Chronic non-pressure ulcers of the skin documentation

To capture the full disease burden of a patient's non-pressure ulcer condition, follow the documentation guidelines below, as applicable.

Definitions:

- A non- pressure ulcer is a chronic ulcer with an etiology other than pressure.[3]
- The terms "ulcer" and "wound" are often interchanged in documentation, they're NOT synonyms when it comes to ICD-10 coding. The term ulcer refers to a break in the skin that fails to heal as it should and is typically more chronic in nature.[5] The term wound is classified as a traumatic injury.

Do document:

Site, laterality and severity:

- *Ex: Right lateral ankle ulcer limited to breakdown of skin.*
- Without laterality claim denial is likely.

Severity is described as:

- Limited to breakdown of skin
- With fat layer exposed
- With muscle involvement without evidence of necrosis
- With necrosis of muscle
- With bone involvement without evidence of necrosis
- With necrosis of bone
- Severity cannot be assumed from photographs and must be otherwise documented.
- If no severity is documented, it'll be coded to unspecified; query may result.

***Do document*:**

Etiology/associated underlying condition:

- *Ex:* Type 2 Diabetes Mellitus with right foot ulcer with fat layer exposed.
- *Ex:* Venous stasis ulcer of other part of left calf limited to breakdown of skin, with varicose veins present.
- *Ex:* Atherosclerosis of native arteries of right leg with ulceration of calf with fat layer exposed.

Do document:

All present ulcers and if the ulcer is current or healing

- If the ulcer is actively healing documentation should include the extent of the ulcer at its most severe stage.
- Ex: Healing

Do document:

Evaluation and management of contributing diagnoses relative to ulcer healing

- *Example:* nutritional status, diabetes, atherosclerosis, or other predisposing conditions

Do include:

Clarification of wound vs ulcer

- If the pathology of the wound is an ulcer, the term ulcer must be present in the documentation and clear in diagnosis.

Do document:

- The presence (and extent of) or absence of signs of infection.
- The presence (and extent of) or absence of necrotic, devitalized or non-viable tissue.

References:

1. Centers for Medicare & Medicaid Services. ICD-10-CM Official Guidelines for Coding and Reporting (FY2024):https://ftp.cdc.gov/pub/Health_Statistics/NCHS/Publications/ICD10CM/2024-Update/ICD-10-CM-Guidelines-April-1%20FY2024.pdf page 58.
2. Risk Adjustment Documentation & Coding. 2nd Edition. Sheri Poe Bernard. 2020. pages 275-277
3. Prescott, L., Manz, J., Reiter, A. (2023). *2023 ACDIS Outpatient Pocket Guide The essential CDI Resource for Outpatient Professionals* (pp. 4442-446).: HCPro, a Simplify Compliance Brand.
4. Billing and Coding: Wound and Ulcer care (2022, February). *CMS.gov*. https://www.cms.gov/medicare-coverage-database/view/article.aspx?articleId=58567
5. Lehrman, J. D. (2017). Coding, Compliance, and Documentation for Diabetic Foot Ulcers: Thorough documentation and accurate coding are key. *Podiatry Management*, *36*(9), 71–74. Lehrmann11117web.pdf (podiatrym.com)