Coding POA pressure ulcer after debridement

Q: I understand the Official Guidelines for Coding and Reporting related to pressure injuries and present on admission (POA) status. For example, I know that if a decubitus ulcer is a stage 1 on admission and progresses to stage 4 during the stay, we are to code stage 1 POA-yes and stage 4 POA-no.

However, the Official Guidelines for Coding and Reporting do not specifically address the deep tissue injury and unstageable pressure injuries as related to them being unstageable until the wound bed can be seen.

I understand that unfortunately the Guidelines are not always up to date with the clinical advice.

If an unstageable pressure injury that was POA was immediately debrided and was found to be a stage 3, then it would be a stage 3 POA-yes.

However, it may be some time before the wound is debrided to reveal the stage 3. The documentation would appear to be a progression of the injury.

For example: On the day of admission: November 1, the physician documents an unstageable sacral pressure injury.

Then, on November 5, the physician documents s/p sacral debridement of decubitus ulcer stage 3.

In the above scenario per the Guidelines, it appears one would code the unstageable sacral pressure injury as POA-yes and the stage 3 sacral pressure injury as POA-no. Is that correct?

I have discussed this concern with several wound care nurses. Some are comfortable documenting “unstageable, likely to be a stage 3 or 4 POA,” and others are not.

Would that documentation be clinically accurate and ethically coded as POA-yes?

Any thoughts on how to make this coding and clinical situation correspond?

A: Let’s start by looking at the Guidelines as well as AHA Coding Clinic instruction related to the code assignment for pressure ulcers.

Section 1.C.12.a.2

Assignment of the code for unstageable pressure ulcer (L89.--0) should be based on the clinical documentation. These codes are used for pressure ulcers whose stage cannot be clinically determined (e.g., the ulcer is covered by eschar or has been treated with a skin or muscle graft) and pressure ulcers that are documented as deep tissue injury but not documented as due to trauma. This code should not be confused with the codes for unspecified stage (L89.--9). When there is no documentation regarding the stage of the pressure ulcer, assign the appropriate code for unspecified stage (L89.--9).

This instruction tells me that the codes classifying a pressure ulcer as unstageable should be assigned when the wound bed of the ulcer cannot be visualized to accurately apply staging.

This can be a wound covered with a thick eschar covering, one with a thick covering of slough and necrotic tissue, or one that has been treated with a skin or muscle graft. We cannot stage the wound because we clinically cannot see the depth or extent of the tissue damage.

I am not a wound specialist, but from my years of nursing experience, I can say that those wounds
with a thick covering of eschar are likely a stage 3 or 4. But since I cannot see how deep the wound is, I must describe it as unstageable.

This Guideline also reinforces that a deep tissue injury not due to trauma is classified as an unstageable pressure ulcer as well. Clinically this makes sense as this type of injury describes damage to the subcutaneous tissue.

Let’s compare that to the definition of a stage 3 pressure ulcer—an ulcer that extends into the underlying subcutaneous tissue layer, but not all the way to the bone.

Most nurses have seen the patient who presents with intact skin, but with a deep tissue injury that when bumped or irritated can instantaneously open up, and when cleaned or debrided demonstrates a stage 3 or 4 ulcer.

Section 1.C.12.a.6

If a patient is admitted to an inpatient hospital with a pressure ulcer at one stage and it progresses to a higher stage, two separate codes should be assigned: one code for the site and stage of the ulcer on admission and a second code for the same ulcer site and the highest stage reported during the stay.

This Guideline introduced last year also makes sense and was devised to more accurately capture quality measures related to the care of pressure ulcers.

It also stresses the importance of accurate and timely skin assessments to be completed on admission, and throughout a patient’s stay.

When introduced, however, it prompted many questions as to how it pertains to ulcers we cannot stage, because likely these wounds are stage 3 or 4 ulcers and we simply could not assess them on admission.

This led to the following advice in AHA Coding Clinic, Fourth Quarter 2017:

**Question:** What are the correct ICD-10-CM codes and POA indicator for an unstageable pressure ulcer in which an eschar is removed during the patient’s stay to reveal either stage III or stage IV pressure ulcer?

**Answer:** If a patient is admitted with an unstageable pressure ulcer, and the eschar is removed to reveal the stage of the ulcer, assign the code for the ulcer site with the highest stage reported during the stay with a POA indicator of “Y.” Do not assign a code for unstageable pressure ulcer, as the true stage of an unstageable ulcer cannot be determined until the slough/eschar is removed. The opening of the wound does not indicate a progression to a higher stage. The code for unstageable pressure ulcer should only be assigned when it is not possible to stage the ulcer during the current encounter.

Now let’s apply this Coding Clinic advice to your scenario.

There is no timeline guidance in this Coding Clinic, meaning that even if there is a delay of several days after admission, the unstageable pressure ulcer on admission would be coded with only one code of a stage 3, POA after the debridement or unroofing was complete.

Clinically, the fact that the wound was opened does not indicate a progression in the wound—the wound was a stage 3 on admission. There is no need for the clinician to state “unstageable pressure ulcer, likely a stage 3 on admission.”

No pun intended, but the AHA Coding Clinic has this situation “covered.” (OK, well maybe the pun was intended.)

I encourage you to continue to work with the wound care nurses so they understand the importance of capturing these wounds accurately on admission as well as throughout the stay. Their documentation is so important in your efforts to ensure accurate code capture.

**Editor’s Note:** Laurie L. Prescott, MSN, RN, CCDS, CDIP, CRC, CDI Education Specialist at HCPro in Danvers, Massachusetts, answered this question. Contact her at lprescott@hcpro.com. If you have a question for the instructors, contact ACDIS Editor Linnea Archibald at larchibald@acdis.org. For information regarding CDI Boot Camps visit www.hcprobootcamps.com/courses/10040/overview.