Reporting the Severity of Decubitus Ulcers

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Decubitus ulcers, commonly called pressure sores or bedsores, may range from a mild discoloration of the skin, which disappears in a few hours after repositioning, to a deep wound extending into the bone, which requires resource-intensive wound management.

Though the code for decubitus ulcers was recently expanded, the level of specificity in ICD-9-CM remains insufficient to fully reflect a patient's severity of illness. With the possibility of pay for performance and an increased focus on measuring quality outcomes, facilities need a mechanism to adequately report severity of illness. Upgrading to ICD-10-CM would provide additional specificity, thereby reflecting the quality of care provided to a patient.[1]

This article will provide clinical information on the cause and severity of decubitus ulcers and explain past, present, and future diagnosis code assignments and how well each reflects severity of illness.

The Cause and the Affected

Though many factors may contribute to the development of decubitus ulcers, the principal etiology is localized pressure leading to tissue ischemia. Soft tissue can withstand significant pressure for brief periods of time, but prolonged exposure to unrelieved pressure causes an ischemic response that can lead to ulceration.

Unrelieved pressure over a bony prominence can cause local ischemia in as little as 20 minutes. Tissue covering bony prominences that is under prolonged pressure is the most susceptible to decubitus ulcers. The most common anatomic sites for ulcers are the tissues over the sacrum, ischia, ankles, heels, occiput, and elbows.

Decubitus ulcers occur in patients with alterations in normal sensitivity, mobility, and mental faculty; in other words, individuals who are unable to independently change position and relieve pressure on certain areas. Patients most at risk include those who are unconscious, sedated, debilitated, emaciated, paralyzed, or bedridden.

Physiological and nutritional factors also contribute to the development of decubitus ulcers. Tissue is less able to withstand brief episodes of hypoxia when there is low blood flow due to hypotension or reduced tensile strength from dehydration or poor nutrition. A frequently underestimated contributor to decubitus ulcers is sheering forces across the skin surface; sitting upright on a firm surface is less risky than slouching in a wheelchair and sliding across the sacrum.

Skin, soft tissue, and muscle are different types of tissue, and each has a different tolerance for pressure. Muscle has a lower tolerance to poor oxygen supply and will often necrose before skin breakdown. In addition, because pressure is the greatest at a bony prominence, the more peripheral tissue may breakdown more slowly. This means that what may appear to be only a small skin ulceration to the untrained eye may actually be a small opening to a large cavity with ischemic extension into surrounding tissue and underlying muscle. Adequate evaluation or staging of an ulcer cannot be determined unless the examining healthcare provider can visualize the entire extent of the ulcer.

Treatment

Treatment decisions are based on the severity of the decubitus ulcer, classified as stages. There are several staging systems, but the present National Pressure Ulcer Advisory Panel classification system is widely accepted. The system consists of four stages. The numbering of the stages does not mean that ulcers naturally progress from stage I to stage IV or regress from stage IV to a healed wound. An ulcer will always be staged to the most severe state it achieved before healing. Proper use of this system prohibits restaging as healing progresses. This is important for future treatment considerations as the healed area consists of granulation tissue and scar, which is more susceptible to recurrent damage.

The National Pressure Ulcer Advisory Panel classification system describes the depth of the decubitus ulcer so that comparisons can be made over time (see "Four Stages of Decubitus Ulcer," below). Stage I and II ulcers typically heal with appropriate medical treatment, whereas stage III and IV ulcers more commonly require surgical intervention.

Decubitus ulcers are a common problem in specific, at-risk patient populations. The prevalence of decubitus ulcers in nursing homes is estimated to be 17 to 28 percent, while the incidence in patients hospitalized with acute illness is estimated at 3 to 11 percent. In addition, the recurrence rate for patients who achieve a healed wound is as high as 90 percent.[2]

Reporting of One Case Compared

Case Scenario	FY 2004 ICD-9-CM code	FY 2005 ICD-9-CM code	Current ICD-10-CM code
Two decubitus ulcers, one on the right side of the buttock, with necrosis down to the muscle; one on the right upper back, with involvement of the epidermis and dermis only	**707.0**, Decubitus ulcer	**707.05**, Decubitus ulcer, buttock **707.02**, Decubitus ulcer, upper back	**L89.113**, Decubitus ulcer of right buttock with necrosis of muscle **L89.011**, Decubitus ulcer of right upper back limited to breakdown of the skin

Four Stages of Decubitus Ulcer

Stage	Description
I	There is blanchable erythema, which progresses to erythema that does not blanch when palpated. The skin is unbroken but there is impending ulceration.
II	Partial-thickness loss of skin involving epidermis and sometimes dermis. May present as an abrasion or superficial ulceration.
III	Full-thickness loss of skin with extension into subcutaneous tissue but not going through the underlying fascia. Presents as a crater with or without undermining adjacent tissue.
IV	Full-thickness loss of skin and subcutaneous tissue and extension into muscle, bone, tendon, or joint capsule. Osteomyelitis with bone destruction, dislocations, or pathologic fractures may be present.

Source: National Pressure Ulcer Advisory Panel Classification System

Comparing Severity Reporting

Prior to fiscal year 2005, there was only one ICD-9-CM diagnosis code for reporting decubitus ulcers: 707.0, Decubitus ulcer. Code 707.0 was used regardless of the number, location, or depth of decubitus ulcers. A patient may have more than one ulcer at different sites on the body, and these ulcers may differ in severity and thus treatment. For instance, one ulcer might require time-intensive wound management or costly pressure-relieving devices, while another may require less costly monitoring and repositioning. There is no way to report these differences in ICD-9-CM.

New codes were established in ICD-9-CM for fiscal year 2005, which allow for more accurate reporting on patients with decubitus ulcers at more than one site. This update added fourth digits to subcategory 707.0 to specify the common body sites where decubitus ulcers occur. Multiple codes in this subcategory may be used to report decubiti located at different sites. This code change, while insufficient to fully reflect severity of illness, is an improvement and moves ICD-9-CM a bit closer to the level of specificity available in ICD-10-CM.

The current version of ICD-10-CM classifies decubitus ulcers by site, including laterality, and by the extent of involvement of underlying tissue. In ICD-10-CM decubitus ulcers can be classified as:

- Limited to breakdown of the skin only
- With fat layer exposed
- With necrosis of muscle
- With necrosis of bone
- With unspecified severity

As illustrated in "Reporting of One Case Compared," above, the level of specificity in ICD-9-CM remains insufficient to fully reflect a patient's severity of illness. ICD-10-CM resolves this problem, providing a mechanism to capture clinical data that can be used to adjust outcomes for severity of illness. The increased specificity in ICD-10-CM more adequately meets increasingly complex healthcare data needs.

Notes

1. ICD-10-CM is not currently in use for reporting morbidity in the United States, though it is under consideration to replace ICD-9-CM as the HIPAA-mandated uniform code set for diagnosis reporting. For more information on ICD-10-CM, visit www.cdc.gov/nchs/about/otheract/icd9/abticd10.htm.
2. Revis, Don R. Jr. "Decubitus Ulcers." March 3, 2004. Available online at www.emedicine.com/med/topic2709.htm.

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