Wound vs. Ulcer: Selecting the Correct Diagnosis Code

When should you use a wound code and when should you use an ulcer code in your wound clinic? This author offers a comprehensive guide to the intricacies of coding to increase accuracy.

Donna Cartwright, MPA, RHIA, CCS RAC, FAHIMA

Information regarding coding, coverage, and payment is provided as a service to our readers. Every effort has been made to ensure accuracy. However, HMP and the author do not represent, guarantee, or warranty that coding, coverage, and payment information is effort-free and/or that payment will be received.

I t has come to this author's attention that there are many coding questions regarding wound versus ulcer diagnosis coding. Hopefully, this article will eliminate the confusion between wounds and ulcers.

> **From a coding guideline perspective, there is no timeline during which an acute wound turns into a chronic ulcer.**

From the coding perspective, there are 2 major categories of wounds: acute **(wound)** and chronic **(ulcer)**. Acute wounds are classified by many coding terms, e.g.:

- Superficial injuries include the terms contusions, abrasions, blisters, external constriction, superficial injuries with foreign bodies, insect bites (non-venomous and venomous), and other superficial bites.
- Open wounds include lacerations with and without foreign bodies,

Table 1. Superficial Injuries and Open Wound Code Examples

1. Superficial Injuries	2. Open Wounds	3. Crushing

S90.31 Contusion of right foot
    S90.31XA …… initial encounter
    S90.31XD …… subsequent encounter
    S90.31XS …… sequela
S90.32 Contusion of left foot
    S90.32XA …… initial encounter
    S90.32XD …… subsequent encounter
    S90.32XS …… sequela
S90.81 Abrasion, right foot
    S90.811A …… initial encounter
    S90.811D …… subsequent encounter
    S90.811S …… sequela
S90.812 Abrasion, left foot
    S90.812A …… initial encounter
    S90.812D …… subsequent encounter
    S90.812S …… sequela
S90.821 Blister (nonthermal), right foot
    S90.821A …… initial encounter
    S90.821D …… subsequent encounter
    S90.821S …… sequela
S90.822 Blister (nonthermal), left foot
    S90.822A …… initial encounter
    S90.822D …… subsequent encounter
    S90.822S …… sequela
S90.84 External constriction of foot
    S90.841 External constriction, right foot
        S90.841A …… initial
                encounter
        S90.841D …… subsequent
                encounter
        S90.841S …… sequela
    S90.842 External constriction, left foot
        S90.842A …… initial
                encounter
        S90.842D …… subsequent
                encounter
        S90.842S …… sequela
S90.851 Superficial foreign body, right foot
    S90.851A …… initial encounter
    S90.851D …… subsequent encounter
    S90.851S …… sequela
S90.852 Superficial foreign body, left foot
    S90.852A …… initial encounter
    S90.852D …… subsequent encounter
    S90.852S …… sequela
S90.862 Insect bite (nonvenomous), left foot
    S90.862A …… initial encounter
    S90.862D …… subsequent encounter
    S90.862S …… sequela
S90.861 Insect bite (nonvenomous), right foot
    S90.861A …… initial encounter
    S90.861D …… subsequent encounter
    S90.861S …… sequela
S90.869 Insect bite (nonvenomous), unspecified foot
    S90.869A …… initial encounter
    S90.869D …… subsequent encounter
    S90.869S …… sequela
S90.871 Other superficial bite of right foot
    S90.871A …… initial encounter
    S90.871D …… subsequent encounter
    S90.871S …… sequela
S90.872 Other superficial bite of left foot
    S90.872A …… initial encounter
    S90.872D …… subsequent encounter
    S90.872S …… sequela
	S91.302 Unspecified open wound, left foot
	    S91.302A …… initial encounter
	    S91.302D …… subsequent encounter
	    S91.302S …… sequela
	S91.301 Unspecified open wound, right foot
	    S91.301A …… initial encounter
	    S91.301D …… subsequent encounter
	    S91.301S …… sequela
	S91.309 Unspecified open wound, unspecified foot
	    S91.309A …… initial encounter
	    S91.309D …… subsequent encounter
	    S91.309S …… sequela
	S91.31 Laceration without foreign body of foot
	    S91.311 Laceration without foreign
	        body, right foot
	        S91.311A …… initial
	                encounter
	        S91.311D …… subsequent
	                encounter
	        S91.311S …… sequela
	    S91.312 Laceration without foreign
	        body, left foot
	        S91.312A …… initial
	                encounter
	        S91.312D …… subsequent
	                encounter
	        S91.312S …… sequela
	S91.32 Laceration with foreign body of foot
	    S91.321 Laceration with foreign body,
	        right foot
	        S91.321A …… initial
	                encounter
	        S91.321D …… subsequent
	                encounter
	        S91.321S …… sequela
	    S91.322 Laceration with foreign body,
	        left foot
	        S91.322A …… initial
	                encounter
	        S91.322D …… subsequent
	                encounter
	        S91.322S …… sequela
	S91.331 Puncture wound without foreign body, right foot
	    S91.331A …… initial encounter
	    S91.331D …… subsequent encounter
	    S91.331S …… sequela
	S91.332 Puncture wound without foreign body, left foot
	    S91.332A …… initial encounter
	    S91.332D …… subsequent encounter
	    S91.332S …… sequela
	S91.341 Puncture wound with foreign body, right foot
	    S91.341A …… initial encounter
	    S91.341D …… subsequent encounter
	    S91.341S …… sequela
	S91.342 Puncture wound with foreign body, left foot
	    S91.342A …… initial encounter
	    S91.342D …… subsequent encounter
	    S91.342S …… sequela
	S91.35 Open bite of foot
	    S91.351 Open bite, right foot
	        S91.351A …… initial
	                encounter
	        S91.351D …… subsequent
	                encounter
	        S91.351S …… sequela
	    S91.352 Open bite, left foot
	        S91.352A …… initial
	                encounter
	        S91.352D …… subsequent
	                encounter
	        S91.352S …… sequela
		S97.81 Crushing injury of right foot
		    S97.81XA Crushing injury of right
		               foot, initial encounter
		    S97.81XD Crushing injury of
		               right foot, subsequent
		               encounter
		    S97.81XS …… sequela
		S97.82 Crushing injury of left foot
		    S97.82XA Crushing injury of left foot,
		               initial encounter
		    S97.82XD Crushing injury of left foot,
		               subsequent encounter
		    S97.82XS …… sequela

