Pressure injury/ulcer

Clinical overview

Definition

A pressure injury is localized damage to the skin and underlying soft tissue, usually over a bony prominence or related to a medical or other device. The injury can present as intact skin or an open ulcer and may be painful. The injury occurs as a result of intense and/or prolonged pressure or pressure in combination with shear. The tolerance of soft tissue for pressure and shear may also be affected by microclimate, nutrition, perfusion, comorbidities and condition of the soft tissue.[1]

Causes/Risk factors[2]

- Older age/Immobility/Fragile skin
- Poor or limited hygiene and moisture
- Poor nutrition and hydration
- Chronic conditions

Signs and symptoms[1]

The NPIAP publishes each stage of pressure injury as follows:

- Stage 1: Non-blanchable erythema of intact skin
- Stage 2: Partial-thickness skin loss with exposed dermis
- Stage 3: Full-thickness skin loss
- Stage 4: Full-thickness skin and tissue loss
- Unstageable pressure injury/ulcer: Obscured full-thickness skin and tissue loss
- Deep tissue pressure injury: Persistent non-blanchable deep red, maroon or purple discoloration

Complications[2]

- Skin cancer
- Bone and joint infections
- Cellulitis and/or sepsis

Prevention[2]

- Regular and frequent skin inspection and proper skin care
- Proper positioning with frequent position changes
- Balanced nutrition and exercise
- Individual and caregiver education

Diagnostic tools[3]

- Wound culture if infection is suspected
- Skin biopsy
- Diagnostic testing related to underlying conditions and nutritional status

Treatment[4]

- Relieving pressure on area
- Pain/infection/underlying condition management
- Other treatment according to physician orders (e.g.; cleaning ulcer, dressing changes, ointments and creams, debridement procedures)

Best documentation practices for healthcare providers

Subjective
The subjective section of the office note should document any current patient or caregiver complaints or symptoms related to pressure injury.

Objective
In the objective section, document the physical examination findings and detailed description of any current pressure injury, including the following:

- The specific stage (per NPIAP descriptions); site/location with laterality
- Precise measurements (length, width, depth in centimeters); including any Undermining, sinus tracts or tunneling (recorded in centimeters) if applicable
- Wound-base description (granulation, necrotic tissue, eschar, slough, new epithelial tissue)
- Absence or presence of drainage (amount, color, consistency and odor, as appropriate) and/or if odor present
- Describe characteristics (light pink, deep red, purple, macerated, calloused, etc.)
- Current status (healing, worsening, no change, stable, etc.)

Assessment
Specificity: Describe each final pressure injury diagnosis to the highest level of specificity, including cause, appearance, stage, location with laterality.

Plan

- Document a clear and concise treatment plan for pressure ulcers (e.g., devices such as foam pads or mattresses; wound care instructions; prescriptions for ointments, creams or other medications; planned debridement; etc.)
- Indicate in the office note to whom or where any referral or consultation requests are made.
- Document when the patient will be seen again, even if only on an as-needed basis.

Coding tips

- Coding Pressure Injury/Pressure Ulcer

For pressure injury, there is an Alphabetic Index entry as follows:

Injury
pressure
injury – see Ulcer, pressure, by site[5]

- Assign as many codes from category L89 as needed to identify all the pressure ulcers the patient has, if applicable.[6]
- Unstageable codes (L89.--0) are used for pressure ulcers whose stage cannot be clinically determined by the provider. This code should not be confused with the codes for unspecified stage (L89.--9).[6]
- For clinical terms describing the stage that are not found in the Alphabetic Index, and there is no documentation of the stage, the provider should be queried.[6]
- Pressure ulcers described as healing should be assigned the appropriate pressure ulcer stage code based on the documentation in the medical record.[6]
- For ulcers that were present on admission but healed at the time of discharge, assign the code for the site and stage of the pressure ulcer at the time of admission.[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:[6]
  - 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
- There are classification systems that grade or stage diabetic foot ulcers from no ulcer to superficial

ulcer to deep/infected/ischemic or gangrenous ulcers. Examples include the Wagner system or the University of Texas system. These classification systems should not be confused with pressure ulcer staging.

