

Skin Failure Codes Position Paper

The Case for ICD-10-CM
Diagnostic Codes for Skin
Failure

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Post Acute Wound & Skin Integrity Council

PAWSIC Skin Failure Codes

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(PSFCPP)*

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ABSTRACT

Skin failure is an increasingly recognized clinical phenomenon in which the skin, as the body's largest organ, sustains injury because of systemic physiologic compromise—hypoperfusion, multi-organ dysfunction, critical illness, advanced frailty, or the dying process—rather than pressure and mechanical forces alone. Although clinical observation of this phenomenon spans more than a century and recognition has expanded across the wound care, critical care, geriatric, and palliative medicine communities, the International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) currently provides no dedicated diagnostic code to distinguish skin failure from other skin conditions, especially pressure injury.

This gap persists despite growing regulatory acknowledgment of the distinction, including the October 2023 guidance from the Centers for Medicare & Medicaid Services (CMS) stating that Skin Changes at Life's End (SCALE), Kennedy Terminal Ulcers (KTUs) and skin failure are not primarily caused by pressure and should not be documented as pressure injuries on the Minimum Data Set (MDS). In this position paper, the Post Acute Wound and Skin Integrity Council (PAWSIC) examines the evolution of the skin failure concept, its role in contemporary clinical practice, and the consequences of the diagnostic gap for patients, families, clinicians, researchers, and healthcare organizations.

Drawing on the organ-failure precedent—in which classification has historically preceded complete mechanistic understanding—PAWSIC supports the development of ICD-10-CM skin failure diagnostic codes that reflect contemporary clinical practice while allowing for continued refinement as evidence evolves. Accurate classification is presented not as the conclusion of scientific inquiry, but as the infrastructure upon which improved communication, patient-centered care, quality measurement, and research can develop.

Box 1.

PAWSIC POSITION STATEMENT ON SKIN FAILURE CODES & DEFINITION OF SKIN FAILURE

The Post Acute Wound and Skin Integrity Council (PAWSIC) recognizes skin failure as an increasingly identified clinical phenomenon associated with systemic physiologic compromise. The absence of dedicated diagnostic codes for skin failure within ICD-10-CM creates challenges for patient-centered care, documentation, communication, quality measurement, and research. PAWSIC supports the development of an ICD-10-CM skin failure code framework that reflects contemporary clinical practice while allowing for continued scientific refinement as evidence evolves.

“Skin failure is a state of impaired tissue tolerance associated with systemic physiological compromise in which the skin and/or underlying tissue cannot maintain viability despite appropriate preventive measures. Contributing mechanisms may include, but are not limited to, hypoperfusion, hypoxia, infarction, ischemia, inflammation, infection, impaired nutrient delivery, edema, vascular dysfunction, malignancy, medications, and local mechanical stressors/deformation.”

(PAWSIC, PSFPP, 2026)

Box 2.

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The authors, the SIG Co-Chairs & Reviewers, and the members of the PAWSIC Board of Directors declare that they have no financial conflicts of interest in relation to the subject matter of this paper. No author, SIG Co-Chair or Reviewer, or Board member holds a financial interest in, employment with, consultancy for, or advisory role to any organization with a commercial stake in the content or conclusions of this paper. No funder or external party had any role in the design, drafting, review, or approval of this work, or in the decision to publish.

Collaboration Statement

This position paper was developed, drafted, and approved independently by PAWSIC. PAWSIC values collaboration and is grateful for the support of national and global organizations that share its commitment to improving patient care. These organizations recognize that skin failure has long been acknowledged in clinical practice and described in the literature, yet it still has no corresponding diagnostic code. PAWSIC welcomes continued collaboration with these partners, and with others who share this goal, to develop coding guidelines and educational resources should the proposed ICD-10-CM codes be adopted. No supporting organization provided funding or in-kind support for this paper, and none had a role in its drafting, review, or approval, or in the decision to publish.

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Keywords: skin failure; ICD-10-CM; Kennedy Terminal Ulcer; Skin Changes at Life's End (SCALE); pressure injury; unavoidable skin breakdown; organ failure; end-of-life care; wound care classification; quality measurement.

Disclaimer: *The content of this position paper is intended solely for informational purposes and should not be interpreted as medical, clinical or coding advice. It is not a substitute for professional guidance, diagnosis, coding, or treatment. Participants are encouraged to consult with their physicians and other qualified healthcare providers for any coding guidance, medical concerns or questions related to patient care. Additionally, always seek the advice of a coding specialist to ensure proper coding practices. Any reliance on the information presented here is at your own discretion and risk.*

Box 3.

PAWSIC MISSION

Mission. We are a patient-centered, inter-professional team that serves the post-acute care community as the source and voice to guide in quality wound and skin prevention and management, through collaborative evidence-based education, practice, and advocacy.

Vision. To create a future where post-acute wound management is patient-centered, addressing not only the wound and skin but also the person's unique needs, preferences, and overall well-being.

The Post Acute Wound & Skin Integrity Council is a 501(c)(6) nonprofit education and advocacy organization dedicated to advancing patient-centered, interdisciplinary care and evidence-based practices for skin health and wound management. www.pawsic.org

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ABBREVIATIONS & INITIALISMS

AADA

American Academy of Dermatology Association

CMS

Centers for Medicare & Medicaid Services

ICD-10-CM

International Classification of Diseases, Tenth Revision, Clinical Modification

KTUs

Kennedy Terminal Ulcers

MDS

Minimum Data Set

PAWSIC

Post Acute Wound & Skin Integrity Council

SCALE

Skin Changes at Life's End

EXECUTIVE SUMMARY

Clinicians across healthcare settings have long encountered patients who develop skin breakdown in the setting of severe illness, physiologic decline, advanced frailty, and end-of-life transition. While the concept of skin failure continues to evolve, efforts to better characterize the condition have grown throughout the wound care community and across multiple healthcare disciplines. At the same time, existing healthcare classification systems provide limited mechanisms for consistently documenting, studying, and communicating about these complex clinical presentations.

The absence of dedicated skin failure diagnostic codes affects more than documentation. It influences conversations with patients and families, shapes expectations regarding treatment and healing, impacts quality measurement and reporting, and limits opportunities for research. Clinicians are increasingly asked to distinguish skin failure from pressure injury in practice, yet existing classification systems do not adequately support that distinction. As recognition of limitations within current diagnostic frameworks has expanded, the challenges created by this diagnostic gap have become increasingly apparent. Medical ethicist John LaPuma, MD, has addressed these challenges in his commentary on skin failure [Table 1].

The Post Acute Wound and Skin Integrity Council (PAWSIC) believes that healthcare has reached a point where the absence of skin failure diagnostic codes is creating problems for patients, caregivers, clinicians, researchers, and healthcare organizations. Although important questions remain regarding terminology, diagnosis, and pathophysiology, decades of clinical experience, scientific literature, and regulatory recognition suggests that skin failure is frequently observed in wound care and related disciplines.

PAWSIC further believes that accurate classification supports patient-centered care. The language used to describe skin breakdown influences how clinicians communicate with patients and caregivers, establish treatment goals, document clinical findings, and interpret outcomes. Improved diagnostic precision can help ensure that skin changes associated with systemic physiologic compromise are considered within the broader context of a patient's overall condition while continuing to support accountability for prevention and evidence-based wound care.

This position paper examines the evolution of the skin failure concept, its role in contemporary clinical practice, the challenges created by the current diagnostic gap, and the implications for patients, families, clinicians, researchers, healthcare organizations, and policymakers. It also outlines PAWSIC's position regarding the need for a diagnostic framework that reflects contemporary clinical practice while allowing for continued refinement as evidence evolves [Table 2].

Ultimately, this discussion is about more than classification. It is about improving understanding, communication, research, and patient care. As healthcare systems work to better understand and classify patterns of skin breakdown associated with systemic physiologic compromise, healthcare systems should have the ability to accurately describe, study, and communicate a condition that is increasingly encountered across care settings. Clinicians have long observed patterns of skin breakdown that cannot be fully explained within traditional pressure injury frameworks. More recent scientific investigation and regulatory developments have highlighted the limitations of existing diagnostic and classification systems in describing these clinical presentations.

BACKGROUND

PAWSIC was called to this question of skin failure codes by the October 1, 2023, release by CMS of the Resident Assessment Instrument (RAI) User's Manual, which states that "Skin Changes at Life's End (SCALE), Kennedy Terminal Ulcers (KTUs), and skin failure are not coded in Section M because they are not primarily caused by pressure." For PAWSIC, this guidance brought increased attention to an important challenge: while CMS had acknowledged skin failure as distinct from pressure injury for MDS coding purposes, no corresponding ICD-10-CM diagnostic code existed to document that distinction. PAWSIC decided to address the absence of skin failure codes because of its importance to patients, caregivers, clinicians, researchers, and healthcare organizations. [Table 1 & Figure 1]

Section 1. EVOLUTION OF SKIN FAILURE

1A. Origins of the skin failure concept

For decades, wound care clinicians have observed forms of skin breakdown that do not fit within traditional pressure injury frameworks. Some patients developed tissue breakdown despite attentive care and appropriate preventive interventions, particularly during periods of severe illness, physiologic decline, or the dying process. These observations prompted an important question that continues to influence wound care practice today: are all forms of skin breakdown the result of pressure and mechanical forces, or are some manifestations of broader systemic dysfunction? [Charcot 1877] [Kennedy 1989] [La Puma 1991]

Although the terminology has evolved over time, the underlying clinical observation is not new. Historical descriptions of unavoidable skin breakdown can be traced back more than a century, while contemporary recognition grew through observations of Kennedy Terminal Ulcers (KTUs) and other skin changes occurring near the end of life. [Charcot 1877] [Kennedy 1989] [Langemo & Brown 2006] [Levine 2005] [SCALE 2008] [SCALE 2010] [Trombley et al. 2012]. These experiences challenged the assumption that all skin breakdown should be viewed through the lens of preventability and prompted clinicians to consider the role of systemic illness, organ dysfunction, and the physiologic processes associated with dying. [La Puma 1991] [Witkowski & Parish 1993]

1B. Expansion beyond end-of-life skin changes

As clinicians gained experience caring for medically complex patients, the conversation surrounding skin failure expanded beyond end-of-life care. Increasingly, clinicians described similar patterns of skin breakdown in patients experiencing sepsis, shock, multiorgan dysfunction, vasopressor dependence, and other forms of severe physiologic compromise. [Langemo & Brown 2006] [Delmore et al. 2015] [Dagleish et al. 2020] [Levine et al. 2022]

This shift marked an important evolution in thinking. Skin failure was no longer discussed solely as a phenomenon associated with dying, but as a broader clinical concept linked to systemic illness and declining physiologic reserve. During this period, influential work from Langemo and Brown helped establish a framework describing acute, chronic, and end-stage skin failure, while the Skin Changes at Life's End (SCALE) consensus statements provided additional recognition that some forms of skin breakdown may occur despite appropriate care. [Langemo & Brown 2006] [SCALE 2008] [SCALE 2010] [Trombley et al. 2012]

