

MDS CODING OF PRESSURE ULCERS AND OTHER SKIN CONDITIONS

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OBJECTIVES

Identify the wound types coded on the MDS.

- Explain CMS guidance for wound coding.
- Describe the characteristics the RAI Manual lists for each type of wound including:
 - Pressure Ulcers/Pressure Injuries;
 - Venous Ulcers;
 - Arterial Ulcers;
 - Diabetic foot ulcers;
 - Other open lesion(s) on the foot;
 - Open lesion(s) other than ulcers, rashes, cuts;
 - Moisture Associated Skin Damage.

MDS ASSESSMENT

- A core set of screening, clinical, and functional status elements, including common definitions and coding categories, which forms the foundation of a comprehensive assessment.
- Required for all residents of nursing homes certified to participate in Medicare or Medicaid.
- The items in the MDS standardize communication about resident problems and conditions within nursing homes, between nursing homes, and between nursing homes and outside agencies.

MDS ASSESSMENT

Federal regulations require that:

- 1) the assessment accurately reflects the resident's status;
- 2) a RN conducts or coordinates each assessment with the appropriate participation of health professionals;
- 3) the assessment process includes direct observation, as well as communication with the resident and direct care staff on all shifts.

Nursing homes are left to determine:

- 1) who should participate in the assessment process;
- 2) how the assessment process is completed;
- 3) how the assessment information is documented while remaining in compliance with the requirements of the Federal regulations and the instructions contained within the RAI Manual.

PRESSURE ULCERS/PRESSURE INJURIES

- The PU/PI definitions used in the RAI Manual have been adapted from those recommended by the National Pressure Ulcer Advisory Panel (NPUAP) 2016 Pressure Injury Staging System.
- NHs may adopt the NPUAP guidelines in their clinical practice and nursing documentation, however, they must code the MDS according to the instructions in the RAI Manual.
- Do not reverse or back stage pressure ulcers. They do not heal in a reverse sequence, that is, the body does not replace the types and layers of tissue (e.g., muscle, fat, and dermis) that were lost during pressure ulcer development before they re-epithelialize.

PRESSURE ULCERS/PRESSURE INJURIES

Pressure ulcer/injury: Localized injury to the skin and/or underlying tissue, usually over a bony prominence, as a result of intense and/or prolonged pressure or pressure in combination with shear. The pressure ulcer/injury can present as intact skin or an open ulcer and may be painful.

- Key areas for PU/PI development include the sacrum, coccyx, trochanters, ischial tuberosities, and heels. Other areas, such as bony deformities, skin under braces, and skin subjected to excess pressure, shear, or friction, are also at risk for pressure ulcers/injuries.

PRESSURE ULCERS/PRESSURE INJURIES

- If an ulcer/injury arises from a combination of factors that are primarily caused by pressure, then the area should be coded as a PU/PI.
- Residents with Diabetes Mellitus (DM) can have a pressure, venous, arterial, or diabetic neuropathic ulcer. The primary etiology should be considered when coding whether a resident with DM has an ulcer/injury that is caused by pressure or other factors.
- An ulcer caused by pressure on the heel of a diabetic resident is a pressure ulcer and not a diabetic foot ulcer.

PRESSURE ULCER/INJURY

Stage 1 Pressure Injury: Intact skin with non-blanchable redness of a localized area usually over a bony prominence. Darkly pigmented skin may not have a visible blanching; in dark skin tone only it may appear with persistent blue or purple hues.

- May include changes in one or more of the following parameters: skin temperature (warmth or coolness); tissue consistency (firm or boggy); sensation (pain, itching).

Non-blanchable: Reddened areas of tissue that do not turn white or pale when pressed firmly with a finger or device.

PRESSURE ULCER/INJURY

Stage 2 Pressure Ulcer:

Partial thickness loss of dermis presenting as a shallow open ulcer with a red-pink wound bed, without slough or bruising.

- May also present as an intact or open/ ruptured blister.
- Granulation tissue, slough, and eschar are **not** present.
- When a PU presents as an intact blister, examine the adjacent and surrounding area for signs of deep tissue injury (e.g., color change, tenderness, boggy or firmness, warmth or coolness). When a deep tissue injury is determined, do **not** code as a Stage 2.

PRESSURE ULCER/INJURY

- Epithelial tissue: New skin that is light pink and shiny. In Stage 2 PUs, epithelial tissue is seen in the center and at the edges of the ulcer.
- Granulation tissue: Red tissue with “cobblestone” or bumpy appearance; bleeds easily when injured.
- Slough: Non-viable yellow, tan, gray, green or brown tissue; usually moist, can be soft, stringy and mucinous in texture. Slough may be adherent to the base of the wound or present in clumps throughout the wound bed.
- Eschar: Dead or devitalized tissue that is hard or soft in texture; usually black, brown, or tan in color, and may appear scab-like. Necrotic tissue and eschar are usually firmly adherent to the base of the wound and often the sides/edges of the wound.

PRESSURE ULCER/INJURY

Stage 3 Pressure Ulcer:

Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle is not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling.

- The depth of a Stage 3 PUs varies by anatomical location. Stage 3 PUs can be shallow, particularly on areas that do not have subcutaneous tissue, such as the bridge of the nose, ear, occiput, and malleolus.

PRESSURE ULCER/INJURY

- **Undermining:** The destruction of tissue or ulceration extending under the skin edges (margins) so that the pressure ulcer is larger at its base than at the skin surface.
- **Tunneling:** A passage way of tissue destruction under the skin surface that has an opening at the skin level from the edge of the wound.

PRESSURE ULCER/INJURY

Stage 4 Pressure Ulcer:

Full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present on some parts of the wound bed. Often includes undermining and tunneling.

