Decubitus Ulcer and pressure injuries

Muhammad Taha Farooq, MBBS, CCS, CCDS
CDI at Marian Regional Medical Center (Optum360)

Salman Syed, MBBS, CCDS
CDI at Marian Regional Medical Center (Optum360)

1. **Difference between decubitus ulcer and pressure injury:**
    - As per the National Pressure Ulcer Advisory Panel (NPUAP) changes in April 2016, there is a change in terminology from pressure ulcer to pressure injury, and the stages of pressure injury were also updated. In other words, the two terms are synonymous. Therefore, pressure injury can be coded as a pressure ulcer.

2. Stages of Ulcers:

- **Stage 1:** Non-blanchable erythema of intact skin
- **Stage 2:** Partial thickness skin loss involving epidermis, dermis or both
- **Stage 3:** Full thickness skin loss involving damage to or necrosis of subcutaneous tissue that may extend down to but not through underlying fascia
- **Stage 4:** Full thickness skin loss w/ extensive destruction, tissue necrosis or damage to muscle, bone or supporting structures (i.e. tendons, joint capsule)
- **Unstageable**: If slough or eschar obscures the extent of tissue loss this is an unstageable pressure ulcer.

According to the Fourth Quarter 2017 Coding Clinic, Unstageable Pressure Ulcer, if a patient is admitted with an unstageable pressure ulcer, and the eschar is removed to reveal the stage of ulcer site with the highest stage reported during the stay with a POA indicator of Y.

3. **Documentation required to code pressure ulcers:**
   Pressure ulcers have specific documentation requirements:

- Document the exact location of the ulcer
- Document the stage of the ulcer
- Document if the ulcer is Present on Admission
- Documentation Reminders to physicians:
- Be sure to investigate for the presence of decubitus ulcers at the time of admission, if it is "present on admission" – please document POA
- Remember to document both the location and the stage at the time of admission, if present
- **Note:** Staging of ulcers can be taken from nursing/wound care notes documentation, if physician documents etiology and site of ulcer.

4. HAC and Present on Admission indicators:

- Ulcers **NOT** documented as being Present on Admission count **as Hospital Acquired Conditions (HACs)** and are quality "red flags" that are tracked by CMS (Schenke_Sen, C., 2018)
- According to the latest coding guidelines, if a patient is admitted with a non-pressure ulcer at one severity level and it progresses to a higher severity level, we have to code both levels of severity with a POA status indicated Y.

5. Excisional Vs Non-Excisional Debridement:

Excisional Debridement: The surgical removal or cutting away of devitalized tissue, necrosis, or slough.

Document:

- Excisional vs Non-excisional

Non-Excisional Debridement: The non-operating brushing, irrigating, scrubbing, or washing of devitalized tissue, necrosis, or slough.

- Tool used
- Must specify deepest layer of tissue removed

It is helpful to use phrase down to but not including, or down to and including

- Document location (body part and laterality), depth of wound, and characteristics such as necrotic tissue or drainage

6. Query opportunities for CDI:

If the site, etiology or POA status is not clear in the physician's documentation, then the CDI has to query for it. They can take the stage of an ulcer from the wound care notes. The CDI should also query for the depth and type of debridement if it is not clear in the documentation.

Please see table below for documentation and coding purposes:

Code	Main term in ICD-10-CM	Comorbidity/Complication
L89.90	Pressure Ulcer unspecified (site not specified)	N/A
L89.511	Pressure Ulcer Right Ankle Stage 1	N/A
L89.502	Pressure Ulcer Right Ankle Stage 2	N/A
L89.513	Pressure Ulcer Right Ankle Stage 3	MCC
L89.14	Pressure Ulcer Right Ankle Stage 4	MCC