Pressure Ulcer

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CMS-HCC_V28 Model Updates

At Healthfirst, we are committed to helping providers accurately document and code their patients' health records. This tip sheet is intended to assist providers and coding staff with the documentation and **ICD-10-CM selection, along with the Centers for Medicare & Medicaid Services (CMS) Hierarchical Condition Category (HCC) Version 28 Model Updates**, on services submitted to Healthfirst—specifically for **Pressure Ulcer**. It provides information from industry sources about proper coding practice. However, this document does not represent or guarantee that Healthfirst will cover and/or pay for services outlined. Coverage decisions are based on the terms of the applicable evidence of coverage and the provider's participation agreement. This includes the determination of any amounts that Healthfirst or the member owes the provider.

Pressure ulcer includes bed sore, decubitus ulcer, plaster ulcer, pressure area, or pressure sore/injury.

Documentation Recommendations		
Identify Status of Condition	**Identify Type of Ulcer**	**Document the stage**
• Stable • Improved • Worsening • Healing • Healed	• Pressure ulcer – Codes L89* • Non-pressure ulcer – Codes L97* - L98.4*	• Unstageable • Stage 1 (Non-HCC) • Stage 2 • Stage 3 • Stage 4

*Requires an additional digit to complete the code

Document Location		
• Elbow • Upper Back (shoulder blade) • Lower Back • Sacral Region (coccyx & tailbone)	• Ankle • Heel • Head (face)	• Other Site • Buttock • Hip • Contiguous site of back, buttock and hip

Document Laterality	Link Associated Conditions	Document Risk Factors/ Complications
• Left • Right	• Due to i.e. bed immobility • Secondary to i.e. immobility • Associated with i.e. vascular condition	• Immobility • Incontinence • Lack of Sensory Perception • Conditions affecting Blood Flow • Cellulitis • Infections i.e. sepsis, bacteremia, bone necrosis

Treatment Plan
• Cleaning and dressing of pressure ulcers • Any diagnostic/procedures with findings • Adjacent or overlapping ulcer(s) if present • If debridement of necrotic tissue was done and includes tools used • Multiple pressure ulcers, include stage and location, whether a new or (old) healing ulcer • Wound dimensions (surface measurements, depth), Granulation or Necrotic tissue/slough • Any change in stage (severity or progression) during an admission or encounter ◦ i.e., if a pressure ulcer worsens from a stage 2 to stage 3

ICD-10-CM Codes, Location & Stage

Location	Laterality	Unstageable	Stage 2	Stage 3	Stage 4
Elbow	RT	L89.010	L89.012	L89.013	L89.014
	LT	L89.020	L89.022	L89.023	L89.024
	Unspecified	L89.000(†)	L89.002(†)	L89.003(†)	L89.004(†)
Upper Back	RT	L89.110	L89.112	L89.113	L89.114
	LT	L89.120	L89.122	L89.123	L89.124
	Unspecified	L89.100(†)	L89.102(†)	L89.103(†)	L89.104(†)
Lower Back	RT	L89.130	L89.132	L89.133	L89.134
	LT	L89.140	L89.142	L89.143	L89.144
Sacral Region		L89.150	L89.152	L89.153	L89.154
Hip	RT	L89.210	L89.212	L89.213	L89.214
	LT	L89.220	L89.222	L89.223	L89.224
	Unspecified	L89.200(†)	L89.202(†)	L89.203(†)	L89.204(†)
Buttock	RT	L89.310	L89.312	L89.313	L89.314
	LT	L89.320	L89.322	L89.323	L89.324
	Unspecified	L89.300(†)	L89.302(†)	L89.303(†)	L89.304(†)
Contiguous Site Of Back, Buttock		L89.45	L89.42	L89.43	L89.44

Location	Laterality	Unstageable	Stage 2	Stage 3	Stage 4
Ankle	RT	L89.510	L89.512	L89.513	L89.514
	LT	L89.520	L89.522	L89.523	L89.524
	Unspecified	L89.500(†)	L89.502(†)	L89.503(†)	L89.504(†)
Heel	RT	L89.610	L89.612	L89.613	L89.614
	LT	L89.620	L89.622	L89.623	L89.624
	Unspecified	L89.600(†)	L89.602(†)	L89.603(†)	L89.604(†)
Head		L89.810	L89.812	L89.813	L89.814
Other Site		L89.890	L89.892	L89.893	L89.894
Unspecified Site	Unspecified	L89.95(†)	L89.92(†)	L89.93(†)	L89.94(†)

(†) Use only in the event that no other code describes the condition.

Please note this is not an all-inclusive list of ICD-10-CM codes. Listed diagnosis codes are Hierarchical Condition Categories (HCC).

Description of Stages Below

Unstageable
Cannot be clinically determined

→

Stage 1
Skin changes limited to persistent focal edema

→

Stage 2
Open wound or blister involving epidermis/ dermis

→

Stage 3
Full thickness skin loss/necrosis of subcutaneous tissue

→

Stage 4
Extending into the muscle, tendon, ligament, cartilage, or bone

Coding Tips

- Coded first any associated **Gangrene I96**
- **Healed** pressure ulcers are not coded
- If documentation states "**Pressure Ulcer**," assign codes from category L89*
- If a patient has **more than one pressure ulcer**, a code for each should be coded
- **Pressure ulcer** (L89*) is reported by stage; **chronic non-pressure ulcer of the skin** (L97*–L98*) is reported by severity as documented in the record
- **Non Pressure Ulcers** (Category L97*– L98*) can be assigned as additional code if supported by documentation
- There is an assumed relationship between **diabetes and foot/skin ulcers**
    - Diabetic foot ulcer **E11.621** use additional code to identify site of ulcer from category L97*
    - Diabetic skin ulcers **E11.622** use additional code to identify site of ulcer from category L97* and L98*
- **Do not** confuse unstageable ulcer with unspecified ulcer stage (refer to description of stages)
- **Healing pressure** ulcers are coded to the site and stage; If no stage is documented, assign a code for unspecified stage
- The stage of a **diagnosed pressure ulcer** can be based on documentation from clinicians who are not the patient's provider, i.e., nurse
- **Inpatient setting:**
    - For ulcers that were present on admission (POA) but healed at the time of discharge, assign the code for the site and severity of the non-pressure ulcer at the time of admission
    - Two codes should be assigned for a pressure ulcer site that evolves from one stage to another during the admission:
        - The first code should be the stage of the ulcer upon admission
        - The second code should be the highest stage the ulcer progressed to during the admission

*Requires an additional digit to complete the code.

Coding Example

Case 1	A patient presents with a sacral deep tissue injury (DTI) and undergoes surgical debridement. Following excisional debridement, the provider documents "Stage 4 pressure ulcer of the sacrum." Should guideline **I.C.12.a.7** be interpreted to mean that only one code (**L89.-6**) is assigned for the DTI, whether the stage is later revealed or not? What is the correct **ICD-10- CM** code assignment and present on admission (POA) indicator, for this case?
AHA Coding Clinic 2021 1st Quarter Rationale	Assign code **L89.154**, Pressure ulcer of sacral region, stage 4, to capture the stage 4 pressure ulcer revealed following debridement of the DTI, with the POA indicator "Y."

Contact us at **#Risk_Adjustments_and_clinical_Documentation@healthfirst.org**.

Questions

For additional documentation and coding guidance, please visit the coding section on **HFproviders.org**.

References

- **www.cms.gov/files/document/fy-2024-icd-10-cm-coding-guidelines-updated-02/01/2024.pdf**
- **www.codingclinicadvisor.com**

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