- The depth of a Stage 4 pressure ulcer varies by anatomical location. The bridge of the nose, ear, occiput, and malleolus do not have subcutaneous tissue, and these ulcers can be shallow.
- Cartilage serves the same anatomical function as bone. Therefore, pressure ulcers that have exposed cartilage should be classified as Stage 4.

PRESSURE ULCER/INJURY

Unstageable – Non-Removable Dressing/Device

Known but not stageable due to a non-removable dressing/device.

- Includes, for example, a primary surgical dressing that cannot be removed, an orthopedic device, or cast.

PRESSURE ULCER/INJURY

Unstageable – Slough and/or eschar:

Known but not stageable due to coverage of wound bed by slough and/or eschar.

PRESSURE ULCER/INJURY

Unstageable – Deep Tissue Injury:

Purple or maroon area of discolored intact skin due to damage of underlying soft tissue. The area may be preceded by tissue that is painful, firm, mushy, boggy, warmer or cooler as compared to adjacent tissue.

- If the area adjacent to, or surrounding an intact blister shows signs of tissue damage (e.g., color change, tenderness, bogginess or firmness, warmth or coolness), code as a deep tissue injury.
- Once deep tissue injury has opened to an ulcer, reclassify the ulcer into the appropriate stage.

PU/PI VERSUS SURGICAL WOUNDS

- Surgical debridement of a pressure ulcer does not create a surgical wound. Surgical debridement is used to remove necrotic or infected tissue from the pressure ulcer in order to facilitate healing. A pressure ulcer that has been surgically debrided should continue to be coded as a pressure ulcer.
- If a PU is surgically closed with a flap or graft, it should be coded as a surgical wound and not as a PU. If the flap or graft fails, continue to code it as a surgical wound until healed.

VENOUS ULCERS

Ulcers caused by peripheral venous disease, which most commonly occur proximal to the medial or lateral malleolus, above the inner or outer ankle, or on the lower calf area of the leg.

- May or may not be painful.
- Are typically shallow with irregular wound edges, a red granular (e.g., bumpy) wound bed, minimal to moderate amounts of yellow fibrinous material, and moderate to large amounts of exudate.
- The surrounding tissues may be reddened or appear brown-tinged.
- Leg edema may also be present.
- The wound may start with some kind of minor trauma, such as hitting the leg on a wheelchair.
- The wound does not typically occur over a bony prominence, and pressure forces play virtually no role in the development of the ulcer.

ARTERIAL ULCERS

Ulcers caused by peripheral arterial disease, which commonly occur on the tips and tops of the toes, tops of the foot, or distal to the medial malleolus.

- Trophic skin changes (e.g., dry skin, loss of hair growth, muscle atrophy, brittle nails) may also be present.
- Ischemia is the major etiology of these ulcers. Lower extremity and foot pulses may be diminished or absent.
- Arterial ulcers are often painful and have a pale pink wound bed, necrotic tissue, minimal exudate, and minimal bleeding.
- The wound may start with some kind of minor trauma, such as hitting the leg on a wheelchair.
- The wound does not typically occur over a bony prominence, however, can occur on the tops of the toes. Pressure forces play virtually no role in the development of the ulcer, however, for some residents, pressure may play a part.

DIABETIC FOOT ULCERS

- Ulcers caused by the neuropathic and small blood vessel complications of diabetes.
- Typically occur over the plantar (bottom) surface of the foot on load bearing areas such as the ball of the foot.
- Are usually deep, with necrotic tissue, moderate amounts of exudate, and callused wound edges.
- The wounds are very regular in shape and the wound edges are even with a punched-out appearance.
- These wounds are typically not painful.

OPEN LESION(S) ON THE FOOT

- Cuts;
- Fissures.

OPEN LESIONS OTHER THAN ULCERS, RASHES, OR CUTS

Most typically skin lesions that develop as a result of diseases and conditions such as syphilis and cancer.

- Open lesions that develop as part of a disease or condition and are not coded elsewhere on the MDS.
- Wounds, boils, cysts, and vesicles.

MOISTURE ASSOCIATED SKIN DAMAGE (MASD)

Is superficial skin damage caused by sustained exposure to moisture such as incontinence, wound exudate, or perspiration.

- Also referred to as maceration.
- MASD without skin erosion is characterized by red/bright red color, and the surrounding skin may be white.
- MASD with skin erosion has superficial/partial thickness skin loss and may have hyper- or hypopigmentation.

MOISTURE ASSOCIATED SKIN DAMAGE

- Usually blanchable and diffuse and has irregular edges.
- Inflammation of the skin may be present.
- Necrosis is not found in MASD.
- If pressure and moisture are both present, code the skin damage as a PU/PI.
- Moisture exposure and MASD are risk factors for pressure ulcer/injury development.
- If there is tissue damage extending into the subcutaneous tissue or deeper and/or necrosis is present, code the skin damage as a PU.

REFERENCES

CMS MDS 3.0 RAI Manual Webpage

- <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/MDS30RAIManual.html>

QUALITY IMPROVEMENT PROGRAM FOR MISSOURI (QIPMO)

www.nursinghomehelp.org

573-882-0241

Free Resource

Administrator Support Groups

MDS Coordinator Support Groups

Monthly Webinars

MDS Tools

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ACRONYMS IN THIS PRESENTATION

- **CMS:** Centers for Medicare and Medicaid Services
- **DM:** Diabetes Mellitus
- **MASD:** Moisture Associated Skin Damage
- **MDS:** Minimum Data Set
- **NH:** Nursing Homes
- **NPUAP:** National Pressure Ulcer Advisory Panel
- **PI:** Pressure Injury
- **PU:** Pressure Ulcer
- **RAI:** Resident Assessment Instrument