As a result, many clinicians began viewing skin integrity within the larger context of overall physiologic function. Like other organs, the skin depends on adequate blood flow, oxygen delivery, and nutritional support to maintain normal function. This perspective helped lay the foundation for the organ failure framework that continues to shape contemporary discussions of skin failure. [Langemo & Brown 2006] [Levine et al. 2022]

1C. Current state of the science

Today, skin failure remains an evolving clinical concept. Scientific efforts have grown substantially throughout the wound care, long-term care, critical care, palliative care, and geriatric medicine communities. At the same time, important questions remain regarding terminology, diagnostic criteria, pathophysiology, and clinical presentation. [Dalglish et al. 2021] [Levine et al. 2022] [Cross 2023]

Recent years have seen increasing scholarly and professional engagement with the topic. Researchers have explored potential risk factors, predictive models, assessment tools, and physiologic mechanisms associated with skin failure. [Hill & Peterson 2020] [Hill & Peterson 2025] [Latimer et al. 2023] [Latimer et al. 2025] [Sun et al. 2025a] Professional organizations have also contributed to the discussion. The National Pressure Injury Advisory Panel (NPIAP) Skin Failure Think Tank brought together thirteen multidisciplinary experts to examine the concept and identify priorities for future research. [Black et al. 2025]

Importantly, continued discussion and debate should not be interpreted as evidence that the skin failure concept lacks clinical reality. Rather, they reflect a field that is actively working to improve understanding of a complex condition. Similar scientific evolution has occurred throughout medicine as clinicians and researchers have sought to better define, classify, and study emerging clinical phenomena. [Ayello et al. 2019] [Mody et al. 2025] [Olshansky 2016]

1D. Why the discussion matters today

Several developments have highlighted limitations in existing diagnostic and classification frameworks. Patients are living longer with multiple chronic illnesses. Advances in medicine have increased survival among critically ill individuals. Healthcare systems place greater emphasis on documentation, quality measurement, public reporting, and evidence-based care than ever before. At the same time, clinicians continue to encounter patients whose skin changes do not fit neatly within existing diagnostic frameworks.

As recognition of skin failure has grown, the conversation has expanded beyond questions of terminology and definition. Clinicians are attempting to document and communicate complex clinical situations. Researchers are working to better understand the condition. Patients and families are seeking explanations for skin breakdown that occurs despite attentive care. Regulatory agencies have begun acknowledging distinctions between skin failure and pressure injury. [CMS RAI Manual 2023]

Increasingly, the discussion has shifted from whether skin failure is recognized to how skin failure is consistently recognized, defined, documented, and classified. The challenge is how healthcare systems should recognize, document, study, and communicate a condition that has long been encountered across care settings but is not adequately represented within current classification systems. [Table 1, LaPuma Commentary] It is within this context that PAWSIC has undertaken the present position paper.

Box 4.

PAWSIC POSITION STATEMENT ON SKIN FAILURE CODES

The Post Acute Wound and Skin Integrity Council (PAWSIC) recognizes skin failure as a distinct clinical phenomenon associated with systemic physiologic compromise. The absence of dedicated diagnostic codes for skin failure within ICD-10-CM creates challenges for patient-centered care, documentation, communication, quality measurement, and research. PAWSIC supports the development of an ICD-10-CM skin failure code framework that reflects contemporary clinical practice while allowing for continued scientific refinement as evidence evolves.

Section 2. SKIN FAILURE IN CLINICAL PRACTICE

2A. Clinical presentation and recognition

Although definitions and diagnostic criteria continue to evolve, clinicians across care settings seek to characterize skin failure as a distinct clinical phenomenon associated with severe illness and physiologic decline. Discussions surrounding skin failure most commonly occur in patients experiencing conditions such as sepsis, shock, multiorgan dysfunction, vasopressor dependence, advanced frailty, and end-of-life decline. In these situations, skin changes can develop within the context of broader systemic deterioration rather than as isolated or detached events.

For wound care clinicians, skin failure is often recognized not by a single defining characteristic, but by the clinical context or circumstances in which skin breakdown occurs. Patients may experience rapid changes in skin integrity during periods of worsening illness despite comprehensive prevention efforts, including pressure redistribution, repositioning, nutritional support, and ongoing skin assessment. These observations have led clinicians to consider whether factors beyond local pressure and mechanical forces may contribute to tissue breakdown in selected patients.

2B. Clinical observations

Over time, clinicians have described recurring patterns associated with skin failure. Tissue breakdown may develop in patients experiencing severe illness, worsening organ dysfunction, hemodynamic instability, or end-of-life decline, despite appropriate prevention efforts and attentive wound care.

These observations have prompted ongoing discussion regarding the relationship between systemic physiologic compromise and skin integrity. While pressure, shear, moisture, and other external factors remain important considerations, clinicians increasingly characterize situations in which local factors alone do not appear to fully explain the skin changes being observed.

The continued discussion surrounding skin failure reflects efforts to better understand these complex clinical presentations and improve the care of patients experiencing severe illness and physiologic decline.

2C. Documentation and clinical communication

As recognition of skin failure has increased, so too has the importance of clear documentation and communication. Clinicians documenting skin failure often consider not only the wound itself, but also the broader physiologic circumstances surrounding its development. Factors such as hemodynamic instability, vasopressor dependence, multiorgan dysfunction, advanced frailty, and end-of-life decline provide important context for understanding changes in skin integrity. [Table 1, PAWSIC Skin Failure Assessment Guide]

Documentation serves several purposes. It supports communication among members of the healthcare team, helps guide treatment planning, and provides context for discussions with patients and families. In situations where skin failure is suspected, clinicians should document why systemic physiologic compromise may be contributing to tissue breakdown rather than relying solely on descriptions of wound appearance.

2D. Challenges in clinical practice

Despite decades of clinical recognition of skin failure, important challenges remain. There is no universally accepted diagnostic standard, and clinicians may differ in how they interpret specific clinical presentations. Distinguishing skin failure from pressure injury can be particularly difficult when multiple contributing factors are present simultaneously.

These challenges are not unique to skin failure. Many clinical concepts evolve over time as understanding improves and diagnostic frameworks are refined. However, the absence of a dedicated diagnostic code adds another layer of complexity. Clinicians are often left trying to document and communicate a condition that is increasingly recognized in practice but not represented by existing classification systems. PAWSIC proposes a resolution to these challenges. We have come to a point on our journey, to draw a line in the sand.

Skin failure is both a clinical reality and an evolving area of study. Continued research and discussion is important for improving understanding, supporting diagnostic consistency, and guiding future advances in patient care.

Section 3. REGULATORY RECOGNITION AND CURRENT CLASSIFICATION GAPS

3A. Regulatory recognition of skin failure

Over the past several decades, clinical observations of skin failure have increasingly been reflected in the scientific literature, professional education, and regulatory guidance. As clinicians have increasingly recognized skin changes associated with severe illness, end-of-life decline, and systemic physiologic compromise, regulatory frameworks have also begun to acknowledge distinctions between skin failure and pressure injury.

A notable example occurred in October 2023, when the Centers for Medicare & Medicaid Services (CMS) revised the MDS 3.0 Resident Assessment Instrument (RAI) User's Manual to state that Skin Changes at Life's End (SCALE), Kennedy Terminal Ulcers (KTUs), and skin failure are not primarily caused by pressure and should not be coded within Section M as pressure injuries. This guidance represented an important acknowledgement that some forms of skin breakdown may differ from traditionally understood pressure injuries in both etiology and clinical context.

For many clinicians, this recognition reflected observations that have been occurring at the bedside for years. However, while regulatory recognition has evolved, classification systems have not kept pace.

3B. The regulatory and classification paradox

As regulatory guidance has evolved, an important disconnect has become increasingly apparent for clinicians, healthcare organizations, and researchers. Although CMS guidance acknowledges skin failure as distinct from pressure injury, ICD-10-CM currently provides no dedicated diagnostic code to document that distinction.

As a result, clinicians may find themselves in a difficult position. They are increasingly asked to recognize and document skin failure in clinical practice, yet they lack a corresponding diagnostic mechanism within the current primary classification system. In effect, healthcare systems have begun to acknowledge the phenomenon while continuing to rely on an inadequate classification system to support it.

This disconnect creates a regulatory and documentation paradox. Clinicians are encouraged to distinguish skin failure from pressure injury, but they have no options for capturing that distinction within structured healthcare data.

3C. Current documentation and coding limitations

In the absence of dedicated diagnostic codes, clinicians generally rely on one of several approaches when documenting skin failure. Some wounds may be classified as pressure injuries despite important differences in clinical context and suspected etiology. Others may be assigned nonspecific dermatologic diagnoses that provide little insight into the underlying physiologic processes contributing to tissue breakdown. In many cases, clinicians rely heavily on narrative documentation to explain what cannot be adequately captured through existing coding systems.

Each of these approaches has limitations. Pressure injury codes do not address the role of systemic physiologic compromise. Nonspecific diagnoses may obscure important clinical information. Narrative documentation, while valuable, cannot easily be extracted for quality reporting, research, or population-level analysis.

For wound care clinicians, the challenge is not simply one of documentation. It is the challenge of finding language that accurately reflects what is being observed at the bedside while remaining consistent with existing classification systems.

3D. Consequences of regulatory misalignment

When clinical practice, regulatory guidance, and classification systems are not aligned, the effects extend beyond documentation alone. Diagnostic uncertainty can influence communication among clinicians, create challenges for quality measurement, complicate research efforts, and limit the usefulness of healthcare data.

The absence of dedicated skin failure diagnostic codes does not eliminate the condition from practice; it simply limits the ability of healthcare systems to consistently identify, measure, and study it. As regulatory recognition and scientific understanding continue to evolve, the limitations of the current classification framework become increasingly apparent.

In this sense, the absence of skin failure diagnostic codes is not neutral. It contributes to ongoing diagnostic ambiguity and highlights the need for greater alignment between clinical reality and healthcare classification systems.

For wound care clinicians, the challenges created by the current classification gap extend well beyond issues of coding. They are encountered during conversations with patients and families, in decisions regarding treatment goals, in efforts to measure quality, and in attempts to better understand complex patterns of skin breakdown. Examining these consequences helps illustrate why the absence of skin failure diagnostic codes affects far more than administrative reporting.

Box 5.

The absence of skin failure codes is not neutral. It contributes to ongoing diagnostic ambiguity and highlights the need for greater alignment between clinical reality and healthcare classification systems.

Section 4. CONSEQUENCES OF THE DIAGNOSTIC GAP

4A. Implications for patients and residents

For patients and residents, the impact of the diagnostic gap is often most evident at the bedside. Skin breakdown can be painful, distressing, and emotionally significant, particularly when it develops during a period of serious illness or physiologic decline. Changes in skin integrity are often among the most visible signs that a patient's condition is worsening, making the language used to describe these changes especially important.

The words clinicians use help shape how patients understand their condition and what they can realistically expect from treatment. When skin failure is documented and managed as a pressure injury, the broader physiologic factors contributing to tissue breakdown may not be fully recognized. As a result, patients and families may assume that healing

should occur if the appropriate interventions are applied, even when severe illness limits the body's ability to repair damaged tissue.

