Codify
BY AAPC

Dermatology Coding Alert

You Be the Coder: Pressure Ulcers

Question: A 75-year-old established patient reports to the dermatologist 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 left lower back. The NPP refers the patient to a dermatologist for treatment of the ulcer. How should I report this diagnosis?

Indiana Subscriber

Answer: 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
- L89.141 (Pressure ulcer of left lower back, stage 1) appended to 99213 to represent the pressure ulcer.

Don't miss: ICD-10 contains 149 different pressure ulcer codes in the L89.000 to L89.95 range.

The fourth digit of each ICD-10 pressure ulcer code covers the general location of the pressure ulcer (such as "hip") and the fifth digit gives further location specifics, (such as "right hip" or "left hip"). Rather than listing an additional code to report the pressure ulcer stage, in ICD-10, the sixth digit describes the stage Stages1-4, or whether the ulcer is unstageable or of an unspecified stage.

For example: Suppose your patient has a stage 3 pressure ulcer on his right buttock and a stage 3 pressure ulcer on his left buttock. Report two codes to describe both pressure ulcers. For this patient, you would report L89.313 (Pressure ulcer of right buttock, stage III) as well as L89.323 (Pressure ulcer of left buttock, stage III) to better specify your patient's condition.