



Pressure Injuries (Ulcers)

The purpose of this Tip for Coders is to provide clarity on the correct ICD-10-CA code assignment for pressure injuries (ulcers) and on the correct application of direction in the coding standard *Pressure Ulcers*.

Pressure injuries pose a serious challenge for clinical care and impact quality of life. However, pressure ulcers are potentially under-reported in Canadian hospital administrative data submitted to CIHI's Discharge Abstract Database (DAD) and National Ambulatory Care Reporting System (NACRS).

Pressure Ulcers: Coding direction

To improve pressure ulcer data collection, CIHI developed the following, which came into effect April 1, 2022:

- The ***Pressure Ulcers* coding standard**, directing that
 - It is **mandatory** to assign an ICD-10-CA code from category L89 *Decubitus [pressure] ulcer and pressure area* for any pressure injury whenever documented — **whether by a physician or a regulated allied health professional**.
 - In addition to the ICD-10-CA code, you must also apply the diagnosis prefix “N” when the pressure injury is documented **only** by a regulated allied health professional.
- An **ICD-10-CA code** to identify suspected pressure injury: L89.6 *Suspected deep pressure-induced tissue damage; depth unknown*.

ICD-10-CA code assignment for pressure injuries

- It is mandatory to assign a code from category L89 *Decubitus [pressure] ulcer and pressure area* whenever a diagnosis of pressure injury is documented.
- You may use either a physician's documentation or a regulated allied health professional's documentation to inform code assignment.
- If there are multiple sites with pressure injuries of different stages, assign only 1 code that identifies the greatest degree of severity or the highest stage. This direction is per the instructional note at category L89 *Decubitus [pressure] ulcer and pressure area*.
- You may use a regulated allied health professional's documentation of the severity of the pressure injury to assign the more specific code.





Diagnosis prefix “N”

- Apply diagnosis prefix “N” to the code from category L89 *Decubitus [pressure] ulcer and pressure area* when the **only** documentation of a pressure injury has been made by a regulated allied health professional (i.e., there is **no** physician documentation of a pressure injury).
- Do not apply diagnosis prefix “N” when there is physician documentation of a pressure injury.
- Do not assign multiple codes from category L89 *Decubitus [pressure] ulcer and pressure area* when a pressure injury is documented by both a physician and a regulated allied health professional.

Note

When both a physician and a regulated allied health professional document a pressure injury, assign the 1 ICD-10-CA code that describes the greatest degree of severity or highest stage. For example, if the physician documents decubitus ulcer of the buttock stage I and the nurse documents that the patient had a stage III decubitus ulcer of the sacrum, assign L89.2 *Stage III decubitus [pressure] ulcer*. Apply prefix “N” when the only documentation of pressure injury has been made by a regulated allied health professional and there is no physician documentation of the pressure injury. In this case, prefix “N” is **not** applied.

See the coding standards *Main and Other Problem Definitions for NACRS* and *Diagnosis Typing Definitions for DAD* for direction on applying problem type and diagnosis type.



Tip for Coders

Assess your understanding

The following table provides scenarios to assess your understanding of the classification of pressure injuries and the application of the *Pressure Ulcers* coding standard direction.

Scenario	Who documented the pressure injury — a physician and/or a regulated allied health professional?	Assign the ICD-10-CA code(s) for the pressure injury	Should diagnosis prefix “N” be applied?
<p>The patient presents to hospital with emesis and hypotension, and is subsequently admitted. The final diagnosis is recorded by the physician as “sepsis secondary to infected decubitus ulcer.” The physician documents that the sepsis was due to <i>Proteus mirabilis</i>. The stage of the ulcer is not documented by the physician nor by a regulated allied health professional.</p>	Enter your answer here	Enter your answer here	Enter your answer here
<p>The patient is admitted to hospital with pneumonia. On day 15, the physician documents that the patient has a pressure ulcer and requests a consultation with a wound care specialist. On day 15 of the patient’s stay, they are seen in consultation by a wound care specialist who documents that the patient has a stage III coccygeal decubitus ulcer. Treatment involves cleaning and dressing the ulcer 3 times a day.</p>	Enter your answer here	Enter your answer here	Enter your answer here
<p>The patient is admitted to hospital with a sacral pressure ulcer. The nurse documents that the patient has a stage IV sacral ulcer.</p>	Enter your answer here	Enter your answer here	Enter your answer here
<p>A patient is admitted to hospital and the physician documents a stage II pressure ulcer on the buttock and a stage III pressure ulcer on the foot.</p>	Enter your answer here	Enter your answer here	Enter your answer here