This distinction becomes particularly important for patients experiencing advanced frailty, multiorgan dysfunction, hemodynamic instability, or end-of-life decline. In these situations, complete wound closure may no longer be a realistic or appropriate goal. Instead, care may focus on managing symptoms, maintaining comfort, preserving dignity, and supporting the best possible quality of life. Recognizing skin failure within the context of a patient's overall condition can help clinicians establish treatment goals that are more closely aligned with clinical realities and patient preferences.

Importantly, acknowledging skin failure does not lessen the importance of prevention or quality wound care. Patients experiencing skin failure continue to benefit from comprehensive skin assessment, pressure redistribution, nutritional support, symptom management, and ongoing clinical evaluation. Rather, recognition of skin failure provides a framework for understanding why tissue breakdown may occur despite appropriate preventive efforts in selected patients and supports care that remains centered on the needs of the individual patient or resident.

4B. Implications for families and caregivers

Families and caregivers often experience skin breakdown differently than clinicians. While healthcare professionals may view changes in skin integrity within the broader context of serious illness and physiologic decline, family members frequently see a wound first. Skin changes are visible, tangible, and often difficult to reconcile with the care being provided.

When tissue breakdown develops despite attentive care and evidence-based prevention efforts, families naturally search for explanations. In the absence of language that reflects the role of systemic illness, skin breakdown may be interpreted as preventable harm or inadequate care. Questions about why a wound developed, whether it could have been prevented, and what it means for the patient's future can become difficult to answer when the available diagnostic terminology does not fully capture the clinical situation.

These conversations are particularly challenging when skin changes occur in patients experiencing severe illness, advanced frailty, or end-of-life decline. Families often struggle to understand how wounds can develop despite repositioning, pressure redistribution, nutritional support, and other preventive measures. Providing clear explanations requires clinicians to discuss not only the wound itself, but also the broader physiologic changes occurring throughout the body.

Greater diagnostic clarity may help support these conversations. Recognizing skin failure as a distinct clinical phenomenon provides language that more accurately reflects the role of systemic illness in skin breakdown and may help families better understand what is happening to their loved one. While no diagnosis can eliminate the emotional impact of these changes, clearer communication can support shared understanding and more informed decision-making during difficult times.

4C. Implications for patients and residents

Clinicians are increasingly required to assess skin changes that occur in the setting of severe illness, physiologic instability, and end-of-life decline. While many wounds fit within established diagnostic frameworks, others present more complex challenges. Patients may develop tissue breakdown despite comprehensive prevention efforts, leaving clinicians to reconcile what they are observing at the bedside with the limitations of existing diagnostic terminology.

In the absence of dedicated skin failure diagnostic codes, clinicians often rely on pressure injury codes, nonspecific dermatologic diagnoses, or narrative documentation to describe complex clinical situations. None of these approaches fully captures the role that systemic physiologic compromise may play in tissue breakdown. As a result, diagnostic uncertainty can complicate documentation, interdisciplinary communication, and discussions regarding treatment goals and prognosis.

Recognizing skin failure does not diminish accountability for prevention or high-quality wound care. Rather, it provides clinicians with language that may better reflect the clinical realities of selected patients whose skin changes occur within the context of severe illness and systemic decline.

4D. Implications for healthcare organizations and health systems

Healthcare organizations invest substantial resources in skin integrity programs, pressure injury prevention initiatives, staff education, and quality improvement efforts. As a result, how wounds are classified has implications that extend beyond individual patient encounters.

Pressure injury rates are widely used to evaluate performance, guide quality improvement activities, and support public reporting and regulatory oversight. Organizations that care for medically-complex, critically ill, or end-of-life populations may encounter skin failure more frequently than lower-acuity settings. When skin failure is documented as a pressure injury, quality metrics will not fully reflect the clinical realities of the patients being served.

Accurate classification supports more meaningful quality measurement by helping healthcare organizations better understand patient outcomes and evaluate prevention efforts within the appropriate clinical context.

4E. Implications for research and scientific advancement

The wound care community has made significant progress in understanding skin failure, yet many important questions remain unanswered. Researchers continue to explore issues related to risk factors, clinical presentation, outcomes, and epidemiology.

One of the greatest challenges for researchers is the inability to consistently identify patients with skin failure within large healthcare datasets. Without dedicated diagnostic codes, researchers must rely on chart reviews, case studies, and other methods that limit the ability to study the condition at scale.

As a result, scientific understanding continues to evolve more slowly than it otherwise might. Improved classification has the potential to support future research efforts and generate the evidence needed to advance clinical practice.

4F. Implications for healthcare data integrity

Healthcare data play an important role in quality improvement, research, resource allocation, and policy development. The usefulness of those data depends on the accuracy of the classifications used to generate them.

When skin failure and pressure injuries are captured within the same diagnostic categories, it becomes more difficult to understand the true prevalence and impact of each condition. This can complicate benchmarking efforts, quality reporting, and interpretation of healthcare trends.

Accurate classification supports accurate measurement. As recognition of skin failure continues to grow, ensuring that healthcare data reflect clinical reality becomes increasingly important for clinicians, researchers, healthcare organizations, and policymakers alike.

Section 5. SKIN FAILURE AS AN ORGAN FAILURE SYNDROME

5A. The skin as an organ

When people think about organs, they typically name the heart, lungs, kidneys, or liver, and the skin is not always included in that discussion despite being the body's largest organ. Yet the skin performs many of the same essential functions that make other organs vital to health and survival. It serves as the body's first line of defense against injury and infection, helps regulate body temperature, maintains fluid balance, provides sensation, and supports healing when injury occurs. Healthy skin protects the body from the external environment while helping maintain physiologic stability within it; when these functions begin to falter, the consequences can mirror the seriousness associated with failure of other organ systems.

For wound care clinicians, the importance of these functions is evident every day. When skin integrity is compromised, patients may experience pain, infection, fluid loss, reduced mobility, delayed healing, and a decline in overall quality of life. In many cases, changes in the skin can also provide important clues about what is happening elsewhere in the body.

Despite its recognized role as an organ, the skin has traditionally been viewed differently from other organ systems when discussing failure or dysfunction. Conditions affecting the heart, lungs, kidneys, and liver are routinely described using organ failure terminology when those organs can no longer function normally. The skin, however, has historically lacked a similar framework, even though it depends on many of the same physiologic processes that support the function of other organs.

As clinicians have gained experience caring for patients with severe illness, advanced frailty, and end-of-life decline, questions have emerged regarding whether certain forms of skin breakdown may reflect more than a local wound. Increasingly, attention has turned to the probability that some skin changes represent a manifestation of broader systemic dysfunction occurring throughout the body.

5B. Organs fail

The concept of organ failure is familiar throughout healthcare. Heart failure occurs when the heart can no longer meet the body's demands. Kidney failure develops when the kidneys can no longer adequately filter waste and maintain fluid balance. Similar concepts exist for the lungs, liver, and other organ systems.

While the causes of these conditions vary, they share a common feature: the organ is no longer able to perform its normal functions because the body is under stress that exceeds its ability to compensate.

The skin is no different. Like every other organ, it depends on an adequate supply of blood, oxygen, and nutrients to remain healthy and function properly. When the body experiences severe illness, shock, multiorgan dysfunction, or other forms of physiologic stress, resources may be redirected to support critical organs needed for immediate survival. As a result, the skin may become increasingly vulnerable to injury and breakdown.

Wound care clinicians have long observed skin changes that occur in patients experiencing profound illness. In some cases, tissue breakdown develops despite appropriate prevention efforts, including pressure redistribution, repositioning, nutritional support, and attentive skin care. These observations have contributed to growing discussion regarding whether some forms of skin breakdown are better understood as manifestations of systemic physiologic decline rather than solely the result of local pressure or mechanical forces.

Viewing skin failure through the lens of organ failure does not answer every question about the condition, nor does it eliminate the need for continued research. It does, however, provide a practical framework for understanding why skin breakdown may occur in certain patients despite appropriate care. It also offers a way to connect what clinicians observe at the bedside with the broader physiologic changes occurring throughout the body.

5C. A physiologic framework for skin failure

As clinicians gained experience caring for patients with severe illness, a recurring observation began to emerge. Some patients developed rapid skin changes and tissue breakdown during periods of profound physiologic decline, even when appropriate prevention measures were in place. These observations prompted questions about whether skin breakdowns could be explained solely by pressure and mechanical forces, or whether broader systemic processes might also contribute.

Like every organ, the skin depends on an adequate supply of blood, oxygen, and nutrients to remain healthy and function properly. During conditions such as sepsis, shock, multiorgan dysfunction, or end-of-life decline, the body's ability to maintain normal physiologic function may become compromised. Under these circumstances, the skin may become increasingly vulnerable to injury and breakdown.

This understanding has led many clinicians and researchers to view skin failure as a manifestation of systemic physiologic compromise rather than simply a localized wound. While pressure, shear, moisture, and other external factors remain important considerations, they do not fully explain the tissue breakdown observed in some critically ill patients. Viewing skin failure through a physiologic lens helps connect what clinicians observe at the bedside with the broader systemic changes occurring throughout the body.

5D. Organ failure precedent and ICD-10 classification

The concept of organ failure is well established throughout healthcare. Heart failure, respiratory failure, kidney failure, and liver failure are recognized diagnoses that help clinicians describe serious physiologic dysfunction, communicate patient status, guide treatment decisions, and support research. Importantly, these classifications were developed to capture clinically significant patterns of organ dysfunction even before their biology was completely delineated.

Historically, healthcare classification systems have evolved alongside scientific knowledge. Broad diagnostic categories were often established first, allowing clinicians and researchers to identify affected populations, study disease patterns, and refine understanding over time. As evidence accumulated, these categories became increasingly sophisticated through the development of subtypes, staging systems, and more precise diagnostic criteria.

The history of organ failure classification demonstrates an important principle: recognition and classification often precede complete mechanistic understanding. Scientific uncertainty has not historically prevented healthcare systems from establishing diagnostic frameworks when doing so supports clinical communication, patient care, quality measurement, and research.

This precedent is relevant to the discussion of skin failure. While important questions regarding pathophysiology, diagnostic criteria, and clinical presentation remain, these questions are not unique among conditions recognized within healthcare classification systems; rather, they reflect the natural evolution of clinical understanding.

Viewed in this context, the discussion surrounding skin failure is not simply about coding. It is about whether healthcare systems have an appropriate way to describe, study, and communicate a clinical phenomenon that is increasingly recognized in practice.

5E. Implications of an organ failure framework

Viewing skin failure through an organ failure framework has implications that extend beyond terminology. Most importantly, it encourages clinicians to consider skin breakdown within the broader context of a patient's overall health rather than focusing exclusively on the wound itself. For patients experiencing severe illness, advanced frailty, multiorgan dysfunction, or end-of-life decline, changes in skin integrity may represent one manifestation of a larger physiologic process affecting multiple organ systems.

This perspective would also support more meaningful communication. By acknowledging the role of systemic illness, clinicians may be better equipped to discuss skin changes with patients, families, and caregivers while placing wound development within the context of the patient's overall condition, prognosis, and goals of care.

An organ failure framework would also contribute to greater diagnostic precision. Documentation that reflects both the wound and the physiologic circumstances surrounding its development can provide a more complete representation of the patient's condition and support clearer communication across disciplines.

