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Empowering Better Health

START SMART CODING TIP

Decubitus Ulcers

Coding pressure ulcers – documentation, staging & status

KEY REFERENCE

Guideline I.B.14

DOCUMENTATION & TERMINOLOGY

Decubitus & Pressure Ulcers

Who can document the diagnosis vs. the stage — and terms to watch

WHO DOCUMENTS WHAT

The diagnosis of "pressure ulcer" can only be reported from **physician / eligible provider** documentation.
Nursing or wound-care notes may be used to code the **stage** of a decubitus ulcer (Guideline I.B.14).
When those notes set the stage, confirm the pressure-ulcer **diagnosis is documented by the provider.**

TERMINOLOGY WATCH

"Wound" does **NOT** index to "ulcer."
Deep tissue injury – use caution to be sure it isn't a contusion or trauma-related.

ALSO DOCUMENTED AS

- **Bed sore**
- **Pressure sore**
- **Pressure area**
- **Deep tissue injury**

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STAGING & STATUS · CONT'D

Decubitus & Pressure Ulcers

Capture the highest stage – and confirm the ulcer is still current

HIGHEST STAGE

Code to the **highest stage** documented during the year.

WATCH THE VERBIAGE

Be careful with **"history of," "healing," or "healed."**
Bottom line: is the ulcer **still present / current** at the visit? If "healing," code the current stage.

UNSTAGEABLE ≠ UNSPECIFIED

"Unstageable" does **not** equal "unspecified."
If documented as unstageable, assign the code for **"unstageable" – not "unspecified."**

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