



Coding, Compliance, and Documentation for Diabetic Foot Ulcers

Thorough documentation and accurate coding are key.

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In caring for diabetic foot ulcer patients, we must be thorough and accurate with our coding, compliance, and documentation. There are more codes and more detailed codes with ICD-10 than what we had with ICD-9. Thorough documentation is necessary to support our coding, appropriately manage risk, and provide a complete medical record for our patients.

“Wound” Versus “Ulcer”

The difference between what is considered a “wound” and what is considered an “ulcer” has been long debated in multiple forums. However, for diagnosis coding, there is no debate. Sometimes ICD-10 is almost like its own language and this is one of those situations. Be aware that in ICD-10 language, a wound is something that occurred traumatically. All of the “wound” codes start with the letter S, placing them in Chapter 19 of the tabular index titled, “Injury, poisoning, and certain other consequences of external causes”. The term “ulcer” refers to a break in the skin that fails to heal as it should and is typically more chronic in nature. While many of us may interchange the terms “ulcer” and “wound” as if they are synonyms, they are not synonyms when it comes to ICD-10 coding.

Ulcer Type

Once you have determined that the pathology you are dealing

with is as an ulcer, you must decide which type of ulcer it is. This is the next step in identifying the correct diagnosis code. The options for ulcer type include diabetic foot ulcer, pressure ulcer, stasis ulcer, or arterial ulcer. Diabetic foot ulcer coding begins with the L97- codes. Throughout this article a “-” at the end of any code stem indicates that this code is not complete and more characters are required to complete

a diabetic, it is considered a diabetic foot ulcer, and therefore should be coded using an L97- code. This is true even if arterial disease and/or pressure played a role in the development of this ulcer.

ICD-10 Coding

After starting a code for a diabetic foot ulcer with L97-, we have to choose a 4th character of either “4” or “5” with the options being L97.4-

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the code. Pressure ulcer codes begin with L89-. I83- codes are used for stasis ulcers, and I70- codes are appropriate for arterial ulcers.

You may be wondering what to do when a diabetic foot ulcer is also pressure-related. For example, a diabetic patient with arterial disease and neuropathy may develop an ulcer on the dorsal proximal interphalangeal joint of a contracted 2nd toe. This ulcer could be considered an arterial ulcer, a neuropathic ulcer, or a pressure ulcer. Thankfully, the National Pressure Ulcer Advisory Panel (NPUAP) has provided us with guidance in this area. For ICD-10 purposes, if there is an ulcer on the foot of

(non-pressure chronic ulcer of heel and midfoot) or L97.5- (non-pressure chronic ulcer of other part of foot). The word “and” is in the description of the L97.4- codes. This brings us to an important ICD-10 lesson and another example of it sometimes being its own language. Whenever the word “and” is used in ICD-10 code descriptions, it actually means “and/or”. Therefore, if you use an L97.4-code, it does not imply that the patient has two ulcers, one involving the heel and one involving the midfoot. The ulcer can involve the heel or the midfoot.

We are still not done because
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TABLE 1

5th character options for L97.4-

- 0—Unspecified heel and midfoot
- 1—Right heel and midfoot
- 2—Left heel and midfoot

5th character options for L97.5-

- 0—Unspecified foot
- 1—Right foot
- 2—Left foot

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once you have decided on a 4th character, a 5th character is required and the 5th character options are listed in Table 1. This code is not complete after selecting the 5th character because a 6th character is required. The 6th character codes are listed in Table 2. You will notice the “unspecified” options in these 5th and 6th character listings. An “unspecified” selection indicates to the payer that the documentation was incomplete, and should almost

code descriptions that would address this inconsistency but no changes have been made.

The coding of a diabetic foot ulcer is still not complete after the 4th, 5th, and 6th characters have been chosen because the L97- codes require you to “code first any associated underlying condition, such as (among others) diabetic ulcers (E08.621, E08.622, E09.621, E09.622, E10.621, E10.622, E11.621, E11.622, E13.621, E13.622).” Of these options, the most commonly used codes for di-

ditional code.” If the patient is on diabetic medication, the Z79.4 and/or Z79.84 code should be listed after E11.621. If this is not something you have been asking your type 2 diabetic patients, you may be surprised how many type 2 diabetics are now taking insulin as compared to ten or more years ago. If the patient is not on any type of diabetic medication, neither of these need to be coded. If the patient is on both types of diabetic medication, both of these should be coded. If the patient is a type 1 diabetic, you will see that E10.621 does not carry this instruction to use a “z” code.

