneous tissue

Stage 4: Pressure ulcer with necrosis of soft tissues through to underlying muscle, tendon, or bone

Finding those specific terms in your dermatologist's documentation can lead you to the correct diagnosis code.

Question: What about procedure codes for treatment?

Answer: The CPT® code you report for your dermatologist's treatment of pressure ulcers (also known as decubitus ulcers) will depend on the location and the method of treatment. Your coding will also change if the surgeon also removed infected bone under the sore; however, it would be unlikely that a dermatologist would do this.

Your dermatologist may just close the ulcer wound using a primary suture. This is usually the case when your surgeon is treating smaller pressure ulcers. In these situations, you confirm the location of the pressure ulcer and report code 15931 (Excision, sacral pressure ulcer, with primary suture), 15940 (Excision, ischial pressure ulcer, with primary suture), or 15950 (Excision, trochanteric pressure ulcer, with primary suture) for ulcers on the sacrum, ischium, or trochanter, respectively.

Note: The 15920-15958 series of CPT® contains specific codes for these anatomic areas:

- Sacrum (bottom of the spine)
- Ischium (base of the pelvis)
- Trochanter (hip area)

If the pressure ulcer is somewhere else □ the elbow, for example □ you would need to turn to CPT® code 15999 (Unlisted procedure, excision pressure ulcer).

Although CPT® provides 20 "pressure ulcer" codes (15920-15999), those aren't your only choices when your surgeon treats a decubitus ulcer.

Find out: Did the dermatologist excise the ulcer and close the wound, or did she debride the ulcer and allow the wound to stay open to heal? A debridement will lead you to CPT® codes 11042-+11047 (Debridement...).

Both debridement and excision are ways to "remove" the ulcer and clear infection, so you'll need to look for documentation regarding the closure to help you choose the proper code. For example, the dermatologist might

document an ulcer removal by stating, "The skin was cut in an elliptical fashion around the lesion, and the excised lesion was sent to pathology," notes **Pamela Biffle, CPC, CPC-P, CPC-I, CCS-P, CHCC, CHCO**, owner of PB Healthcare Consulting and Education Inc. in Austin, Texas. But the code choice could depend on a statement such as, "The wound was packed open to drain and heal by secondary intention," (debridement) versus "The surgeon closed the wound with 4-0 sutures in a layered fashion," (excision).

According to CPT® instruction, you should report debridement codes 11042-+11047 "by depth of tissue that is removed and by surface area of the wound."

The codes describe the following three depths:

- Subcutaneous tissue (includes epidermis and dermis, if performed) □ 11042 and +11045
- Muscle and/or fascia (includes epidermis, dermis, and subcutaneous tissue, if performed) -- 11043 and +11046
- Bone (includes epidermis, dermis, subcutaneous tissue, muscle and/or fascia, if performed) -- 11044 and +11047

Calculate area: Each of the preceding pairs of codes identifies the "first 20 sq. cm. or less" for the first code in the pair, and "each additional 20 sq. cm. or part thereof" for the add-on code from the pair.