Importantly, recognizing skin failure within an organ failure framework does not diminish accountability for prevention or quality wound care. Rather, it acknowledges that in selected patients, tissue breakdown may occur despite appropriate preventive efforts because of factors that extend beyond local mechanical forces alone.

Perhaps most importantly, the framework provides a foundation for continued scientific inquiry. Like other organ failure syndromes, understanding of skin failure will continue to evolve over time. Classification systems historically evolve in response to recurring clinical observations that can no longer be adequately represented within existing diagnostic frameworks. The framework itself is not the final answer; rather, it offers a way to better understand, communicate about, and study a clinical phenomenon that is increasingly recognized in practice.

Section 6. IMPORTANCE OF CLASSIFICATION FOR RESEARCH AND QUALITY MEASUREMENT

6A. Scientific advancement and research

The skin failure conversation has advanced considerably over the past several decades, yet many important questions remain unanswered. Clinicians have long observed skin failure in practice, but researchers still face significant challenges when attempting to study it.

One of the greatest barriers is the inability to reliably identify affected patients. Without dedicated diagnostic codes, cases of skin failure cannot be easily located within large healthcare databases or research datasets. As a result, much of the existing literature relies on retrospective chart reviews, case studies, expert opinion, and observations from individual institutions.

This limitation affects more than research methodology. It restricts opportunities to validate diagnostic criteria, identify risk factors, evaluate outcomes, and better understand the relationship between systemic illness and skin breakdown. Scientific progress depends on the ability to consistently identify and study a condition. Without a mechanism to do so, the pace of advancement is inevitably slowed.

6B. Epidemiologic understanding

Many of the most basic questions about skin failure remain difficult to answer. How common is it? Which patients are most likely to experience it? How does it vary across care settings and patient populations?

At present, estimates of skin failure prevalence are largely derived from retrospective studies and clinical observations rather than population-level data. While these studies suggest that skin failure affects a meaningful number of patients experiencing severe illness, advanced frailty, or end-of-life decline, the true scope of the condition remains uncertain.

Diagnostic classification provides the foundation for epidemiologic research. It allows researchers to identify patient populations, track trends over time, compare outcomes across settings, and evaluate factors associated with disease development. In the case of skin failure, dedicated diagnostic codes could help generate the data needed to better understand the condition and inform future clinical practice.

6C. Quality measurement

Skin integrity outcomes are widely used as indicators of quality and patient safety across healthcare settings. Pressure injury rates, in particular, influence quality improvement initiatives, benchmarking efforts, public reporting programs, and value-based purchasing models.

The effectiveness of these measures depends on the accuracy of the underlying classifications. When skin failure is documented using pressure injury codes, quality metrics may not fully reflect the clinical realities of patients experiencing severe physiologic compromise. This can be especially challenging in settings that care for medically complex, critically ill, or end-of-life populations.

Accurate classification supports more meaningful quality measurement by helping ensure that healthcare outcomes are evaluated within the appropriate clinical context. For clinicians, healthcare organizations, and regulators alike, reliable measurement begins with reliable classification.

6D. Data integrity

Healthcare decisions increasingly rely on data. Clinicians use data to evaluate outcomes and improve care. Researchers use data to generate evidence. Healthcare leaders use data to allocate resources and guide decision-making.

When classification systems do not adequately distinguish between different clinical phenomena, the resulting datasets become more difficult to interpret. Cases of skin failure may be incorporated into pressure injury statistics, making it challenging to understand the true prevalence and impact of each condition. Over time, this may contribute to distorted reporting, inaccurate benchmarking, and uncertainty regarding healthcare trends.

Accurate classification supports accurate data. As recognition of skin failure continues to evolve, ensuring that healthcare data reflect clinical reality becomes increasingly important.

6E. Skin failure diagnostic codes as infrastructure

Classification is not an end point; it is infrastructure. Diagnostic codes provide a common language that supports clinical communication, research, quality measurement, and healthcare planning. They create the foundation upon which knowledge can be built and refined.

The history of medicine demonstrates that classification often precedes complete understanding. Heart failure, kidney failure, respiratory failure, and other clinical syndromes continued to evolve long after they were incorporated into healthcare classification systems. Recognition enabled study, and study led to greater refinement.

The same principle applies to skin failure. Dedicated diagnostic codes would not resolve every question surrounding the condition. Rather, they would provide the infrastructure necessary to better understand it. In this sense, skin failure diagnostic codes should be viewed not as the conclusion of scientific inquiry, but as a prerequisite for its continued advancement.

The core of our argument is that classification has always preceded complete understanding but never preceded a working definition. Every major organ failure syndrome received classification before its pathophysiology was fully understood. The field is ready to take the same definitional step to skin failure as it did to acute kidney injury (AKI), acute respiratory distress syndrome (ARDS), and sepsis each took before their codes were created.

AKI is the most compelling analogy because it underwent a transformation remarkably similar to what skin failure is experiencing now. Before 2004, "acute renal failure" had no standardized definition — over 35 different definitions existed in the literature, producing wildly variable prevalence estimates (1–25%) and mortality rates (15–60%). The field resolved this not by waiting for complete mechanistic understanding, but by convening the Acute Dialysis Quality Initiative (ADQI), an international, interdisciplinary expert group which produced the RIFLE (Risk, Injury, Failure, Loss, and End-Stage) criteria in 2004. These criteria were deliberately simple: they used two readily available clinical parameters (serum creatinine changes and urine output) to create a staged classification system.

RIFLE criteria did not require novel biomarkers, advanced imaging, or complete pathophysiologic understanding. They used existing, routinely collected clinical data to create a reproducible framework. The KDIGO (Kidney Disease Improving Global Outcomes) guidelines later noted that through use of these standard criteria, "estimates of incidence and prevalence of AKI, and comparisons of outcomes across centres are now possible." The same argument applies directly to skin failure, routinely available clinical data (hemodynamic parameters, vasopressor use, organ dysfunction scores, documented prevention measures) could form the basis of provisional criteria.

ARDS had a prolonged timeline before its definition was normalized. It was first described in 1967, but 27 years elapsed before the first consensus definition (AECC, 1994), and another 18 years before the Berlin definition (2012) refined it further. A new global definition was proposed in 2024 to expand applicability to resource-limited settings and incorporate pulse oximetry and ultrasound. This ongoing evolution, four major definitional iterations over 57 years, demonstrates that classification systems are expected to be revised and refined.

The Berlin definition succeeded specifically because it combined consensus discussion with empirical evaluation. The ARDS Definition Task Force drafted criteria, then tested them against patient-level meta-analysis of 4,188 patients from four multicenter datasets. Ancillary variables that did not improve predictive validity were removed. The result had better predictive validity for mortality than the prior AECC definition (AUC 0.577 vs. 0.536).

Box 6.

Skin failure diagnostic codes are not the culmination of research on the condition; they are the foundation for population-level research.

Classification systems do not represent the conclusion of scientific inquiry; they provide the foundation upon which scientific inquiry advances. The history of other organ failure syndromes demonstrates that classification often precedes complete mechanistic understanding. In this context, skin failure diagnostic codes are not an endpoint, but an infrastructure that supports future population-level research, quality measurement, clinical communication, and ongoing refinement of knowledge.

Section 7. ADDRESSING AREAS OF CONCERN AND ONGOING DEBATE

The discussion surrounding skin failure continues to evolve, and reasonable questions remain regarding diagnosis, classification, and implementation. PAWSIC recognizes these concerns and believes they warrant thoughtful consideration. At the same time, ongoing debate should not prevent continued progress toward improved clinical communication, research, and classification.

7A. Skin failure remains an evolving clinical construct

Like many conditions recognized throughout healthcare, skin failure continues to be studied and refined. Definitions, diagnostic criteria, and clinical frameworks will evolve as new evidence emerges. Continued scientific uncertainty should be viewed as an opportunity for further research rather than a barrier to recognition.

7B. Diagnostic reliability and clinical consistency

Questions regarding diagnostic consistency are common whenever emerging clinical concepts are discussed. While additional research is needed, clinicians routinely diagnose complex conditions that rely on clinical judgment, supporting evidence, and patient context. Continued refinement of diagnostic criteria may improve consistency over time, but the need for refinement should not preclude classification.

7C. Accountability and prevention remain essential

Recognition of skin failure does not diminish the importance of prevention, assessment, documentation, or high-quality wound care. Patients at risk for skin breakdown continue to require comprehensive preventive interventions and ongoing clinical evaluation. Diagnostic precision and accountability are complementary goals, both of which are strengthened by accurate documentation and communication.

7D. Distinguishing skin failure from unavoidable pressure injury

Skin failure and unavoidable pressure injury are often discussed together because both may occur despite appropriate preventive efforts. However, they represent different clinical concepts. Continued discussion of their intersection is appropriate, but areas of overlap should not prevent efforts to better define and classify skin failure.

7E. Future refinement should be expected

Healthcare classification systems routinely evolve as scientific understanding advances. Any future skin failure diagnostic framework should be viewed as a foundation for ongoing refinement, not as an endpoint. Ongoing research will remain essential to improving understanding of the condition and informing future revisions.

While important questions regarding skin failure continue to be explored, ongoing scientific debate should not be viewed as a barrier to thoughtful classification. Rather, it highlights the need for a framework that can evolve alongside emerging evidence and growing clinical experience.

Section 8. FRAMEWORK FOR ICD-10-CM SKIN FAILURE DIAGNOSTIC CODES

As limitations within existing diagnostic and classification frameworks have become increasingly apparent, the conversation has expanded beyond whether the condition exists to how it should be documented, communicated, studied, and measured across healthcare settings. From PAWSIC's perspective, the goal of a skin failure diagnostic code is not simply to add another entry to a classification system. Rather, it is to provide clinicians, patients, caregivers, researchers, and healthcare organizations with a common language for describing a condition that is increasingly recognized in practice.

8A. Reflecting clinical reality

Any future skin failure diagnostic code should reflect what clinicians are already seeing at the bedside. Wound care professionals routinely encounter skin breakdown occurring in the setting of severe illness, multiorgan dysfunction, advanced frailty, and end-of-life decline. A diagnostic framework should help clinicians document these situations in a way that more accurately reflects the broader clinical picture while supporting communication among members of the healthcare team.

8B. Supporting patient care, quality measurement, and research

The value of classification extends well beyond documentation. The words used to describe a condition influence conversations with patients and families, shape treatment goals, and contribute to quality measurement and research efforts. Before a condition can be measured, studied, or reported accurately, it must first be identified consistently.

A skin failure diagnostic code would provide a mechanism for identifying affected patients across healthcare settings, creating opportunities to better understand the condition through research while supporting more meaningful interpretation of quality metrics and healthcare data.

8C. Allowing for continued growth and refinement

Like many emerging clinical concepts, our understanding of skin failure continues to evolve. Future research will likely refine definitions, improve diagnostic consistency, and expand knowledge regarding risk factors, clinical presentation, and outcomes. Any skin failure diagnostic framework should be flexible enough to evolve alongside this growing evidence base.

The history of other organ failure syndromes demonstrates that classification often serves as a starting point rather than an endpoint. Recognition enables study, and study leads to greater understanding. Skin failure should be viewed through the same lens.