Let’s go through the diagnosis coding of a type 2 diabetic patient taking daily insulin for a chronic left lateral midfoot ulcer with necrosis of muscle. When coding this encounter, you would start with L97.4- because this ulcer is on the midfoot. The 5th character would be “2” because it is the left foot, and the 6th character would be “3”

With the 5th character laterality options, for example, a selection of “0” would indicate that neither left nor right was specified in the documentation.

TABLE 2

6th character options for L97.4- and L97.5- codes

- 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

always be avoided as this may lead to denial of payment. With the 5th character laterality options, for example, a selection of “0” would indicate that neither left nor right was specified in the documentation.

Notice in the 6th character options for L97.4- and L97.5- (Table 2) that “1” and “2” reference the depth of the ulcer, but “3” and “4” reference the depth of tissue that is necrotic. Just because an ulcer extends to a certain depth does not necessarily mean there is necrosis of tissue to that depth. Multiple agencies, including the American Podiatric Medical Association and the Alliance of Wound Care Stakeholders have submitted requests to the World Health Organization to make changes to the

diabetic foot ulcers are E10.621 (Type 1 diabetes mellitus with foot ulcer) and E11.621 (Type 2 diabetes mellitus with foot ulcer). “Code first” indicates that an additional code is required, the orders matter, and you should list this code first. Therefore, E10.621 or E11.621 should precede the L97-code on the claim form.

In a Type 2 diabetic with a foot ulcer, we may still not be finished because E11.621 carries with it the instruction to “use additional code to identify control with insulin (Z79.4) or oral hypoglycemic drugs (Z79.84)”. Just as the order matters when we see “code first”, the order in which the codes are listed is important when instructed to “use ad-

ditional code.” because there is necrosis of muscle. That leaves us with L97.423, which carries the instruction to code first E11.621 (type 2 diabetes mellitus with foot ulcer). Because this patient uses daily insulin, Z79.4 is necessary as well. Following the rules of “code first” and “use additional code”, the order of these codes would be E11.621 first, Z79.4 second, and L97.423 last.

Debridement Coding

After the diagnosis code is complete, the next step is to identify the Current Procedural Terminology (CPT) code for the debridement that was performed. There are four

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base codes to choose from when an ulcer debridement is performed (Table 3).

The code you choose from Table 3 is determined by the deepest layer of tissue that is removed during the debridement. The depth of the ulcer itself does not determine the code selection, but rather the deepest depth to which the debridement is performed. For example, you may be treating an ulcer with bone exposed at its base, but if the deepest layer to which you debride is subcutaneous tissue, CPT 11042 would be the appropriate code.

The amount of tissue removed is also important when selecting the CPT code. The codes listed in Table 3 are used if a total of 20 sq. cm. or less of tissue is removed at that depth. If multiple ulcers are debrided at the same depth, the amount of tissue removed from all of them should be totaled to determine the appropriate code. If more than one ulcer is debrided at different depths, then different codes can be used to

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| <p>CPT 97597—Debridement (eg, high pressure waterjet with/without suction, sharp selective debridement with scissors, scalpel and forceps), open wound (eg, fibrin, devitalized epidermis and/or dermis, exudate, debris, biofilm), including topical application(s), wound assessment, use of whirlpool, when performed and instruction(s) for ongoing care, per session; total wound(s) surface area; first 20 sq cm or less</p> |
| <p>CPT 11042—Debridement, subcutaneous tissue (includes epidermis and dermis, if performed); first 20 sq cm or less</p> |
| <p>CPT 11043—Debridement, muscle and/or fascia (includes epidermis, dermis, and subcutaneous tissue, if performed); first 20 sq cm or less</p> |
| <p>CPT 11044—Debridement, bone (includes epidermis, dermis, subcutaneous tissue, muscle and/or fascia, if performed); first 20 sq cm or less</p> |

represent each depth. For example, if 4 sq. cm. of dermis is removed from one ulcer and 6 sq. cm. dermis is removed from another ulcer, a total of 10 sq. cm. of dermis has been removed and the appropriate CPT code would be one unit of CPT 97597. If 4 sq. cm. of dermis is re-

moved from one ulcer and 6 sq. cm. of subcutaneous tissue is removed from another ulcer, then both CPT 97597 and CPT 11042 should be used to represent the two different depths.

