Coding, Compliance, and Documentation for Diabetic Foot Ulcers

Thorough documentation and accurate coding are key.

BY JEFFREY D. LEHRMAN, DPM

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 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 the code. Pressure ulcer codes begin with L89-. L83- codes are used for stasis ulcers, and L70- 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 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- (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 Continued on page 72
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 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 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 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-

Diabetic 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
**TABLE 3**

| 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 |
| CPT 11042 | Debridement, subcutaneous tissue (includes epidermis and dermis, if performed); first 20 sq cm or less |
| CPT 11043 | Debridement, muscle and/or fascia (includes epidermis, dermis, and subcutaneous tissue, if performed); first 20 sq cm or less |
| CPT 11044 | Debridement, bone (includes epidermis, dermis, subcutaneous tissue, muscle and/or fascia, if performed); first 20 sq cm or less |

**TABLE 5:**

**Documentation**

- 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

*Continued on page 76*
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 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/Unstagenable1.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
Noridian Medicare, Wound care and débridement—Provided by physician, NPP or as incident-to services, https://www.noridianmedicare.com/cgi-bin/coranto/viewnews.cgi?id=EF-FZFZyyEpAJGJXcxK&impl=part_a_viewnews&style=part_ab_viewnews

Some LCDs require that a pathology specimen be sent for debridements at certain depths.