



October 16, 2026

Shannon McConnell-Lamprey, MS, RHIA, PMP
ICD-10-CM Coordination and Maintenance Committee
National Center for Health Statistics
Centers for Disease Control and Prevention
3311 Toledo Road
Hyattsville, MD 20782-2064

Submitted electronically via email: nchsacd10cm@cdc.gov

RE: Proposal to Modify ICD-10-CM Coding for Diabetic Foot Ulcers

Dear Ms. McConnell-Lamprey:

The American Podiatric Medical Association (APMA) would like to take this opportunity to provide comments to the National Center for Health Statistics at the Centers for Disease Control and Prevention, regarding improvements to the ICD-10-CM coding system for diabetic foot ulcers (DFUs). APMA is the national organization representing the vast majority of the nation's estimated 15,000 DPMs, also known as podiatric physicians and surgeons.

This is in follow up to the presentation by Caroline Fife, MD, on behalf of the Wound Care Collaborative Community (WCCC) on September 15, 2026.

Separating DFU coding from the general category of non-pressure chronic ulcers is important because DFUs present distinct risks and documentation needs. Unlike other non-pressure chronic ulcers of the lower extremity, between 14 and 31% of DFUs lead to amputation, with risk varying by ulcer severity and location on the foot. Approximately 85% of patients with DFUs have more than one DFU at the same time, often in a similar anatomical area but usually of different severity. In addition, 40% of patients with DFUs develop a new foot ulcer while still receiving services for a previous DFU. Once a patient has had a DFU, the annual recurrence rate is 30%–60%.

APMA supports the development of a new, detailed ICD-10-CM code set for DFUs to address critical gaps in clinical documentation. The code set proposed by the WCCC would enable clinicians to describe wound depth, severity, and progression more specifically, including recurrence and remission status.

Below we highlight current gaps in coding that are specific for tracking DFUs:

1. The existing anatomic sites for the foot are inadequate to provide needed specificity to identify multiple wounds by anatomic site. For example:
 - a) Individual toes have different ramifications for amputation, developing new wounds on adjacent toes and altering ambulation.

- b) Heel and midfoot wounds currently are grouped together yet have very different prognosis. More specific codes would allow clinicians to differentiate between heel ulcers that occur from pressure (posterior heel) vs a true diabetic heel ulcer that resulted from repetitive trauma on a neuropathic foot. Furthermore, advanced heel ulcers often lead to above knee amputation whereas more distal ulcers may be able to be treated with a lesser amputation or surgical treatment that promotes independent ambulation.
- 2. Expansion of descriptions is needed to include adding qualifiers such as dorsal, plantar, medial and lateral to identify multiple wounds on the same anatomic site. Dorsal and plantar wounds in ambulatory patients with diabetic neuropathy heal quite differently and need to be separated out for tracking outcomes.
- 3. Anatomic specificity is critical in staging DFUs.
 - a) Exposure of bone or joint capsule cannot be described with the current coding system.
 - b) The metatarsal head of the foot does not have muscle and the bone may be exposed but not necrotic. This cannot be described with the current coding but is important for continuity of patient care and communication between providers.
- 4. Unlike ICD-10-CM codes for pressure ulcers or oncologic conditions, the current coding system requires two codes to identify the connection with diabetes and does not reflect severity, chronicity, multiplicity or discrete anatomical location of the ulcer. Therefore, it is difficult to perform database research to specifically identify DFUs.

New codes will empower clinicians to provide targeted treatment plans and monitor response to treatment more accurately. However, there is an important population health benefit in that tracking of specific sites that lead to amputation, infection and prolonged hospitalization will support better healthcare management with enhanced epidemiological data on diabetic complications from foot ulcers, ability to analyze trends in ulcer prevalence across different demographics and facilitate a better understanding of current and future treatment outcomes.

The presentation by Dr. Fife addressed many, but not all, of these concerns. APMA supports adoption of the proposed changes and recommends ongoing review and refinement of the resulting data to support research and accurately represent the morbidity and mortality associated with DFUs.

Thank you for the opportunity to provide comments. If you require additional assistance or need further information, please do not hesitate to contact Dominic Sawaya, JD, MPPA, Director of Health Policy and Practice (dsawaya@apma.org/301-581-9235).

Sincerely,



Patrick DeHeer, DPM
President