

SKIN ULCER

During review of the above patient's medical record, the Clinical Documentation Improvement Specialist (CDIS) determined that additional documentation clarification is needed in order to capture the severity of illness, presence on admission, and code assignment. Please consider the clinical presentation, workup and treatment for this patient and exercise your professional judgment when responding to the query below for pressure ulcer.

In order to capture the severity of condition; **please clarify the condition, site/location, laterality and whether present on admission (POA):**

- **Stage 1 Pressure/Decubitus Ulcer (intact skin, non-blanching redness of local area)**
- **Stage 2 Pressure/Decubitus Ulcer (partial thickness, loss of dermis, pink wound bed)**
- **Stage 3 Pressure/Decubitus Ulcer (full thickness tissue loss)**
- **Stage 4 Pressure/Decubitus Ulcer (full thickness tissue loss with exposed bone, tendon, or muscle, may have slough or eschar present)**
- **With gangrene?**
- **Unstageable**
- **Other condition, please specify**
- **Please indicate cause if known**
- **Was this condition present on admission?**

If the wound care RN has documented the stage of the ulcer, you may refer to her note for this documentation, however the type, site and presence on admission, if applicable, must be documented by the attending physician.

In the absence of documentation by the wound care RN, the medical provider must also document the stage as appropriate.