PAWSIC believes that an effective skin failure diagnostic framework should support patient care, clinical communication, quality measurement, and scientific inquiry while remaining adaptable as evidence evolves. The proposed ICD-10-CM skin failure diagnostic codes represent an important step toward achieving these goals and improving the ability of healthcare systems to accurately reflect the realities of clinical practice. [Table 2]

Section 9. PAWSIC POSITION STATEMENT AND RECOMMENDATIONS ON SKIN FAILURE CODES

9A. PAWSIC Position Statement on Skin Failure Codes

Patterns of skin breakdown associated with severe illness, physiologic decline, advanced frailty, and end-of-life transition have long been recognized in clinical practice, while efforts to define and classify these presentations continue to evolve. While understanding of skin failure continues to evolve, the condition is increasingly encountered in clinical practice and discussed throughout the wound care community.

Existing classification systems no longer adequately reflect this clinical reality. The absence of dedicated skin failure diagnostic codes creates challenges for patients, caregivers, clinicians, researchers, and healthcare organizations by limiting the ability to consistently document, communicate about, study, and measure the condition.

PAWSIC acknowledges that important questions remain regarding skin failure diagnosis, presentation, and pathophysiology. Continued research is essential. However, the need for further study should not be viewed as a barrier to classification. Rather, classification provides the foundation needed to support continued scientific advancement.

For these reasons, PAWSIC supports the development of ICD-10-CM skin failure diagnostic codes that reflect contemporary clinical practice while allowing for continued refinement as evidence evolves.

9B. PAWSIC Recommendations on Skin Failure Codes

Based on the considerations discussed throughout this paper, PAWSIC offers the following recommendations.

1. Recognize skin failure as a distinct clinical entity within ICD-10-CM.

Healthcare classification systems should provide a mechanism for documenting skin failure when supported by appropriate clinical assessment and documentation.

2. Align clinical, regulatory, and administrative frameworks.

Classification systems should better reflect distinctions that are increasingly recognized in clinical practice and healthcare guidance.

3. Support diagnostic precision while maintaining accountability.

Recognition of skin failure should complement ongoing efforts related to prevention, assessment, documentation, and evidence-based wound care.

4. Promote research focused on skin failure.

Dedicated diagnostic codes should be used to support epidemiologic studies, outcomes research, validation of diagnostic criteria, and continued scientific advancement.

5. Support ongoing refinement as evidence evolves.

Any future skin failure diagnostic framework should remain adaptable and responsive to emerging research, clinical experience, and advances in understanding.

9C. PAWSIC Definition of Skin Failure

“Skin failure is a state of impaired tissue tolerance associated with systemic physiological compromise in which the skin and/or underlying tissue cannot maintain viability despite appropriate preventive measures. Contributing mechanisms may include, but are not limited to, hypoperfusion, hypoxia, infarction, ischemia, inflammation, infection, impaired nutrient delivery, edema, vascular dysfunction, malignancy, medications, and local mechanical stressors/deformation.”

(PAWSIC, PSFCPP, 2026)

Section 10. CONCLUSION

Skin failure is not simply a coding issue. For clinicians, it is a reality encountered when caring for patients experiencing severe illness, advanced frailty, physiologic decline, and end-of-life transition. For patients and families, it may represent one of the most visible and distressing manifestations of serious illness. For researchers and healthcare organizations, it remains a condition that is difficult to consistently identify, study, and measure. Although perspectives may differ regarding terminology, diagnosis, and pathophysiology, the challenges created by the absence of dedicated diagnostic codes are increasingly difficult to ignore.

PAWSIC recognizes that important questions remain. Continued research is needed to better understand the causes, presentation, diagnosis, and outcomes associated with skin failure. Ongoing discussion and refinement should be expected. However, the need for continued scientific inquiry should not be mistaken for a reason to delay progress. Throughout healthcare, classification has often provided the foundation upon which greater understanding is built.

Ultimately, the discussion surrounding skin failure diagnostic codes is about more than classification. It is about supporting patient-centered care, improving communication, strengthening research, and ensuring that healthcare systems can accurately reflect the conditions clinicians encounter every day.

Federal regulation has acknowledged the distinction. Clinicians recognize the phenomenon. Researchers continue to explore its implications. Patients and families are affected by the language used to describe it. The opportunity now is to build a framework that supports continued learning while better aligning clinical practice, scientific inquiry, and healthcare classification.

For PAWSIC, the goal is straightforward: to support a healthcare system that more accurately reflects the realities of patient care while creating opportunities to improve understanding, communication, and outcomes for the patients and families we serve.

APPENDIX A. ONE FIGURE & TWO TABLES

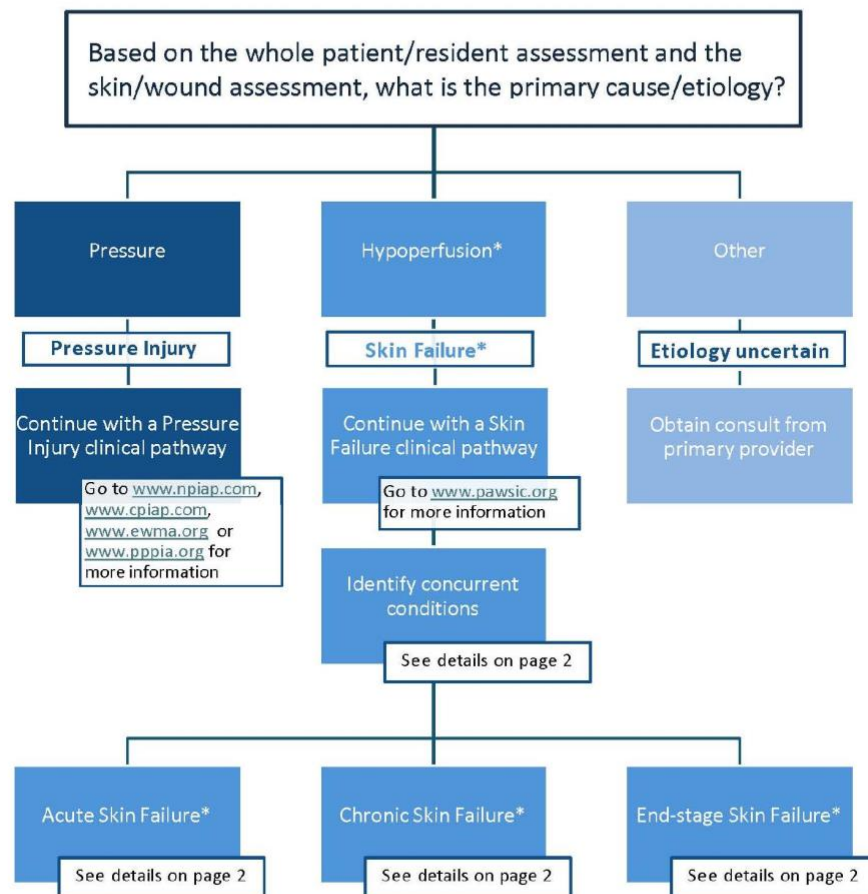
The following figure and tables accompany this position paper and are referenced throughout the text.

FIGURE 1

PAWSIC Skin Failure Clinical Assessment Guide®

A bedside tool supporting clinicians in distinguishing skin failure from pressure injury.

Post Acute Wound & Skin Integrity Council PAWSIC Skin Failure Clinical Assessment Guide®



* Definitions on page 2

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1. Identify and document concurrent conditions

Examples of concurrent conditions for Acute Skin Failure*	Examples of concurrent conditions for Chronic Skin Failure*	Examples of concurrent conditions for End-stage Skin Failure*
- Acute Respiratory Failure - Acute Renal (Kidney) Failure - Multi-organ system failure or Multi-Organ Dysfunction Syndrome (MODS)	- Chronic Respiratory Failure - Chronic Renal (Kidney) Failure - Congestive Heart Failure	- Failure-to-Thrive - Palliative Diagnosis - Hospice Diagnosis

2. Assess and document whether skin change/wound is

• Intact skin	• Partial Thickness	• Full Thickness
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If more than one skin condition/wound is present, describe and document each one. Code as indicated by the coding guidelines in effect for your clinical setting.

3. Select and document the correct nursing diagnosis

	Acute	Chronic	End-stage
Skin intact	• Acute skin changes due to skin failure, skin intact	• Chronic skin changes due to skin failure, skin intact	• End-stage skin changes due to skin failure, skin intact
Partial Thickness	• Acute skin changes due to skin failure, partial thickness	• Chronic skin changes due to skin failure, partial thickness	• End-stage skin changes due to skin failure, partial thickness
Full Thickness	• Acute skin changes due to skin failure, full thickness	• Chronic skin changes due to skin failure, full thickness	• End-stage skin changes due to skin failure, full thickness

Note: End-stage skin changes due to skin failure include:

- Kennedy Lesions (KL) – skin intact
- Trombley-Brennen Terminal Tissue Injury (TB-TTI) – skin intact
- Kennedy Terminal Ulcers (KTU) – partial or full thickness
- Skin Changes At Life's End (SCALE) Wounds – skin intact, partial or full thickness

4. Develop a plan of care that appropriately reflects the whole patient/resident Skin Failure skin/wound assessment

Definitions

Hypoperfusion is reduced or decreased blood flow to a body tissues or organs.

"Skin failure is an event in which the skin and underlying tissue die due to hypoperfusion that occurs concurrent with severe dysfunction or failure of other organ systems."^{*}

"Acute skin failure is an event in which skin and underlying tissue die due to hypoperfusion concurrent with a critical illness."^{*}

"Chronic skin failure is an event in which skin and underlying tissue die due to hypoperfusion concurrent with a chronic disease."^{*}

"End-stage skin failure is an event in which skin and underlying tissue die due to hypoperfusion concurrent with the end-of-life."^{*}

^{*} Langemo DK, Brown G. Skin fails too: Acute, chronic, and end stage skin failure. *Advances in Skin & Wound Care*, 2006, 19(4), 206-211.

TABLE 1

Commentary on Skin Failure — John La Puma, MD, FACP**Commentary on Skin Failure** — John La Puma, MD, FACP

“The scarcity of dedicated data on Skin Failure (SF) is a direct consequence of the problem we aim to solve, but there is a growing body of literature that, when synthesized, makes a powerful case.

My thoughts on the matter are that we must reframe Skin Failure not as a severe type of pressure injury (PI), but as a distinct clinical syndrome. SF is a systemic phenomenon where the skin, as an organ, begins to fail due to hypoperfusion, often in the context of critical illness, multi-organ dysfunction, or the dying process. This conceptual shift recognizes SF across its acute, chronic, and end-stage presentations.

The persistent misclassification of SF as a PI is a categorical error with devastating ethical, economic, and personal consequences. Ethically, it robs patients, particularly those at the end of life, of a dignified experience by subjecting them to painful, futile interventions aimed at “healing” an organ that is shutting down, rather than shifting to palliative goals focused on comfort. This misdiagnosis creates a false and painful narrative of neglect for families and inflicts a profound moral distress on clinicians who are wrongly blamed for an unavoidable outcome. Economically, this confusion fuels a deeply irrational system, wasting billions on inappropriate treatments and triggering unjust financial penalties for healthcare institutions under policies never intended for unavoidable organ failure.

