BlueCross BlueShield of North Carolina

Documentation and Coding

Wounds, Ulcers & Amputations

A quick reference guide to assist with accurate, complete documentation and coding that reflects the true nature of a patient's current health status at the highest level of specificity. Per ICD-10 official guidelines reporting and coding. *"The importance of consistent, complete documentation in the medical record cannot be over-emphasized. Without such documentation, accurate coding cannot be achieved."*

A **wound** is something that occurs acutely and traumatically. An **ulcer** refers to a break in the skin that fails to heal as it should and is typically chronic in nature. While many providers may use these terms interchangeably, they have distinct meanings within the framework of diagnosis coding and should not be used as synonyms.

Wounds

Documentation and Coding Tips:

Documentation should include the following:

- Type of wound: Common open wound types include:
  - ***Abrasions***: minor to no bleeding, some pain
  - ***Lacerations***: deep cut or tearing of the skin, mostly accidental
  - ***Punctures***: small round wound, can be deep enough to damage internal organs
- Anatomical location and laterality
- Specify whether the injury is with/without **foreign body, open bite, simple or uncomplicated**, or if there is tendon involvement

Coding Tips:

- All wound codes start with the letter "S", putting them in Chapter 19 of the tabular index "Injury, Poisoning and Certain Other Consequences of External Causes (S00-T88)."
- In ICD-10CM, injuries are classified into various category code ranges including S00-S09 (head), S10-S19 (neck), S20-29 (thorax), S40-S49 (shoulder and upper arm), S80-S89 (knee and lower leg), etc.
- 7th digit character: Whether the encounter is initial (**A**), subsequent (**D**) or sequela (**S**)
- Use additional codes to identify causative or environmental factors

Example codes:

ICD-10CM Code	Description
S41.031A	Puncture wound without foreign body of right shoulder, initial encounter
S41.031D	Puncture wound without foreign body of right shoulder, subsequent encounter
S41.031S	Puncture wound without foreign body of right shoulder, sequela

An **ulcer** is normally the cause of an underlying disease or internal reason. There are various types and are usually associated with another chronic condition such as diabetes, vascular disease, etc.

Ulcers

Documentation and Coding Tips:

Documentation should include the following:

- **Type of ulcers:**
  - Pressure ulcer (L89.-), including stage:
    - **Stage 1:** Skin changes that are limited to persistent focal edema
    - **Stage 2:** An abrasion, blister, and partial thickness skin loss involving the dermis and epidermis
    - **Stage 3:** Full thickness skin loss involving damage and necrosis of subcutaneous tissue
    - **Stage 4:** Necrosis of soft tissues through the underlying muscle, tendon, or bone
  - Non-pressure ulcer (L97.-)
  - Arterial ulcer (I70.-)
  - Stasis ulcer (I83.-)
- Laterality, anatomic site and severity are required for all ulcers identified.
- The associated underlying condition should be coded first. Most often, the underlying conditions are related to diabetes, arterial and/or venous diseases.

Coding Tips:

- In ICD-10CM, Pressure and Non-Pressure chronic ulcer diagnosis codes are in ICD-10CM Chapter 12, "Disease of the skin and subcutaneous tissue."
- **Pressure ulcers** – L89.- have four stages and an unstageable and unspecified code when the stage cannot be determined clinically. There is an instructional note that you must code first any associated gangrene (I96).
  - **Section I.C.12.1** of the ICD-10-CM Official Guidelines for coding and reporting also directs us to assign as many codes from category L89 as needed to identify all the pressure ulcers the patient has, if applicable.
- **Non-Pressure Ulcers – L97.-** code first any underlying conditions such as: gangrene, atherosclerosis of the lower extremities, chronic venous hypertension, diabetic ulcers, post-phlebitic syndrome, post-thrombotic syndrome and varicose ulcers.
- **A 6th digit character is required for severity of**
  1 - Limited to breakdown of skin
  2 - With fat layer exposed
  3 - With necrosis of muscle
  4 - With necrosis of bone
  9 - With unspecified severity
- If there is an ulcer on the foot of a diabetic patient, consider it a **Diabetic Foot Ulcer**. These codes are most commonly Type 1 Diabetes Mellitus with foot ulcer (E10.621-E10.622) or Type 2 (E11.621-E11.622). With these diabetic codes, you must also code if there is any insulin use (Z79.4) or oral hypoglycemics (Z79.84).

Common codes:

I83.013		L97.312		E11.621		L97.423
Varicose veins of right lower extremity with ulcer of ankle		Non-Pressure chronic ulcer of right ankle w/necrosis of muscle		Type 2 diabetes mellitus with foot ulcer		Non-pressure chronic ulcer of left heel & midfoot w/necrosis of muscle

I70.245		L97.521		I96		L89.616
Atherosclerosis of native arteries of left leg w/ulceration of other part of foot (toe)		Non-pressure chronic ulcer of other part of left foot limited to breakdown of skin		Gangrene, not elsewhere classified		Pressure-induced deep tissue damage of right heel

Amputations

Documentation and Coding Tips:
An ulcer that won't heal and causes severe damage to tissues and bone may require surgical removal (amputation) of a toe, a foot or part of a leg. People with diabetes are at a higher risk than others. In ICD-10CM Chapter 21 for "Factors influencing Health Status and Contact with Health Services", the Z89.- category, "Acquired absence of limb" is used to identify certain conditions influencing health status.

Acquired absence of limb

- Z89.0 - Thumb and other finger(s)
- Z89.1- Hand and wrist
- Z89.2 - Upper limb above wrist (elbow, shoulder)
- Z89.4 - Toe(s), foot and ankle
- Z89.5 - Leg, below knee
- Z89.6 - Leg, above knee
- Z89.9 - Limb, unspecified

- Z89 codes are used to capture personal history, post-procedural loss of limb and post-traumatic loss of limb. It does not include acquired deformities of limbs (M20-M21) or congenital absence of limbs (Q71-Q73).
- Traumatic amputation codes in the "S48-S98" categories should not be used for acquired absence due to a disease or illness.
- Only use Z89 codes for acquired absence due to disease, not acute traumatic amputations. **Section I.C21.c.3** states that a status code should not be used with the diagnosis code from one of the body system chapters.

Common Codes:

ICD-10CM Code	Description
Z89.611	Acquired absence of right leg above knee
Z89.512	Acquired absence of left leg below knee
Z89.411	Acquired absence of left great toe
Z89.422	Acquired absence of other left (s)

References:
Optum EncoderPro.com for Payers - Home (encoderprofp.com)
ICD-10-CM Official Guidelines for Coding and Reporting (PDF)

For questions, please contact the Blue Cross NC Provider Engagement Risk Team via email at BCBSNCRiskAdj@bcbsnc.com.