Table 1 continues on next page

Table 1. Superficial Injuries and Open Wound Code Examples *(continued)*

4. Traumatic Amputation	5. Acute Osteomyelitis	6. Surgical Complications	7. Other Acute Diagnosis Codes

S98.011 Complete traumatic amputation of right foot at ankle level
   S98.011A …… initial encounter
   S98.011D …… subsequent encounter
   S98.011S …… sequela
S98.012 Complete traumatic amputation of left foot at ankle level
   S98.012A …… initial encounter
   S98.012D …… subsequent encounter
   S98.012S …… sequela
S98.021 Partial traumatic amputation of right foot at ankle level
   S98.021A …… initial encounter
   S98.021D …… subsequent encounter
   S98.021S …… sequela
S98.022 Partial traumatic amputation of left foot at ankle level
   S98.022A …… initial encounter
   S98.022D …… subsequent encounter
   S98.022S …… sequela
S98.31 Complete traumatic amputation of midfoot
  S98.311 Complete traumatic amputation of right midfoot
    S98.311A …… initial encounter
    S98.311D …… subsequent encounter
    S98.311S …… sequela
  S98.312 Complete traumatic amputation of left midfoot
    S98.312A …… initial encounter
    S98.312D …… subsequent encounter
    S98.312S …… sequela
	M86.071 Acute hematogenous osteomyelitis, right ankle and foot
	M86.072 Acute hematogenous osteomyelitis, left ankle and foot
	M86.171 Other acute osteomyelitis, right ankle and foot
	M86.172 Other acute osteomyelitis, left ankle and foot
	M86.271 Subacute osteomyelitis, right ankle and foot
	M86.272 Subacute osteomyelitis, left ankle and foot
		T86820 Skin graft (allograft) rejection
		T86821 Skin graft (allograft) (autograft) failure
		T86822 Skin graft (allograft) (autograft) infection
		T86828 Other complications of skin graft (allograft) (autograft)
		T86829 Unspecified complication of skin graft (allograft) (autograft)
		T8733 Neuroma of amputation stump, right lower extremity
		T85.613A T85.623A T85.693A Complication due to artificial skin graft and decellularized allodermis, (breakdown, displacement, other)
		T87.0x_-T87.2 Complication of reattached extremity or body part
		T87.9 Complication of amputation stump, unspecified
		T88.8xxA Complication of procedure, seroma
		T81.30xA Dehiscence, wound, unspecified
		T81.32xA Dehiscence, wound, internal operation (surgical)
		T81.31xA Dehiscence, wound, external operation (surgical)
		T81.33xA Dehiscence, wound repair, traumatic injury
		T81.4xxA Postoperative infection, seroma
		T81.83xA Postoperative persistent fistula
		T81.89xA Complication of non-healing surgical wound
			Burns and corrosions **(T20-T32)**
			Fracture of ankle and malleolus **(S82.-)**
			Frostbite **(T33-T34)**
			insect bite or sting, venomous **(T63.4)**

