Unstageable (707.25): Full thickness tissue loss and the base of ulcer may be covered by slough and/or eschar

This covering makes it difficult to determine the stage

Coding concerns

First, let’s look at some coding issues. Bed sores, decubitus ulcers, and plaster ulcers all code to decubitus ulcers. Two codes are needed to fully describe a pressure ulcer, one to represent the location of the ulcer (elbow, upper back, lower back, hip, buttock, ankle, heel, and other sites), and another to describe the stage of the ulcer. Note: Although physician documentation is required to code the ulcer, the stage of the ulcer can be coded from a nursing or physical therapist’s notes.

Be familiar with the six stages of pressure ulcers, according to the Coding Clinic Fourth Quarter 2008:

» Unspecified stage (707.20)
» Stage I (707.21): Skin is intact and there is persistent focal erythema
» Stage II (707.22): Pressure ulcer with abrasion, blister, and partial thickness skin loss involving epidermis and/or dermis
» Stage III (707.23): Pressure ulcer with full thickness skin loss involving damage or necrosis of subcutaneous tissue (bone, tendon, and muscle are not exposed)
» Stage IV (707.24): Pressure ulcer with necrosis of soft tissues through to the underlying muscle, tendon, or bone
Note that stages III and IV are MCCs in the MS-DRGs’ payment system.

**Identify high-risk patients**

CDI specialists should be on alert for the presence of pressure ulcers in patients with the following higher incidence factors:

» Transferred from nursing home
» Over 65 years old
» Bed- or chair-ridden
» Problems with mobility
» Contractures
» Have had a hip fracture
» Dementia
» Multiple sclerosis
» Cachexia
» Body mass index less than 25 kg/m2
» Incontinence of urine or stool

Be on the lookout for related terms as well, since physicians may refer to pressure ulcers as wounds, lesions, tissue loss down to the muscle, ulcers (without specifying type), necrosis, or ulcer subsequent to casting.

**Organize your chart review**

Since physicians don’t always document pressure ulcers, you often need to look beyond their notes. You are more likely to find nurses or wound care specialists documenting the pressure ulcers since they are directly involved in treating them.

Review the nurses’ notes from the nursing home patient transfer forms, the emergency department record, the nursing admission history and database, the skin assessment, the daily nursing care notes, and the wound care specialist’s notes.

In addition to the existence of the pressure ulcer, look for documentation of its stage. The physician’s orders may provide a clue. You may find an order for an air mattress, a turning schedule, a wound care consult, or wound dressings.

**Know the financial effect of your work**

Adding a stage III or IV pressure ulcer will greatly improve reimbursement. For example, an 85-year-old nursing home patient is admitted with a hip fracture and a stage III sacral pressure ulcer. If the pressure ulcer is undocumented and cannot be captured by coding staff members, the case groups to MS-DRG 482, hip and femur procedures except major joint without CC/MCC, with a relative weight of 1.4949.

However, if a CDI specialist is able to obtain appropriate documentation of the stage III sacral pressure ulcer, the case will group to MS-DRG 480, hip and femur procedures except major joint with MCC, with a relative weight of 2.8998.

Keep in mind the following important distinction: Pressure ulcers must be present on admission in order for hospitals to receive reimbursement related to them. This is one of several conditions that are on CMS’ no-pay list if they occur after the admission.

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**Editor’s note:** Walker is vice president of clinical quality at FairCode Associates, LLC, in Towson, MD, a healthcare consulting firm specializing in DRG and coding audits. A former RN, she graduated from the University of Maryland School of Medicine and has been board-certified in internal medicine since 1987. Contact her at 410/825-6178 or by e-mail at hwalker@faircode.com.

Illustration by David Harbaugh

“Roses are red. Your documentation is minimal. How do I code it? Your writing’s subliminal.”

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Physician Queries Handbook excerpt:
Need for queries stems from systematic shifts in healthcare

Editor’s note: For more information, visit www.hcmarketplace.com.

In August 2007, CMS finalized its plans to implement a new MS-DRG system as detailed in the fiscal year 2008 inpatient prospective payment system final rule. The primary difference between MS-DRGs and CMS-DRGs (which were implemented in 1983) was the allowance of certain diagnoses to serve as MCCs that improved resource allocation over less intense conditions qualifying as regular CCs.

Given that hospitals were faced with a new DRG methodology and CMS’ across-the-board imposition of documentation and coding adjustments, hospitals were incentivized (and, in fact, were encouraged by AHIMA and other professional organizations) to:

» Partner with their physicians to improve the definition and documentation of their treated conditions using official ICD-9-CM language
» Better structure their query processes to clarify imprecise, illegible, inconsistent, or otherwise incongruent physician documentation
» Consider refinement or implementation of concurrent query processes to support the retrospective processes already in place

All of these changes speak to the importance of a CDI program, including a need for a structured concurrent and retrospective physician query process.

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