Wagner:https://journals.lww.com/aswcjournal/fulltext/2023/05000/wagner_grading_of_diabetic_foot_ulcersand.9.aspx[7]

University of Texas: https://www.swrwoundcareprogram.ca/Uploads/ContentDocuments/HCPR%20-%20U%20of%20T%20DFU%20Staging.pdf[8]

- The fact that an ulcer is staged does not, by itself, support coding as a pressure ulcer. For a staged ulcer to be coded as a pressure ulcer, the staged ulcer must be described with terms that classify to pressure ulcer (e.g., pressure ulcer, pressure injury, decubitus ulcer, bed sore, etc.).
- Documentation of a current, non-pressure skin ulcer that is clearly described as "superficial" can be coded as "limited to skin breakdown." [9]

Additional reminders

- Ulcers are sometimes documented as wound, sore, lesion, etc.
- Be sure to refer to the most current ICD-10-CM Official Guidelines for Coding and Reporting (Section I.C.12.a.1-7) for specific guidelines for pressure injuries/ulcers.[6]

Coding examples

Example 1	
Chief complaint	Right foot diabetic ulcer
Skin exam	Right lower extremity abnormalities: poor turgor, decreased elasticity. Findings specific to the right metatarsal region: plantar aspect, Full-thickness Wagner II diabetic ulcer; pre and post debridement measurements were approx. 1.5cm x 2cm x 0.3cm. Positive serous drainage, negative malodor, negative pallor, negative purulent drainage. 20% fibrous/soft/biofilm/maceration/subcutaneous nonviable tissues: 80% granular.
Assessment	Diabetes with ulceration, diabetic ulcer, pain in foot, peripheral vascular disease, peripheral neuropathy
Plan	Sharply divided her right full-thickness Wagner II diabetic ulcer. All fibrous/slough/biofilm/hyperkeratotic/subcutaneous nonviable tissues were excised 100%. Follow-up in 1 week or sooner if needed.
ICD-10-CM code	• **L97.512** Non-pressure chronic ulcer of other part of right foot with fat layer exposed
Rationale	The ulcer is confirmed as right foot full-thickness Wagner II diabetic ulcer. This would code to **L97.512**. Full-thickness tissue loss - Subcutaneous fat may be visible, but bone, tendon, or muscle are not exposed.[10]

Example 2	
Medical record documentation	Physical Exam: Skin (focused): small approx. 0.5-1cm healing ulcer of the left pretibial leg surrounded by healing erythematous skin. Assessment & Plan**:** 72 y/o female with melanoma of the left pretibial leg, s/p definitive RT. Recovering from radiotherapy. Skin is healing.
ICD-10-CM code	• **L97.829** Non-pressure chronic ulcer of other part of left lower leg with unspecified severity • **C43.72** Malignant melanoma of left lower limb, including hip

Rationale	Diagnosis is Malignant melanoma of the L pretibial leg. Physical exam does document a small healing ulcer of the L pretibial leg under the skin body system.
Example 3	
HPI	Home health has seen patient and determined that the "pressure ulcer on her sacrum is stage II, was stage IV"; home health has been taking care of it.
Problem list/PMHx	Stage IV pressure ulcer of sacral region
Medications	Sacrum dressing, hospital bed (start date for both 09/08/20XX for stage 4 sacrum pressure ulcer)
Assessment and plan	Stage II pressure ulcer of sacral region
ICD-10-CM code	• **L89.152** Pressure ulcer of sacral region, stage 2
Rationale	Overall context of the record supports the pressure ulcer was stage IV (as noted in initial order for dressings and hospital bed with mattress, and the historical section of the problem list/past medical history), but is now stage II sacral pressure ulcer, which codes to **L89.152**.

Example 4	
Medical record documentation	ROS: Musculoskeletal: Back Pain; ROS otherwise negative Physical exam: Skin: No rashes. No jaundice. Pink and warm with good turgor. Good color. No erythema or nodules present. No petechia, bulla, or ecchymosis. Assessment and plan: Stage 2 Sacral Decubitus Ulcer, continue Alevyn dressing and daily wound care with Dexetin**.**
ICD-10-CM code	Query provider for clarification.
Rationale	ICD-10-CM category L89 represents current active ulcers which requires a coder to review the entire record to confirm coding the condition. While the assessment/plan states stage 2 sacral decubitus ulcer, it is not mentioned anywhere else in the record and there is a normal skin ROS and exam which creates doubt on whether the patient still has an ulcer.

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