Figure 1. Open wounds include puncture wounds with and without foreign bodies. For this puncture wound with a foreign body in the left foot, use code S91.342.

puncture wounds with and without foreign bodies, trauma wounds, and open bites.

- Skin trauma codes include crush injuries, partial and total traumatic amputations, burns and corrosions, open fractures, and frostbite.
- Surgical wounds.
- Wounds caused by other acute diseases such as acute and subacute osteomyelitis.
- Surgical complications of grafts and surgical wounds.

See **Table 1** for an example (using the foot as the site of the injury) of how the superficial injury codes and open wound codes appear in the ICD-10-CM index.

Reminder: Any code that appears in

Figure 2. The basic rule of thumb is to code each ulcer or wound separately. If multiple sites are treated at the same encounter, select the diagnosis code that identifies each wound or ulcer. If the wounds or ulcers are similar but their diagnosis codes are even different by one single character, each site's diagnosis code should be reported.

Chapter 17 of ICD-10-CM: *Injury, poisoning and certain other consequences of external causes*, requires a 7th character of (A) initial encounter (which means active treatment being rendered to the wound), (D) subsequent encounter for the same wound, or (S) sequela of the wound.

Chronic wounds are classified by different coding terms that are familiar to most readers, e.g.:
- Pressure ulcers
- Non-pressure ulcers
- Varicose veins with ulcers
- Atherosclerotic disease with ulcers
- Diabetic ulcers
- Chronic osteomyelitis

See **Table 2** for examples of many of the chronic ulcer categories. Chronic ulcers usually have an underlying cause associated with the

> **From a coding perspective, the underlying cause of a chronic ulcer is listed first and the type of ulcer (e.g., pressure ulcer or non-pressure ulcer) is listed second.**

ulcer (diabetes, venous disease, etc.) Please note that these codes are not in Chapter 17 and do not require the addition of the 7th character as described for the acute wounds discussed above.

DO YOU NEED A WOUND CODE OR AN ULCER CODE?

Following are some tips to help you decide whether to select a wound code or an ulcer code.

1. The basic rule of thumb is to code each ulcer or wound separately. If multiple sites are treated at the same encounter, select the diagnosis code that identifies each wound or ulcer. If the wounds or ulcers are similar but their diagnosis codes are even different by one

single character, each site's diagnosis code should be reported.

2. From a coding guideline perspective, there is no timeline during which an acute wound turns into a chronic ulcer. Remember, a nonhealing surgical wound code is listed as a complication in the injury chapter of ICD-10-CM.

3. The progress of all acute injury and wound codes in Chapter 17 can be delineated by using the 7th character (A, D, S).

4. Always match the treatment rendered to the appropriate wound or ulcer site code. Multiple wounds or ulcers may often receive different treatments on the same date of service. Linking the right diagnosis code to the treatment makes it easy for the payer to understand 1) the longitudinal treatment of a single wound or ulcer, and 2) which treatments were provided to multiple wounds or ulcers.

