Internal Medicine Coding Alert

ICD-10 Update: More Specificity For Pressure Ulcer Coding in ICD-10

Separate codes for bilateral locations reduce confusion while reporting multiple ulcers.

Coding for pressure ulcers in ICD-9 seems pretty straightforward. But your coding will look different when ICD-10 goes into effect Oct. 1, 2014. Take a closer look at how you'll report pressure ulcers.

ICD-9: Currently, under ICD-9, you'll first select a location code from the 707.00 to 707.09 range to describe where your patient has a pressure ulcer. Next, you'll list one of the six pressure ulcer stage codes in the 707.2x (Pressure ulcer stages) subcategory.

On the other hand: In ICD-9, if a patient has bilateral pressure ulcers at the same location or several pressure ulcers in different locations but at the same stage, you cannot represent all the pressure ulcers with your coding, point out experts.

Welcome Simplicity, Laterality in ICD-10

You'll choose from 149 different pressure ulcer codes in the L89.000 to L89.95 range once ICD-10 goes into effect. But your pressure ulcer coding won't be any more complicated.

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.

Improvement: The ICD-10 pressure ulcer codes not only cut down on the number of codes you'll need to list, they also provide specificity that was frustratingly lacking in ICD-9.

Remember, in ICD-9, you have no way to report bilateral ulcers of the same 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. You can only report one site and stage code pair to describe both ulcers: 707.05 (Pressure ulcer; buttock) and 707.23 (Pressure ulcer, stage III).

With ICD-10's improved laterality, you can 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.

Stay the Course with Unstageable Pressure Ulcers

Just as you do in ICD-9, you'll have a code for reporting unstageable pressure ulcers in ICD-10. In ICD-9, it's 707.25 (Pressure ulcer, unstageable), while in ICD-10 it's L89.0 (Pressure ulcer ... unstageable). Remember, it's only appropriate to list an unstageable pressure ulcer code when the stage of your patient's pressure ulcer cannot be clinically determined.

For example, you should list an unstageable pressure ulcer code when the pressure ulcer is covered by eschar or when the patient has a documented deep tissue injury that is not due to trauma.

Just as in ICD-9, you'll list a different code when you have no documentation regarding the stage of the pressure ulcer. In ICD-9, look for 707.20 (Pressure ulcer, unspecified stage) while in ICD-10, you'll have to use L89.□9 (Pressure ulcer ... unspecified stage).

Try Your Hand at the Coding Scenario

Now that you know the basics of how pressure ulcer coding will change in ICD-10, why not test your skills with a scenario? If you don't already have an ICD-10 manual, you can find the latest version of the code set online at http://cms.gov/Medicare/Coding/ICD10/2013-ICD-10-CM-and-GEMs.html.

Coding scenario: Your patient has a stage 3 pressure ulcer on her right buttock and a stage 4 pressure ulcer on her right shoulder blade. She also has a DTI on her right heel. She has type 2 diabetes and failure to thrive. You will be providing dressing changes on the stage 3 and stage 4 pressure ulcers and pressure relief for her DTI with no dressings. Code for this patient with the following ICD-10 codes, says Selman-Holman

- L89.114 (Pressure ulcer of right upper back, stage 4);
- L89.313 (Pressure ulcer of right buttock, stage 3);
- E11.9 (Type 2 diabetes mellitus without complications);
- R62.7 (Adult failure to thrive);
- L89.610 (Pressure ulcer of right heel, unstageable); and
- Z48.00 (Encounter for change or removal of nonsurgical wound dressing).

First, list your patient's pressure ulcers, since they are the focus of care. Sequence the stage 4 pressure ulcer first (L89.114) followed by the stage 3 (L89.313).

Next, list your patient's diabetes. Her pressure ulcers aren't a result of the diabetes, so there is no need to use manifestation coding here. Instead, list E11.9 to indicate your patient's type 2 diabetes.

Follow the diabetes code with R62.7 to indicate that your patient has adult failure to thrive. Then, list L89.610, the unstageable pressure ulcer code, to indicate that the patient also has a DTI.

Finally, report Z48.00 to indicate that you will be providing dressing changes. To find this code in the Alphabetic Index of your ICD-10 manual, look under "Aftercare, Involving, Removal of" or "Change, dressing (nonsurgical)" or "Admission, Removal of" or "Removal (of)."