The literature specifically using the term “Skin Failure” is indeed fragmented, as much of the data is incorrectly buried within studies on pressure injuries, thereby contaminating the evidence base. However, a coherent picture emerges when we analyze research on related phenomena now understood as manifestations of SF, such as the Kennedy Terminal Ulcer (KTU), Skin Changes at Life's End (SCALE), and Trombley-Brennan Terminal Tissue Injury (TB-TTI).

The path forward requires a concerted advocacy effort focused on two main goals. First, we need robust educational initiatives to instill the principles of differentiation in all clinicians. Second, and most critically, we must establish a unique ICD code for Skin Failure. This single policy change is the key that will unlock accurate data collection, enable fair quality metrics, drive targeted research, and, most importantly, ensure that our care for the most vulnerable patients is both clinically sound and profoundly compassionate.”

— John La Puma, MD, FACP
August 2025. Used with permission

TABLE 2
PAWSIC Position Statement on Skin Failure Codes & Definition of Skin Failure

The Post Acute Wound and Skin Integrity Council (PAWSIC) recognizes skin failure as a distinct clinical phenomenon associated with systemic physiologic compromise. The absence of dedicated diagnostic codes for skin failure within ICD-10-CM creates challenges for patient-centered care, documentation, communication, quality measurement, and research. PAWSIC supports the development of an ICD-10-CM skin failure code framework that reflects contemporary clinical practice while allowing for continued scientific refinement as evidence evolves.

“Skin failure is a state of impaired tissue tolerance associated with systemic physiological compromise in which the skin and/or underlying tissue cannot maintain viability despite appropriate preventive measures. Contributing mechanisms may include, but are not limited to, hypoperfusion, hypoxia, infarction, ischemia, inflammation, infection, impaired nutrient delivery, edema, vascular dysfunction, malignancy, medications, and local mechanical stressors/deformation.”
(PAWSIC, PSFPP, 2026)

Section 11.

Annotated Bibliography

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This annotated bibliography documents the scientific, clinical, historical, and ethical foundation of the skin failure concept. Selected references are presented in alphabetical order by first author surname.

Ayello, E. A., Levine, J. M., Langemo, D., Kennedy-Evans, K. L., Brennan, M. R., & Sibbald, R. G. (2019). Reexamining the literature on terminal ulcers, SCALE, skin failure, and unavoidable pressure injuries. *Advances in Skin & Wound Care*, 32(3), 109–121. <https://doi.org/10.1097/01.ASW.0000553112.55505.5f>

This landmark synthesis by leading wound care experts proposes a unifying framework that brings together Kennedy terminal ulcers, SCALE, Trombley-Brennan terminal tissue injuries, and skin failure under a single conceptual model. It explicitly distinguishes skin failure as etiologically different from pressure injury while acknowledging the two can co-occur. The paper directly addresses anticipated concerns about overlap between skin failure and KTU/SCALE concepts, providing a scholarly foundation for the distinctiveness of proposed skin failure codes.

Berlowitz, D. R., & Levine, J. M. (2025). The evolving case for skin failure—beyond pressure injury. *JAMA Internal Medicine*, 185(4), 359–360. <https://doi.org/10.1001/jamainternmed.2024.7461>

Published in *JAMA Internal Medicine*, this Viewpoint by researchers from University of Massachusetts Lowell, Boston University, and Mount Sinai argues that skin failure is a distinct clinical syndrome beyond pressure injury and identifies future research directions. Its publication signals that the broader medical community, beyond wound care specialists, now recognizes skin failure as a legitimate clinical construct. It is the highest-impact mainstream medical journal endorsement of the skin failure concept to date.

Black, J., Cox, J., Cuddigan, J., Jenkins, J., Lev-Tov, H., Mervis, J., Nwafor, T. S., Pontieri-Lewis, V., Schallom, M., Siedlik, C., Siparsky, N., Vollman, K., & Walkowiak, N. (2025). Skin failure: Results of a think tank hosted by the National Pressure Injury Advisory Panel. *Journal of Wound, Ostomy, and Continence Nursing*, 52(5), 369–375. <https://doi.org/10.1097/WON.0000000000001211>

This landmark multidisciplinary think tank paper, convened by the National Pressure Injury Advisory Panel (NPIAP) in August 2024, formally examined the concept of skin failure in critically ill adults and reached consensus definitions. The panel defined non-pressure-related skin failure as an injury that occurs despite standard preventive interventions and for which no other etiology has been identified. While identifying significant evidence gaps, the paper constitutes the most authoritative contemporary multi-society engagement with the skin failure classification question and directly informs the regulatory case for distinct ICD codes.

Black, J. M., Edsberg, L. E., Baharestani, M. M., Langemo, D., Goldberg, M., McNichol, L., & Cuddigan, J. (2011). Pressure ulcers: Avoidable or unavoidable? Results of the National Pressure Ulcer Advisory Panel consensus conference. *Ostomy Wound Management*, 57(2), 24–37. PMID: 21350270

This NPIAP consensus paper established the foundational principle that not all pressure ulcers are avoidable, and that certain clinical conditions may lead to unavoidable skin breakdown even with optimal care. It is the formal professional society basis for distinguishing unavoidable skin breakdown from preventable pressure injury. This consensus constitutes the institutional predicate on which the clinical and regulatory case for distinct skin failure codes rests.

Brennan, M. R., Thomas, L., Vargo, D., & Akerman, M. (2026). Defining Trombley-Brennan terminal tissue injury with long-wave infrared thermography. *Advances in Skin & Wound Care*, 39(7), 361–367. <https://doi.org/10.1097/ASW.0000000000000493>

This prospective observational study conducted in a hospital-based palliative care unit used long-wave infrared thermography (LWIT) to establish an objective thermal signature for Trombley-Brennan Terminal Tissue Injury, demonstrating statistically significant differences in mean, maximum, and minimum tissue temperatures between TB-TTI and deep tissue pressure injury. TB-TTI lesions remained thermally consistent with adjacent normal skin, whereas DTPI showed marked thermal deviation, providing physiologic evidence that these are etiologically distinct entities rather than variants of the same injury. This is the first study to supply a reproducible, technology-verified diagnostic criterion for a terminal skin failure manifestation, directly answering the concern that skin failure cannot be reliably differentiated from pressure injury at the bedside. Its demonstrated utility in patients with dark skin tones further addresses health equity gaps in visual assessment, and it strengthens the argument that a distinct ICD-10-CM code for skin failure would be applied with diagnostic rigor rather than clinical guesswork.

Brennan, M. B., & Trombley, K. (2010). Kennedy terminal ulcers—palliative care unit’s experience over a 12-month period of time. *WCET Journal*, 30(3), 20–22.

This observational study from a palliative care unit provides direct clinical evidence that a reproducible pattern of end-of-life skin injuries occurs that is distinct from standard pressure injury management. It documents real-world incidence and clinical characteristics of terminal tissue injuries, supporting the argument that these wounds constitute a recognizable, codable clinical entity. The data underscore the operational gap created by the absence of a specific ICD code for facilities managing this patient population.

Carlsson, M. E., & Gunningberg, L. (2017). Predictors for development of pressure ulcer in end-of-life care: A national quality register study. *Journal of Palliative Medicine*, 20(1), 53–58. <https://doi.org/10.1089/jpm.2016.0213>

Using a national quality registry, this study identifies specific clinical predictors of pressure ulcer development at end of life, providing epidemiologic evidence that skin breakdown in dying patients follows distinct patterns from those in stable patients. The findings support the argument that end-stage skin failure is a clinically distinguishable phenomenon requiring its own classification. Registry-level data of this kind would be substantially enriched if discrete ICD skin failure codes existed to separate these cases from avoidable pressure injuries.

Charcot, J. M. (1877). *Lectures on the diseases of the nervous system* (G. Sigerson, Trans.). The New Sydenham Society.

Charcot’s historical lectures include early descriptions of the “decubitus ominosus”—fatal skin breakdown in patients with neurological conditions—representing the earliest medical recognition of unavoidable, physiologically mediated skin failure as distinct from ordinary pressure injury. This historical grounding demonstrates that the clinical reality of skin failure has been observed for nearly 150 years, long predating modern pressure injury frameworks. The phenomenon therefore represents a long-recognized clinical entity finally being considered for formal classification, not a novel or insufficiently established concept.

Cross, H. (2023). Skin failure: A historical perspective. *American Nurse Journal*, 18(10), 8–11. <https://doi.org/10.51256/ANJ102306>

This continuing nursing education article in the official journal of the American Nurses Association traces the conceptual evolution of skin failure from Irvine’s 1991 coinage through contemporary frameworks. It highlights the persistent absence of validated diagnostic criteria and the ongoing confusion between skin failure and pressure injury, reinforcing the case that standardized ICD codes are essential to resolve this ambiguity. Its publication signals broad nursing community awareness and acceptance of the concept.

Dagleish, L., Campbell, J., Finlayson, K., & Coyer, F. (2020). Acute skin failure in the critically ill adult population: A systematic review. *Advances in Skin & Wound Care*, 33(2), 76–83. <https://doi.org/10.1097/01.ASW.0000617844.69248.92>

This systematic review is one of the most rigorous assessments of the acute skin failure literature in critically ill adults, identifying key risk factors including sepsis, vasopressor use, hemodynamic instability, and multi-organ dysfunction. Its conclusion—that acute skin failure lacks an agreed-upon definition and is conceptually confused with pressure injury—illustrates the urgent need for the definitional clarity that standardized ICD codes would provide.

Dagleish, L., Campbell, J., Finlayson, K., Coyer, F., & Gillespie, B. M. (2021). Understanding skin failure: A scoping review. *Advances in Skin & Wound Care*, 34(10), 542–550. <https://doi.org/10.1097/01.ASW.0000755844.87283.20>

This comprehensive scoping review maps 30 years of skin failure literature across all healthcare settings, finding that while use of the term has grown significantly, empirical evidence remains limited and definitions diverge. The authors explicitly identify the absence of standardized classification as a major barrier to research progress, directly supporting the argument that ICD codes are a prerequisite for scientific advancement.

Delmore, B., Cox, J., Rolnitzky, L., Chu, A., & Stolfi, A. (2015). Differentiating a pressure ulcer from acute skin failure in the adult critical care patient. *Advances in Skin & Wound Care*, 28(11), 514–524. <https://doi.org/10.1097/01.ASW.0000471876.11836.dc>

This foundational study concludes that pressure injury and acute skin failure are two distinct yet clinically related phenomena, with hypoperfusion reducing skin tolerance to pressure as the key mechanistic link. This paper is among the most-cited in the field and provides strong peer-reviewed support for the biological distinctiveness underlying the skin failure code proposal.

Goode, P. S., & Allman, R. K. (1989). The prevention and management of pressure ulcers. *Medical Clinics of North America*, 73(6), 1511–1524. [https://doi.org/10.1016/s0025-7125\(16\)30613-7](https://doi.org/10.1016/s0025-7125(16)30613-7)

This early foundational paper on pressure ulcer prevention and management establishes the clinical framework within which skin failure was subsequently distinguished, providing essential historical context demonstrating that medical science has long recognized the limitations of purely mechanical explanations for skin breakdown.