5. If infection is present, use additional codes to describe an infection agent. If the infection is due to surgery, use post-op complication codes. If the infection is not due to surgery, add the additional organism code(s).

6. From a coding perspective, the underlying cause of a chronic ulcer is listed first and the type of ulcer (e.g., pressure ulcer or non-pressure ulcer) is listed second. **Caution:** Payers' coverage guidelines often require the chronic ulcer to be listed first.

7. If a complication is related to a previous open or traumatic wound that has since closed, use the site of the wound with sequela (S) to indicate a relationship to a previous wound or injury.

8. The first listed code for an outpatient clinic/office visit may not always be the wound or ulcer itself. It could be a complication, an infection, and/or a new wound or ulcer of a different site. Ask yourself, "What diagnosis required most of the treatment during the clinic/office visit?"

IN CONCLUSION

I hope that this article has clarified some of the confusion on wounds versus ulcers and provided you with some specific examples to think about. While this article is not all-inclusive, it should be indicative of how, from a coding perspective, acute wounds and chronic ulcers are delineated. Physicians and other qualified healthcare professionals should know whether to diagnose the problem as a wound or an ulcer. ∎

Donna Cartwright is senior director of health policy and reimbursement at Integra LifeSciences Corp., Plainsboro, NJ. She is approved as a certified trainer on ICD-10-CM by the American Health Information Management Association and she has been designated as a fellow of the American Health Information Management Association.

Table 2. Chronic Ulcer Code Examples	
Category L89	*Pressure ulcers*
Category L97	*Non-pressure ulcers*
Category I83	*Varicose veins*
Category I70.201-I70.298	*Atherosclerosis lower extremities*
Category E10-E11	*Diabetic ulcers*

1. Chronic Osteomyelitis

M86.371	Chronic multifocal osteomyelitis, right ankle and foot
M86.372	Chronic multifocal osteomyelitis, left ankle and foot
M86.471	Chronic osteomyelitis with draining sinus, right ankle and foot
M86.472	Chronic osteomyelitis with draining sinus, left ankle and foot
M86.571	Other chronic hematogenous osteomyelitis, right ankle and foot
M86.572	Other chronic hematogenous osteomyelitis, left ankle and foot
M86.671	Other chronic osteomyelitis, right ankle and foot
M86.672	Other chronic osteomyelitis, left ankle and foot

2. Diabetic and Atherosclerosis of Lower Extremities

E10621	Type 1 diabetes mellitus with foot ulcer
E10622	Type 1 diabetes mellitus with other skin ulcer
E10628	Type 1 diabetes mellitus with other skin complications
E1042	Type 1 diabetes mellitus with diabetic polyneuropathy
E1051	Type 1 diabetes mellitus with diabetic peripheral angiopathy without gangrene
E1052	Type 1 diabetes mellitus with diabetic peripheral angiopathy with gangrene
E10610	Type 1 diabetes mellitus with diabetic neuropathic arthropathy
E1140	Type 2 diabetes mellitus with diabetic neuropathy, unspecified
E1142	Type 2 diabetes mellitus with diabetic polyneuropathy
E1143	Type 2 diabetes mellitus with diabetic autonomic (poly)neuropathy
E1151	Type 2 diabetes mellitus with diabetic peripheral angiopathy without gangrene
E1152	Type 2 diabetes mellitus with diabetic peripheral angiopathy with gangrene
E1159	Type 2 diabetes mellitus with other circulatory complications
E11610	Type 2 diabetes mellitus with diabetic neuropathic arthropathy
E11621	Type 2 diabetes mellitus with foot ulcer
E11622	Type 2 diabetes mellitus with other skin ulcer
E11628	Type 2 diabetes mellitus with other skin complications
I70261	Atherosclerosis of native arteries of extremities with gangrene, right leg
I70262	Atherosclerosis of native arteries of extremities with gangrene, left leg
I70263	Atherosclerosis of native arteries of extremities with gangrene, bilateral legs
I70268	Atherosclerosis of native arteries of extremities with gangrene, other extremity