Dermatology Coding Alert

READER QUESTIONS: Use Code Pair for Pinpoint Pressure Ulcer Dx

Question: A 75-year-old established patient reports to the internist for inspection of sores on her back. The nonphysician practitioner (NPP) performs an expanded problem focused history and an expanded problem focused exam, and then diagnoses a stage I pressure ulcer on her lower back. The NPP refers the patient to a dermatologist for treatment of the ulcer. How should I report this diagnosis?

Indiana Subscriber

Answer: You should submit a pair of codes; one to represent the stage of the pressure ulcer, and another for the ulcer itself. On the claim, report the following:

• 99213 (Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: an expanded problem focused history; an expanded problem focused examination; medical decision making of low complexity ...) for the E/M

• 707.03 (Pressure ulcer; lower back) appended to 99213 to represent the pressure ulcer

• 707.21 (Pressure ulcer stage I) appended to 99213 to represent the pressure ulcer's stage.

Explanation: Use the pressure ulcer ICD-9 codes to describe the healing stages of the patient's wound -- but remember to first code the site of pressure ulcer using 707.00-707.09, according to information beneath 707.2 in ICD-9 2009.