Greenway, A., Leahy, N., Torrieri, L., An, A., Fink, S. A., Witenko, C., Shikar, M., Winchell, R. J., Barie, P. S., & Liu, S. I. (2021). Skin failure among critically ill patients afflicted with coronavirus disease 2019 (COVID-19). *Journal of Intensive Care Medicine*, 36(11), 1331–1339. <https://doi.org/10.1177/08850666211046532>

This prospective cohort study from New York-Presbyterian/Weill Cornell Medical Center characterizes skin failure specifically among critically ill COVID-19 patients in the ICU, identifying risk factors including vasopressor use, prone positioning, and organ failure severity. It demonstrates that skin failure is a clinically identifiable and epidemiologically significant phenomenon even within a single disease cohort, and that its occurrence is distinct from iatrogenic pressure injury. The COVID-19 context substantially broadened the population in which acute skin failure has been empirically documented, strengthening the case for universal ICD coding.

Hill, R., & Peterson, A. (2020). Skin Failure Clinical Indicator Scale: Proposal of a tool for distinguishing skin failure from pressure injury. *Wounds*, 32(10), 272–278. PMID: 33119511

This retrospective case-control study developed and evaluated the Skin Failure Clinical Indicator Scale (SFCIS), identifying ten clinically available variables—including sepsis, vasopressor use, mechanical ventilation, serum albumin, and Braden score—that can differentiate skin failure from pressure injury at the bedside. The SFCIS provides an operationalizable, reproducible assessment framework that makes a distinct ICD code feasible in clinical practice.

Hill, R., & Peterson, A. (2025). Evaluating the use of a skin failure indicator scale in the diagnosis of acute skin failure. *Wounds*, 37(3), 114–119. <https://doi.org/10.25270/wnds/24114>

This 2025 follow-up study evaluates the clinical utility of the SFCIS tool developed in the authors' 2020 work, providing validation evidence for the scale's ability to accurately identify acute skin failure in practice. A validated clinical tool paired with proposed ICD codes strengthens the case that skin failure can be accurately coded with acceptable reproducibility.

Jakobsen, G., Svensson, A. E., Lundstrøm, S., Rustøen, T., & Miaskowski, C. (2020). Incidence and prevalence of pressure ulcers in cancer patients admitted to hospice: A multicenter prospective cohort study. *International Wound Journal*, 17(3), 641–649. <https://doi.org/10.1111/iwj.13326>

This multicenter prospective cohort study provides epidemiological data on skin breakdown incidence in hospice-admitted cancer patients—a population in which skin failure and end-stage skin changes are likely prevalent but currently

undetectable in administrative data due to the absence of specific codes. The hospice setting is directly relevant to the population most affected by skin failure misclassification.

Jin, Q., Chen, Q., Wu, G., Gao, Y., Lu, W., Sun, Y., & Zhu, Q. (2025). Nursing management experience of acute skin failure in critically ill patients: A qualitative study. *Nursing Open*, 12(10), e70336. <https://doi.org/10.1002/nop2.70336>

This qualitative study documents the clinical experience of nurses managing acute skin failure in critically ill patients, revealing the practical challenges of identifying, documenting, and caring for these wounds in the absence of standardized definitions and coding infrastructure. The study adds a frontline clinical voice to the evidence base supporting the need for distinct classification.

Julian, M. K. (2020). Skin failure in patients with a terminal illness. *Nursing Made Incredibly Easy!*, 18(4), 28–35. <https://doi.org/10.1097/01.NME.0000669503.52693.0f>

This clinically oriented nursing education article describes skin failure in terminal illness for a broad nursing audience, reinforcing that skin failure is an operationally recognized concept in frontline clinical practice even without formal ICD classification. The article also highlights the patient care implications of misclassification, including inappropriate treatment goals in dying patients.

Kennedy, K. L. (1989). The prevalence of pressure ulcers in an intermediate care facility. *Decubitus*, 2(2), 44–45. PMID: 2787655

This foundational paper introduced what would become the Kennedy Terminal Ulcer, reporting that 55.7% of nursing home residents who developed pressure injuries died within 6 weeks of onset. It established the first empirical evidence that skin breakdown at end of life follows a distinct clinical trajectory. The proposed skin failure codes would, for the first time, give clinical entities first observed by Kennedy a codable administrative identity.

Kennedy-Evans, K. L., Vargo, D., Ritter, L., Adams, D., Koerner, S., & Duell, E. (2023). Early skin temperature characteristics of the Kennedy lesion (Kennedy Terminal Ulcer). *Wound Management & Prevention*, 69(1), 14–24. <https://doi.org/10.25270/wmp.22051>

This contemporary study characterizes the early thermographic features of the Kennedy lesion, advancing objective identification of a key end-of-life skin failure manifestation beyond visual assessment alone. The use of skin temperature data to distinguish Kennedy lesions represents an emerging objective diagnostic criterion that supports the operationalizability of skin failure codes in clinical practice.

Kim, J. H., Lee, J., & Lee, W. J. (2019). A case of acute skin failure misdiagnosed as a pressure ulcer, leading to a legal dispute. *Archives of Plastic Surgery*, 46(1), 75–78. <https://doi.org/10.5999/aps.2018.00087>

This published case report describes a patient with sepsis who developed multi-site skin ulcerations despite optimal preventive measures, was miscoded as a pressure injury, and whose caregivers subsequently sued the hospital. It provides direct, real-world evidence that the absence of a skin failure ICD code has medico-legal consequences. This case concretely illustrates the harms of the current coding gap for patients, families, and institutions.

Krasner, D. L. (2021). Skin changes at life's end (SCALE): A guide for patients, families & caregivers. *WoundSource*, Kestrel Health Information.

This patient-facing educational guide addresses how to explain inevitable skin changes at end of life to patients, families, and caregivers, helping them understand that skin failure is not a result of neglect or inadequate care. Its existence highlights the profound gap between clinical recognition of skin failure and the administrative coding system, and demonstrates the real-world family and patient impact of misclassification.

Krasner, D. L., & Stewart, T. P. (2015). SCALE wounds: Unavoidable pressure injury. *Wounds*, 27(4), 92–94. PMID: 25938658

This article applies the SCALE framework to unavoidable pressure injuries, explicitly linking end-of-life skin changes to the concept of skin failure and reinforcing the clinical rationale for distinguishing these wounds from avoidable pressure injuries in documentation and coding.

La Puma, J. (1991). The ethics of pressure ulcers. *Decubitus*, 4(2), 43–44. PMID: 2031457

This early ethics commentary raises foundational questions about moral responsibility for pressure injuries, distinguishing avoidable harm from physiologically inevitable skin breakdown. It establishes that the ethics of pressure injury coding have been in question since the earliest days of this field, lending moral weight to the argument that miscoding skin failure as pressure injury is an ethical problem with real consequences for patients and families.

La Puma, J. (2025, August). Commentary on skin failure. PAWSIC Special Interest Group.

This contemporary commentary by a prominent bioethicist addresses the ethical dimensions of skin failure misclassification, providing current expert ethical endorsement of the case for distinct skin failure codes. It reinforces that the moral case for skin failure codes is compelling and recognized by ethics scholars outside the wound care community.

Langemo, D. K., & Brown, G. (2006). Skin fails too: Acute, chronic, and end-stage skin failure. *Advances in Skin & Wound Care*, 19(4), 206–211. <https://doi.org/10.1097/00129334-200605000-00014>

This is the most widely cited definitional paper in the wound care skin failure literature, establishing the taxonomy of acute, chronic, and end-stage skin failure and providing the first widely accepted working definition. Its systematic review of MEDLINE and CINAHL found only seven prior articles referencing skin failure—documenting the state of near-total evidence absence from which the field has since grown. This paper is the definitional bedrock of the skin failure concept.

Langemo, D. K., & Parish, L. C. (2022). The past, present and future of skin failure. *Advances in Skin & Wound Care*, 35(2), 81–83. <https://doi.org/10.1097/01.ASW.0000805944.83475.39>

This perspective article by two of the field’s founding voices traces skin failure’s conceptual evolution and explicitly frames ICD coding as the necessary next step in the concept’s development. Its 2022 publication demonstrates sustained, senior-level scholarly commitment to the skin failure coding project.

Latimer, S., Chuang, S. L., & Malata, C. M. (2023). Development of a wound assessment tool for use in adults at end-of-life: A modified Delphi study. *Advances in Skin & Wound Care*, 36(3), 142–150. <https://doi.org/10.1097/01.ASW.0000911992.83362.eb>

Using a modified Delphi methodology with international wound care experts, this study developed and validated a structured wound assessment tool specifically designed for end-of-life patients. The existence of a validated end-of-life wound assessment tool directly addresses the concern that skin failure lacks reproducible, operationalizable diagnostic criteria.

Latimer, S., Walker, R. M., Hewitt, J., Ray-Barruel, G., Shaw, J., Hunt, T., & Gillespie, B. M. (2025). Testing the study protocol and interrater reliability of a new end-of-life wound assessment tool: A feasibility study. *BMC Palliative Care*, 24, 216. <https://doi.org/10.1186/s12904-025-01853-9>

This 2025 feasibility study tests the interrater reliability of a new end-of-life wound assessment tool, providing empirical evidence that clinicians can consistently identify and classify end-of-life skin wounds using a structured instrument. Strong interrater reliability directly addresses concerns about whether skin failure diagnosis is sufficiently reproducible for reliable coding.

Levine, J. M. (2005). Historical notes on pressure ulcers: The decubitus ominosus of Jean-Martin Charcot. *Journal of the American Geriatrics Society*, 53(7), 1248–1251. <https://doi.org/10.1111/j.1532-5415.2005.53358.x>

This historical analysis recovers Charcot’s 19th-century clinical observations of the “decubitus ominosus” as the earliest documented medical recognition of what we now call skin failure. Demonstrating that the clinical phenomenon has been

observed for over a century directly counters any argument that skin failure is an insufficiently established concept for ICD classification.

Levine, J. M. (2016). Skin failure: An emerging concept. *Journal of the American Medical Directors Association*, 17(7), 666–669. <https://doi.org/10.1016/j.jamda.2016.03.024>

Published in the leading long-term care medicine journal, this article frames skin failure as an emerging clinical concept that provides common nomenclature, opens research directions, and questions the validity of pressure injuries as a universal quality measure. Its publication in JAMDA signals recognition of skin failure's importance in post-acute and long-term care settings.

Levine, J. M. (2017). Unavoidable pressure injuries, terminal ulceration, and skin failure: In search of a unifying classification system. *Advances in Skin & Wound Care*, 30(5), 200–202. <https://doi.org/10.1097/01.ASW.0000515077.61418.44>

This influential paper explicitly argues for a unified classification system bringing together unavoidable pressure injuries, terminal ulceration, Kennedy terminal ulcers, and skin failure—precisely the kind of conceptual architecture that proposed ICD codes would instantiate in administrative data.

Levine, J. M., Delmore, B., & Cox, J. (2022). Skin failure: Concept review and proposed model. *Advances in Skin & Wound Care*, 35(3), 139–148. <https://doi.org/10.1097/01.ASW.0000818572.31307.7b>

This major concept review proposes a comprehensive pathophysiological model of skin failure that integrates risk factors, physiologic mechanisms, and clinical manifestations into a coherent framework suitable for clinical application and research. This is among the most complete single-article summaries of the current state of skin failure science.