Tip for Coders

Correct answers

The following table provides answers to the scenarios presented above.

Scenario	Who documented the pressure injury — a physician and/or a regulated allied health professional?	Assign the ICD-10-CA code(s) for the pressure injury	Should diagnosis prefix “N” be applied?	Rationale
The patient presents to hospital with emesis and hypotension, and is subsequently admitted. The final diagnosis is recorded by the physician as “sepsis secondary to infected decubitus ulcer.” The physician documents that the sepsis was due to <i>Proteus mirabilis</i>. The stage of the ulcer is not documented by the physician nor by a regulated allied health professional.	Physician	L89.9 Decubitus ulcer and pressure area unspecified	No	The physician documents decubitus ulcer but does not specify the stage. Since there is no other documentation to provide specificity, assign L89.9 <i>Decubitus ulcer and pressure area unspecified</i> .
The patient is admitted to hospital with pneumonia. On day 15, the physician documents that the patient has a pressure ulcer and requests a consultation with a wound care specialist. On day 15 of the patient’s stay, they are seen in consultation by a wound care specialist who documents that the patient has a stage III coccygeal decubitus ulcer. Treatment involves cleaning and dressing the ulcer 3 times a day.	Both	L89.2 Stage III decubitus [pressure] ulcer	No	The physician documents that the patient has a pressure ulcer but does not specify the stage. The wound care specialist documents that it is a stage III coccygeal decubitus ulcer. You may use a regulated allied health professional’s documentation to add specificity to the appropriate diagnosis code. Assign L89.2 <i>Stage III decubitus [pressure] ulcer</i> .



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Scenario	Who documented the pressure injury — a physician and/or a regulated allied health professional?	Assign the ICD-10-CA code(s) for the pressure injury	Should diagnosis prefix “N” be applied?	Rationale
<p>The patient is admitted to hospital with a sacral pressure ulcer. The nurse documents that the patient has a stage IV sacral ulcer.</p>	<p>Regulated allied health professional</p>	<p>L89.3 Stage IV decubitus [pressure] ulcer</p>	<p>Yes</p>	<p>A regulated allied health professional documents a stage IV pressure ulcer. There is no documentation by a physician. Documentation of a pressure injury by a regulated allied health professional may be used for code assignment. Prefix “N” is also applied to show that pressure injury was documented only by a regulated allied health professional. Assign L89.3 <i>Stage IV decubitus [pressure] ulcer</i>.</p>
<p>A patient is admitted to hospital and the physician documents a stage II pressure ulcer on the buttock and a stage III pressure ulcer on the foot.</p>	<p>Physician</p>	<p>L89.2 Stage III decubitus [pressure] ulcer</p>	<p>No</p>	<p>A physician documents that the patient has a stage II decubitus ulcer and a stage III decubitus ulcer. Per the instructional note at category L89 <i>Decubitus [pressure] ulcer and pressure area</i>, assign only 1 code indicating the highest stage. Assign L89.2 <i>Stage III decubitus [pressure] ulcer</i>.</p>



Resources

Canadian Coding Standards for ICD-10-CA and CCI:

- *Diagnosis Typing Definitions for DAD*
- *Pressure Ulcers*
- *Specificity*

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