Documentation and Reporting
Ulcers

DOCUMENTATION TIPS

Documentation of ulcers requires greater specificity to support accurate reporting. Report the current status of the ulcer at the time of the office visit. Documentation must identify the type of ulcer – pressure ulcer versus non-pressure or chronic ulcer. The depth or severity of an ulcer may be documented by a clinician who is not the patient's provider.

Non-pressure (chronic) ulcers

Document these elements:

- **Underlying condition:** diabetes, atherosclerosis of lower extremities, chronic venous hypertension, peripheral neuropathy, peripheral vascular disease
- Associated **gangrene**, if applicable
- **Site**
- **Laterality**
- **Severity**
    - Limited to breakdown of skin
    - With fat layer exposed
    - With muscle involvement with or without evidence of necrosis
    - With bone involvement with or without evidence of necrosis

Common documentation errors:

Documentation that states "wound" is inaccurate when the patient has a pressure or non-pressure ulcer. The term wound does not support reporting an ulcer.

Non-pressure chronic ulcers (not an all-inclusive list)

ICD-10-CM Code	Description
L97.1-	Non-pressure chronic ulcer of **thigh**
L97.2-	Non-pressure chronic ulcer of **calf**
L97.3-	Non-pressure chronic ulcer of **ankle**
L97.4-	Non-pressure chronic ulcer of **heel** and **midfoot**
L97.5-	Non-pressure chronic ulcer of **other part of foot**
L97.8-	Non-pressure chronic ulcer of **other part of lower leg**
L97.9-	Non-pressure chronic ulcer of **unspecified** part of lower leg

Laterality is identified by the 5th character in the diagnosis code: 0 = unspecified; 1 = right; 2 = left

Severity is identified by the 6th character: 1 = limited to breakdown of skin; 2 = with fat layer exposed; 3 = with necrosis of muscle; 4 = with necrosis of bone; 5 = with muscle involvement without necrosis; 6 = with bone involvement without necrosis

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Pressure ulcers

Documentation of a bed sore, decubitus ulcer, plaster ulcer, pressure area or pressure sore is acceptable to report a pressure ulcer. Document these elements to support accurate reporting:

- **Site:** elbow, back (upper or lower), hip, buttock, ankle, heel, contiguous sites
- **Laterality**
- **Stage:** unstageable, stages 1 – 4
- **Healing:** document a healing ulcer, including the current stage
- **Deep tissue pressure injury** – identifies patients at-risk of progressing to a pressure ulcer

Pressure ulcers (not an all-inclusive list)

ICD-10-CM Code	Description
L89.0-	Pressure ulcer of **elbow**
L89.1-	Pressure ulcer of **back**
L89.2-	Pressure ulcer of **hip**
L89.3-	Pressure ulcer of **buttock**
L89.4-	Pressure ulcer of **contiguous site** of back, buttock and hip
L89.5-	Pressure ulcer of **ankle**
L89.6-	Pressure ulcer of **heel**
L89.8-	Pressure ulcer of other site

Laterality is identified by the 5th character in the diagnosis code: 0 = unspecified; 1 = right; 2 = left

Staging is identified by the 6th character in the diagnosis code: 0 = unstageable and a 6th character of 1 – 4 corresponds to the stage.

Unstageable ulcer: an unstageable ulcer may be reported when eschar or a skin graft obscures the depth of the ulcer.[2]

Healing ulcer: Document and report the current severity of a healing non-pressure ulcer or the current stage of a healing pressure ulcer. Do not report ulcers that have completely healed.

According to the ICD-10-CM Official Guidelines for Coding and Reporting FY 2022: "A dash (-) at the end of an alphabetic index entry indicates that additional characters are required." Refer to the tabular to verify that all characters are assigned to complete the diagnosis code.

1. DHHS. ICD-10-CM Official Guidelines for Coding and Reporting FY2022. Centers for Disease Control and Prevention. https//www.cdc.gov/nchs/icd/data/10cmguidelines-FY2022-final.pdf. Published October 1, 2021. Accessed November 30, 2021.
2. *2022 ACDIS Pocket Guide: The Essential CDI Resource.* Brentwood, TN, HCPRO, 2021.