Liu, Y. F., Cong, W., Zhou, C. M., Yu, Y., & Zhang, X. J. (2025). Relationship between inflammatory factors, lactic acid levels, acute skin failure, bad mood, and sleep quality. *World Journal of Psychiatry*, 15(4), 102763. <https://doi.org/10.5498/wjp.v15.i4.102763>

This 2025 study examines the relationship between objective biomarkers—specifically inflammatory factors and lactic acid levels—and acute skin failure, representing an important step toward identifying measurable physiological correlates that could support diagnostic criteria.

Loma Linda University Medical Center. (2025). Guideline for determining adult skin failure. Loma Linda University Medical Center.

This institutional clinical guideline from an academic medical center is one of the first formal hospital-level protocols for identifying and documenting adult skin failure, demonstrating that real-world healthcare institutions are already developing operational frameworks for this diagnosis ahead of formal ICD recognition.

Lu, X., Lu, Y., Qin, S., Li, L., & Huang, D. (2025). Survey of ICU nurses' cognition, attitude, and practice on acute skin failure. *Medicine*, 104(36), e42237. <https://doi.org/10.1097/MD.00000000000042237>

This survey of ICU nurses documents significant gaps in clinician awareness and consistent documentation practices related to acute skin failure, underscoring that without standardized ICD codes and associated clinical guidance, even well-trained critical care nurses lack the administrative infrastructure to document skin failure accurately.

Melnychuk, I., & Servetnyk, I. (2024). Kennedy terminal ulcers and Trombley-Brennan terminal tissue injuries: Mystery solved? *Advances in Skin & Wound Care*, 37(5), 233–237. <https://doi.org/10.1097/ASW.0000000000000119>

This 2024 analysis proposes that Kennedy Terminal Ulcers and Trombley-Brennan Terminal Tissue Injuries are both manifestations of the same underlying skin failure phenomenon via hypoperfusion and ischemia. This conclusion supports the proposal for unified skin failure codes and demonstrates that active scholarly engagement with skin failure classification is ongoing.

Miller, L., Pinto-Lima, W., & Mijares, A. (2025). The skin is failing! [Poster presentation]. Loma Linda University, Loma Linda, CA, United States.

This poster presentation from clinical practitioners at an academic medical center represents frontline clinical engagement with skin failure identification and patient/family education, demonstrating that the concept is being implemented in bedside practice ahead of formal ICD recognition.

Mody, L., Rittenberg, E., & Inouye, S. K. (2025). Pressure injuries and skin failure—pressure still matters. *JAMA Internal Medicine*, 185(4), 361–362. <https://doi.org/10.1001/jamainternmed.2024.7808>

Published as a direct response to Berlowitz and Levine (2025) in the same *JAMA Internal Medicine* issue, this counterpoint argues that pressure remains an important etiologic factor even in skin failure cases and urges caution against codes that could dilute accountability for preventable pressure injuries. Its inclusion demonstrates engagement with the full range of scholarly opinion. The proposed AADA-PAWSIC tabular modification, which requires documentation of a primary concurrent condition causing hypoperfusion, directly addresses this concern.

Olshansky, K. (2016). Organ failure, hypoperfusion, and pressure ulcers are not the same as skin failure: A case for a new definition. *Advances in Skin & Wound Care*, 29(4), 150. <https://doi.org/10.1097/01.ASW.0000480556.51219.05>

This letter argues for greater definitional precision in distinguishing skin failure from related phenomena. While posing a definitional challenge, the argument that a clearer definition is needed actually reinforces the case for coding, as definitional clarity in clinical practice follows rather than precedes formal classification, as the history of other organ failure codes demonstrates.

Panahi, A., Couch, K. S., White, P. B., & Chao, J. W. (2023). Acute skin failure associated with severe COVID-19. *Plastic and Reconstructive Surgery*, 151(1), 185e–186e. <https://doi.org/10.1097/PRS.00000000000009748>

This case report from The George Washington University documents the rapid appearance of a characteristic butterfly-shaped acute skin failure ulceration in a critically ill COVID-19 patient despite full repositioning protocols. Published in the leading plastic surgery journal, it demonstrates that acute skin failure was a distinct and underrecognized complication of severe COVID-19, and highlights the ongoing risk of misclassification when no distinct ICD code exists.

Pawlow, P. C., McGrath, L., Alvarez, E., Prieto, J., & Zhi, L. (2025). Hospital-acquired skin injuries associated with end-of-life in critically ill patients: A retrospective cohort study. *Journal of Wound, Ostomy, and Continence Nursing*, 52(3), 190–197. <https://doi.org/10.1097/WON.0000000000001175>

This 2025 retrospective cohort study in critically ill end-of-life patients provides some of the most current epidemiological data on the incidence and characteristics of hospital-acquired skin injuries that may represent skin failure, published in the premier wound care nursing journal. It demonstrates that active research is ongoing and that the field continues to generate new evidence in support of formal classification.

Pittman, J., Beeson, T., Dillon, J., Yang, Z., Mravec, M., Malloy, C., & Cuddigan, J. (2021). Hospital-acquired pressure injuries and acute skin failure in critical care: A case-control study. *Journal of Wound, Ostomy, and Continence Nursing*, 48(1), 20–30. <https://doi.org/10.1097/WON.0000000000000734>

This multi-site case-control study across five academic intensive care units examined clinical characteristics and risk factors distinguishing avoidable from unavoidable hospital-acquired pressure injuries, and their relationship to acute skin failure risk factors. Key risk factors for acute skin failure—including organ failure, tissue hypoperfusion, and sepsis—were significantly associated with unavoidable injury designation, providing important quantitative validation for the biological overlap between these concepts.

Rosen, R. (2026, March 26–28). Skin changes at life's end, reframing the narrative: Improving diagnostic precision in terminal ulcer identification [Paper presentation]. *Post-Acute Long-Term Care (PALTC) Annual Conference, California*.

This 2026 conference presentation represents the most current public discourse on end-of-life skin changes and diagnostic precision in the post-acute and long-term care setting. Its presentation at the PALTC annual conference demonstrates broad sector-level engagement with the skin failure coding issue and signals the urgency and momentum behind the call for formal ICD recognition.

Sibbald, R. G., Krasner, D. L., Lutz, J. B., et al. (2008). Skin Changes at Life's End (SCALE): A preliminary consensus statement. *WCET Journal*, 28(4), 15–22.

This preliminary SCALE consensus statement—developed by an international panel of 18 experts—formally established that skin changes at the end of life are a recognizable category of clinical experience distinct from avoidable pressure injury. It is the first formal multi-stakeholder agreement recognizing that the skin fails as part of the dying process.

Sibbald, R. G., Krasner, D. L., & Lutz, J. (2010). SCALE: Skin Changes at Life's End: Final consensus statement: October 1, 2009. *Advances in Skin & Wound Care*, 23(5), 225–236. <https://doi.org/10.1097/01.ASW.0000363537.75328.36>

This final SCALE consensus document—refined through input from 69 wound care experts—established ten consensus statements on end-of-life skin changes and formally endorsed Langemo and Brown's skin failure definition. Its explicit recognition that some skin breakdown at end of life is unavoidable regardless of care quality is central to the case against misclassification.

Sun, M., Liu, Z., Zhao, C., Gao, P., Shen, K., Wu, Y., & Yin, Y. (2025a). Development of a predictive model for septic shock-associated acute skin failure using readily available clinical variables. *BMC Infectious Diseases*, 26, 47. <https://doi.org/10.1186/s12879-025-12234-1>

This 2025 study develops a clinical predictive model for septic shock-associated acute skin failure using variables routinely available in the ICU setting, representing a significant step toward operationalizable diagnostic criteria. A validated predictive model demonstrates that skin failure risk can be systematically identified using objective clinical data.

Sun, M., Wu, Y., Zhao, C., & Yin, Y. (2025b). Whole-process skin management strategies in a 19-week pregnant woman with acute skin failure induced by inevitable abortion: A case report. *International Journal of Women's Health*, 17, 2595–2601. <https://doi.org/10.2147/IJWH.S529693>

This case report documents acute skin failure in a pregnant patient experiencing hemodynamic collapse, demonstrating that skin failure can occur across diverse patient populations well beyond the typical elderly or critically ill patient. Documenting skin failure in an atypical population strengthens the argument that it is a generalizable physiological response requiring a universal ICD code.

Trombley, K., Brennan, M. R., Thomas, L., & Kline, M. (2012). Prelude to death or practice failure? Trombley-Brennan terminal tissue injuries. *American Journal of Hospice and Palliative Medicine*, 29(7), 541–545. <https://doi.org/10.1177/1049909111432883>

This paper formally defines and characterizes the Trombley-Brennan Terminal Tissue Injury. Its title—"Prelude to Death or Practice Failure?"—encapsulates the central distinction at issue: whether skin breakdown at end of life represents a biological inevitability or an institutional failure. Without a distinct ICD code, the administrative default is always the latter.

White-Chu, E. F., & Langemo, D. (2012). Skin failure: Identifying and managing an under-recognized condition. *Annals of Long-Term Care*, 20(7), 28–32.

This clinical review in a long-term care medicine journal identifies skin failure as a significantly under-recognized condition in the post-acute and long-term care setting, where the coding gap causes the most harm in quality reporting and regulatory oversight.

Witkowski, J. A., & Parish, L. C. (1993). Skin failure and the pressure ulcer [Editorial]. *Decubitus*, 6(5), 4. PMID: 8220066

This early editorial by two prominent dermatologists was among the first to explicitly use the phrase "skin failure" in the wound care context and to argue that the pressure ulcer concept was insufficient to capture all forms of skin breakdown, giving the code proposal cross-disciplinary historical grounding.

Witkowski, J. A., & Parish, L. C. (2000). The decubitus ulcer: Skin failure and destructive behavior. *International Journal of Dermatology*, 39(12), 894–896. <https://doi.org/10.1046/j.1365-4362.2000.00157-2.x>

In this paper, the authors frame decubitus ulcers explicitly as a manifestation of skin failure and destructive physiological behavior, reinforcing the organ-failure paradigm central to the skin failure ICD argument.

Worley, C. A. (2007). Skin failure: The permissible pressure ulcer? *Dermatology Nursing*, 19(4), 384–385.

This short but conceptually significant piece asks whether skin failure should be understood as a “permissible” pressure ulcer—one that is unavoidable and should not trigger quality penalties—framing the regulatory and legal stakes of the skin failure/pressure injury distinction in practical terms.

Yastrub, D. J. (2010). Pressure or pathology: Distinguishing pressure ulcers from the Kennedy terminal ulcer. *Journal of Wound, Ostomy, and Continence Nursing*, 37(3), 249–250. <https://doi.org/10.1097/WON.0b013e3181d73a8b>

Published in the primary wound care nursing journal, this paper directly addresses the clinical and administrative challenge of distinguishing pressure injury from Kennedy terminal ulcers at the bedside, demonstrating that the clinical community recognizes the distinction as real and consequential, not merely theoretical.