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CLINICAL DOCUMENTATION

AHA CODING CLINIC CORNER

First Quarter 2014, pg 23
Third Quarter 2022, pg 11
First Quarter 2021, pg 8
Second Quarter 2020, pg 19

Skin Wounds and Ulcers

A skin wound is a break or opening in the skin caused by an injury or accident. The ICD-10-CM classifies skin wounds based on the type of wound, body location, laterality, and encounter. A skin ulcer is an injury that occurs when the epidermis and dermis layers of the skin are lost, exposing the tissue beneath. The ICD-10-CM classifies skin ulcers based on the cause and deepest layer of tissue involved. Both wounds and ulcers represent a disturbance to the skin. The major difference is how the problem emerged. Wounds come about from external force (a physical injury like cutting oneself,) whereas ulcers develop from internal disturbances (such as disease).

ICD-10-CM CODES *please consult coding manual for full code assignment

S01.-	Open wound of head
S11.-	Open wound of neck
S31.-	Open wound of abdomen, lower back, pelvis and external genitals
S41.-	Open wound of shoulder and upper arm
S51.-	Open wound of elbow and forearm
S61.-	Open wound of wrist, hand and fingers
S81.-	Open wound of knee and lower leg
Z87.828	Personal history of other (healed) physical injury and trauma
T81.3xXx	Disruption of wound
T81.89Xx	Other complications of procedures, not elsewhere classified
L97.1xx	Non-pressure chronic ulcer of thigh
L97.2xx	Non-pressure chronic ulcer of calf
L97.3xx	Non-pressure chronic ulcer of ankle
L97.4xx	Non-pressure chronic ulcer of heel and midfoot
L97.5xx	Non-pressure chronic ulcer of other part of foot
L97.8xx	Non-pressure chronic ulcer of other part of lower leg
L97.9xx	Non-pressure chronic ulcer of unspecified part of lower leg
L98.41x	Non-pressure chronic ulcer of buttock
L98.42x	Non-pressure chronic ulcer of back
L98.49x	Non-pressure chronic ulcer of skin of other sites
Z87.2	Personal history of diseases of the skin and subcutaneous tissue

*Codes in the wound series require additional digits to represent the type, depth, and specific location with a final digit to represent the encounter.

**When an ulcer is clearly documented as due to the presence of diabetes, both the diabetic skin code (E11.6-) as well as the L97.- series should be coded.

**When an ulcer is clearly documented as due to the presence of a varicose vein, both the varicose code (I83.-) as well as the L97.- series should be coded

Fifth digit for codes above represents laterality and/or quadrant of ulcer

6th digit code represents the tissue depth of the ulcer:

1: Skin breakdown
2: Fat layer exposed
3: Necrosis of muscle
4: Necrosis of bone
5: Muscle w/o necrosis
6: Bone w/o necrosis
8: Other severity
9: Unspecified severity

DOCUMENTATION ACRONYMS

DEEP Diagnosis Elements

Include elements of DEEP in documentation to clinically support a skin wound or skin ulcer.

Diagnosis: Puncture wound of right shoulder with foreign body

Evidence: Imaging shows foreign body at base of puncture into the muscle

Evaluation: Penetrating wound of rt shoulder, estimated 6x4 cm and 7cm in depth

Plan: Wound washout to attempt to remove foreign body with primary closure

Final Assessment Details

Include DSP for each addressed condition impacting treatment and patient care.

Diagnosis:

Wound Diagnosis
- Traumatic (external cause)
- Surgical

Ulcer
- Non-pressure (internal cause)
- Pressure

Status:

Present
- Location
- Depth

Healed (coded as history)

Plan:

Present
- Treatment
  - Surgical
  - Medical

Healed (coded as history)

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CLINICAL DOCUMENTATION

BEST PRACTICES & TIPS

- **Specificity is key!** Always indicate the type of skin disturbance, the cause, and the severity, along with the method of treatment as these details cannot be assumed.
- DSP should be applied to show **clinical evidence** of a skin wound or skin ulcer to support its documented status. Incorporate imaging, signs and symptoms and document any and all associated treatments with each corresponding final diagnosis.
- Always indicate the **cause of the skin ailment** since skin wounds and skin ulcers are not synonymous. Within an encounter these terms should be consistent.
- Ulcers **require documentation** of laterality, depth and cause of the ulcer (venous, arterial, diabetic, decubitus, etc) along with any associated complications.
- **Traumatic wounds** require documentation including specific location, type of wound (laceration, puncture, bite, etc), with or without foreign body, surgical repair, and the external cause of injury.
- Documentation should always **include evidence** to support the wound or ulcer. Incorporate any current medical treatment (cleaning, dressing, antibiotic treatment, pain medicine, etc) and current signs or symptoms.
- Avoid using **uncertain terms** for present and active conditions, which include: probable, suspected, likely, questionable, possible, still to be ruled out, compatible with, or consistent with.
- If a traumatic laceration has progressed into an ulcer, documentation must **convey this change without question**. If clearly documented, the ulcer would be classified as a sequela of the laceration.

For more resources go to:

HIOSCAR.COM/PROVIDERS/RESOURCES