

## Informative and educational updates for providers

### FOCUS ON: SKIN ULCERS

#### WHAT ARE SKIN ULCERS?

Skin ulcers are painful, open sores or wounds that keep returning or don't heal properly. Skin ulcers can be caused by various conditions, such as poor circulation, poor nutrition, neuropathy, dermatologic or debilitated status. Skin ulcers are often accompanied by the sloughing-off of inflamed tissue. Ulcers that heal within 12 weeks are classified as acute, and longer-lasting ones as chronic.

#### TYPES OF SKIN ULCERS

There are four types of skin ulcers: venous ulcers, arterial ulcers, neuropathic ulcers and pressure ulcers. The prevalence of pressure wounds may be more widespread than initially thought and it is estimated that 3 million Americans may have pressure ulcers.<sup>1</sup> Prevalence of both venous and arterial ulcers increase with age to about 20/1000 in people aged over 80 years.<sup>2</sup> Neuropathic foot ulcers are extremely common in patients with diabetes. The prevalence of diabetic foot ulcer ranges from 4.4% to 10.5%<sup>3</sup> and during the lifetime the prevalence is 15-25%. Neuropathic foot ulcers are present in almost 80% of diabetic foot ulcers.<sup>4,5</sup>

#### TREATMENT OF SKIN ULCERS

Treatment of skin ulcers depends on the etiology of the wound. Pressure ulcers are treated by reduction of pressure, nutritional support and local care. In some cases treatment may involve skin grafts and/or surgical flaps. Venous and arterial ulcers are treated with local therapy but often require surgical intervention to heal. Surgical intervention for venous ulcers may include ligation of the perforator vessel and/or skin grafting. Arterial ulcers may require revascularization/angioplasty prior to any local graft or flap. Neuropathic ulcers require preventative measures and/or change in weight bearing loads to the foot. In some cases, specialized orthotics may aid in reduction of weight load. These ulcers also require further workup to exclude other causes to the ulcers.

#### Always Remember...

- If coding ulcerated varicose veins that have ruptured and are hemorrhaging, do not code the hemorrhage as a separate clinical entity.<sup>6</sup>
- Documentation may identify similar terms for pressure ulcer such as bed sore, pressure sore, decubitus ulcer, or plaster ulcer.<sup>6</sup>
- When documenting ulcers, it is important not to document them as "wounds," "open wounds" or "lesions". These terms are coded differently.
- No code is assigned if the documentation states that the ulcer is "healed". A "healing" ulcer may be coded as current if documented.<sup>7</sup>

#### Documentation and Coding Tips<sup>7</sup>

- Assign the appropriate code for the site of the pressure ulcer from subclassification **707.0x** with an additional code from subclassification **707.2x** to specify the stage of the ulcer.

*For example:* A patient presents for treatment of a stage II pressure ulcer of the heel is coded to **707.07** (heel) and **707.22** (pressure ulcer stage II).

- Subclassification **707.1x**, Ulcer of lower limb, except pressure ulcer, is differentiated by ulcer type from **707.0x** Pressure ulcer. Code any causal condition first, if applicable.

*For example:* Atherosclerosis with ulcer of the ankle is coded **440.23** (atherosclerosis of the extremities with ulceration) and **707.13** (ulcer of ankle).

- Diabetic patients may develop ulcers. When documented as "due to diabetes" or "diabetic ulcer" then two codes are required.

*For example:* Patient seen for a diabetic ulcer of the toes is coded to **250.80** (diabetes with other specified manifestations) and **707.15** (ulcer of toe).

- When a patient has multiple pressure ulcers at different sites (e.g. heel, buttock, shoulder) and each pressure ulcer is documented at a different stage (e.g. stage II and stage III) assign the appropriate codes for each different site and a code for each different pressure ulcer stage.

*For example:* Patient has a stage II heel ulcer and a stage III shoulder ulcer on the left is coded as **707.07** (pressure ulcer, heel), **707.22** (pressure ulcer stage II) and **707.02** (pressure ulcer, shoulder), **707.23** (pressure ulcer stage III).

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1 Vangilder, C, et al, "Results of Nine International pressure Ulcer prevalence Surveys: 1989-2005" *Ostomy Wound Manage* 2008;54(2):40-52

2 Callam MJ, Ruckley CV, Harper DR, et al. Chronic ulceration of the leg: extent of the problem and provision of care. *Br Med J (Clin Res Ed)* 1985;290:1855-1856.

3 Reiber GE: Epidemiology of foot ulcers and amputation in the diabetic foot. Levin and O'Neal's *The Diabetic Foot*. Bowker JH, Pfeifer MA (eds). St. Louis, CV Mosby, 6th Ed, 2001, pp 13-32

4 Cavanagh PR, Ulbrecht JS, Caputo GM: The biomechanics of the foot in diabetes mellitus. Levin and O'Neal's *The Diabetic Foot*. Bowker JH, Pfeifer MA (eds). St. Louis, CV Mosby, 6th Ed, 2001, pp 125-196

5 Caputo GM, Cavanagh PR, Ulbrecht JS, et al: Current concepts: assessment and management of foot disease in patients with diabetes. *N Engl J Med* 1994; 331:854-860

6 Ingenix Coders' Desk Reference For Diagnosis, 2011. Alexandria, VA: Ingenix 2010  
7 2011 Ingenix Professional ICD-9-CM for Physicians, 6th ed. 2 vols. Chicago, IL: Ingenix, 2010. Print.