

Home Health ICD-9/ICD-10 Alert

YOU BE THE CODER: HOW WOULD YOU CODE FOR A HISTORY OF PRESSURE ULCERS?

Question: Should we use V67.x (Follow-up examination following surgery) rather than a condition code for a healed stage 2 ulcer that we are following for observation due to newly healed status but are recertifying for observation? Should we use the follow-up code in lieu of the actual condition that now is resolved?

-- Connecticut Subscriber

Answer: V67.x code for following surgery would be inappropriate in this case, says **Lisa Selman-Holman, JD, BSN, RN, HCS-D, COS-C**, consultant and principle of Selman-Holman & Associates in Denton, Texas.

Why: The patient did not have surgery for the stage 2 ulcer. The only code from that category that you might consider using is V67.09. That is a very non-specific code. You cannot code the stage 2 ulcer once it is resolved.

The next issue you have is whether the care you are providing (observation and assessment) would be covered, Selman-Holman says. Consider the span of time from healing to the end of the previous episode.

Is there a potential fluctuation in the patient's condition? Has the patient had repeated skin integrity problems or changes in caregivers that make you think that the patient is at increased risk of developing more ulcers? What other diagnoses does the patient have that indicate an increased risk for skin breakdown? Your answers to these questions must support the need for skilled care.

Code V13.3 (Personal history of diseases of skin and subcutaneous tissue) is the appropriate history code for a patient who has a history of ulcers.