MDS Alert

Assessment and Coding: Master Ins And Outs Of Wound Coding In Section M

Use this guide to get this tricky section right.

Implement a best-practice system for assessing and coding skin ulcers in Section M and watch your QIs, bottom line--and survey record--improve.

Key benefits: Your SNF will have more Medicare dollars to heal pressure ulcers. Your quality indicators will flag a systemic breakdown in your skin program before surveyors do. And you'll sidestep F309 tags for misidentifying non-pressure wounds as decubiti.

The first step to success: You can't code or cure what you haven't identified correctly. Thus, the key to proper coding is in knowing what caused a lesion in the first place, says **Marilyn Mines, RN, BC**, director of clinical services for **FR&R Healthcare Consulting** in Deerfield, IL.

Know what the surveyors know: The revised F314/F309 tags give surveyors a roadmap for identifying various types of ulcers--a roadmap that you can use to steer your wound triaging and assessment.

Ready, Assess ... Code

Follow these pointers to identify and code wounds in Section M:

1. Pressure ulcers. The revised 314 tag defines a pressure ulcer as any lesion caused by unrelieved pressure that results in damage to the underlying tissue(s).

In assessing whether a wound is likely to be a pressure ulcer, nurses at **Little Flower Manor** look for skin breakdown over the bony prominences, says **Donna Collins, RN**, director of nursing for the Wilkes-Barre, PA facility. They also consider whether the person has risk factors for developing pressure ulcers, she says.

"Seventy-five percent of pressure ulcers that develop in a nursing home are stage 1 or 2 and occur over the sacrum, coccyx or heels, followed by ischial tuberosities," says **Barbara Bates-Jensen, PhD, RN, CWOCN**, with the **UCLA School of Medicine** and **VA Greater Los Angeles Healthcare System** in Sepulveda, CA.

Keep looking: "Patients may also have skin breakdown on the back of their heads--especially if they lay too long on an operating room or procedure table in the hospital," adds **Clare Hendrick, RN, BSN, CRNP**, a geriatric nurse practitioner and consultant in San Clemente, CA. "You might also find ulcers on earlobes."

Code it: Record the number of ulcers per each ulcer stage at M1--and code the highest stage pressure ulcer during the lookback at M2a.

The MDS requires you to "downstage" a pressure ulcer for payment purposes but you can document in the medical record and care plan that a Stage 3 is a healing Stage 3, as an example.

Tip: Consider using the PUSH tool (Pressure Ulcer Scale for Healing) to score a wound's status over time. The National Pressure Ulcer Advisory Panel developed the PUSH tool as an alternative to downstaging wounds as required by Medicare, says **Joyce Black**, **PhD, RN,** associate professor of nursing at the University of Nebraska in Omaha.

Don't overlook skin breakdown caused by friction and shear, which the revised F314 survey guidance and RAI manual note can cause pressure ulcers.

Example: An abrasion that the staff knows was caused by a shearing force or friction should be coded as a pressure ulcer, says **Rena Shephard, RN, MHA, FACDONA,** president of RRS Healthcare Consulting in San Diego. For example, "if the skin breakdown occurs when the staff transfers the resident or when the resident slides down in the chair, then that counts as a pressure ulcer."

What about a debrided pressure ulcer? Code it as a pressure ulcer, advises Collins. But if the skin ulcer is repaired with a skin graft, code it as a surgical wound.

2. Venous insufficiency ulcer. The revised F309 survey guidance defines a "venous insufficiency ulcer ... as an open lesion of the skin and subcutaneous tissue of the lower leg, usually occurring in the pretibial area of the lower leg or above the medial ankle."

What it looks like: The ulcer may have a moist, granulating wound bed, be superficial and have minimal to copious serous drainage unless infected, according to the revised survey guidance.

To help identify a venous ulcer, "look for a brownish deposit around the wound," suggests **Laura Bolton, PhD**, a wound-care expert and researcher in Metuchen, NJ. "Or if the patient has highly pigmented skin, look for a darker area around the wound," she says.
Code venous ulcers at M1 and M2: Record and stage an ulcer caused by circulation problems in M1, and code the venous ulcer's highest stage at M2b.

3. Arterial wounds. The revised F309 survey guidance defines "arterial ulcer" as an ulceration that occurs as the result of arterial occlusive disease. The area of tissue necrosis results from "non-pressure related disruption"of the arterial blood flow to an area.

What the wound looks like: The arterial ulcer occurs in the distal portion of the lower extremity. It may be over the ankle or bony areas of the foot (e.g., top of the foot or toe, outside edge of the foot), states the F309 survey guidance. "The wound bed is frequently dry and pale with minimal or no exudate."

Suspect an arterial ulcer if the resident has poor pedal pulses and the skin looks white and pale--"almost translucent and shiny and lacks hair," advises **Peggy Dotson, RN**, principal of **Healthcare Reimbursement & Strategy** in Yardley, PA. "Arterial ulcers are also painful," she says.

Check Section I for these diagnoses: The F309 revised survey guidance states arterial/ischemic ulcers may be present in individuals with moderate to severe peripheral vascular disease, generalized arteriosclerosis, inflammatory or autoimmune disorders (such as arteritis), or significant vascular disease elsewhere (e.g., stroke or heart attack).

Run this test: To determine if a wound on the leg may be caused by poor arterial circulation, "use an arterial Doppler to calculate an ankle-brachial index (ABI), which compares the blood pressure in the arm to the blood pressure in the ankles," suggests **Michael Miller, DO,** medical director of the **Wound Healing Center** in Terra Haute, IN.

Cut through the confusion: You record and stage an ulcer caused by circulatory problems at M1, which includes an arterial ulcer. But you don't code an arterial ulcer at M2. "Only pressure ulcers and venous insufficiency ulcers go in M2," says **Jane Belt, MS, RN, CS, CLNC,** a consultant with **Plante & Moran Clinical Group** in Columbus, OH.

4. Malignant and autoimmune lesions. Code any lesion or ulcer secondary to a disease process such as cancer at M4c, which is the "catch all" for open lesions/sores that aren't coded elsewhere in Section M, says Mines.

Know when to biopsy: If a wound doesn't show progress after four to six weeks of adequate therapy, biopsy it, advises Miller. And biopsy earlier than that if a wound worsens despite adequate treatment, he adds.