If over 20 sq. cm. of tissue is removed at any depth, then an add-on code becomes necessary. The add-on codes for each of the depths are listed in Table 4. By definition, 51 and 59 modifiers should not be used with add-on codes. Note that the number of units of each add-on code submitted is determined by the

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TABLE 5:
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- Medical necessity of debridement (why you are doing it)
- Underlying medical diagnosis
- Anesthesia, if used
- Ulcer size(s) in sq. cm.
- Depth of Ulcer
- Square cm. of tissue debrided
- Depth of tissue debrided
- Drainage
- Color
- Absence / presence of necrotic tissue
- Vascularity
- Op Report with a narrative of the debridement
- Patient specific goals
- Ulcer getting better or worse
- Texture of ulcer bed and surrounding tissue
- Temperature
- Condition of surrounding tissue
- Presence or absence of infection
- Location of ulcer
- Presence or absence of undermining/tunneling
- Instrument(s) used
- Dressings used
- Immediate post-debridement care
- Instructions
- Methods of offloading
- Complicating factors/Comorbidities
- Photograph



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amount of tissue removed at that depth in multiples of 20. For example, if 56 sq. cm. of subcutaneous tissue is removed, whether it be from one ulcer or multiple ulcers, CPT 11042 is used for the first 20 sq. cm. Then

**Some LCDs require that
a pathology specimen be sent for
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two units of CPT 11045 should also be submitted to represent the additional 36 sq. cm. of tissue that was removed.

Thorough documentation with ulcer care is important for so many reasons. Your risk management provider may provide guidance on documentation skills that can help to manage risk. From a coding perspective, it is always a good idea to read your Medicare Administrative Contractor's (MAC) Local Coverage Determination (LCD) for ulcer debridement. It will probably provide a guideline of documentation points that they expect to be in the

medical record if one of the ulcer debridement codes is used. Table 5 contains a list of documentation bullets that some LCDs require.

All of the CPT codes described here have a zero day global period. Some LCDs place a restriction on where some of these codes can be performed. For example, some LCDs will not allow CPT 11044 in an office setting. Some LCDs require that a pathology specimen be sent for debridements at certain depths. Some LCDs discuss frequency and duration of debridement, and some have guidelines regarding medical necessity, and other factors impacting coverage for ulcer debridement. Again, it is wise to know your LCD for ulcer debridement inside out and backwards if you are going to be coding for ulcer debridement.

Thorough documentation and accurate coding help to manage risk on multiple levels and assist with high-level patient care. Hopefully, this article and the information contained herein will help to ensure your documentation is excellent and coding is accurate. **PM**

References

NDNQI Pressure Ulcers and Staging <https://members.nursingquality.org/NDNQIPressureUlcerTraining/module1/Unstageable1.aspx>

APMA Coding Resource Center <http://www.apmacodingrc.org/home.asp>

Kesselman, P., DPM. (September, 2013). Wound care billing update, *Podiatry Management* pg 53-59

LeGrand, M., RN, MA CCS-P, CPC., Changes in reporting wound débridement, <http://www.aaos.org/news/aaosnow/jun11/managing2.asp>

CGS Medicare. (May 9, 2012). Documenting surgical debridement services—Measurements matter. <https://www.cgs-medicare.com/ohb/pubs/news/2012/0512/cope18819.html>

Noridian Medicare, Wound care and debridement—Provided by physician, NPP or as incident-to services, https://www.noridianmedicare.com/cgi-bin/coranto/viewnews.cgi?id=EF-FZFZyyEpAJGDJCxK&tmpl=part_a_viewnews&style=part_ab_viewnews

Fife, C.E., MD, FAAFP, CWS. The debridement dilemma returns, <http://www.todaywoundclinic.com/debridement-dilemma-returns?page=4>,

National Government Services. National Government Services LCD for Debridement Services (L27373), http://apps.ngs-medicare.com/lcd/LCD_L27373.htm,

Just Coding News. (August 8, 2012). Differentiate between types of wound debridement. *JustCoding News: Outpatient*

Novitas Local Coverage Determination (LCD): Wound Care (L35139) https://www.cms.gov/medicare-coverage-database/details/lcd-details.aspx?LCDId=35139&ver=40&CntrctrSelected=324*1&Cntrctr=324&s=45&DocType=Active&bc=AggAAAAIAIAAAAA%3d%3d&



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