Codify
BY AAPC

MDS Alert

Clip and Save: Keep This Glossary of Pressure Injury Terminology Handy

Assessing and coding pressure injuries can be daunting, so keep this glossary of RAI Manual terms handy.

Here's an alphabetized list of RAI Manual definitions of words and terms you need to know in order to assess and code pressure injuries accurately on the MDS. For more on each term, consult the RAI Manual via the page number listed in parentheses.

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." (M-24)

Epithelial tissue

"New skin that is light pink and shiny (even in persons with darkly pigmented skin). In Stage 2 pressure ulcers, epithelial tissue is seen in the center and at the edges of the ulcer. In full thickness Stage 3 and 4 pressure ulcers, epithelial tissue advances from the edges of the wound." (M-7)

Eschar tissue

"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." (M-21)

Fluctuance

"Used to describe the texture of wound tissue indicative of underlying unexposed fluid." (M-22)

Granulation tissue

"Red tissue with 'cobblestone' or bumpy appearance; bleeds easily when injured." (M-7)

Healed pressure ulcer

"Completely closed, fully epithelialized, covered completely with epithelial tissue, or resurfaced with new skin, even if the area continues to have some surface discoloration." (M-2)

Non-blanchable

"Reddened areas of tissue that do not turn white or pale when pressed firmly with a finger or device." (M-11)

Non-removable dressing/device

"Includes, for example, a primary surgical dressing that cannot be removed, an orthopedic device, or cast." (M-20)

On admission

"As close to the actual time of admission as possible." (M-8)

CPT® 2023 American Medical Association. All rights reserved.

Pressure ulcer/injury

"A pressure ulcer/injury is 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." (M-4)

Pressure ulcer/injury risk factor

"Examples of risk factors include immobility and decreased functional ability; co-morbid conditions such as end-stage renal disease, thyroid disease, or diabetes; drugs such as steroids; impaired diffuse or localized blood flow; resident refusal of care and treatment; cognitive impairment; exposure of skin to urinary and fecal incontinence; microclimate, malnutrition, and hydration deficits; and a healed ulcer." (M-2)

Pressure ulcer/injury risk tools

"Screening tools that are designed to help identify residents who might develop a pressure ulcer/injury. A common risk assessment tool is the Braden Scale for Predicting Pressure Sore Risk©." (M-2)

Slough tissue

"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." (M-21)

Stage 1 pressure injury

"An observable, pressure-related alteration of intact skin whose indicators, as compared to an adjacent or opposite area on the body, may include changes in one or more of the following parameters: skin temperature (warmth or coolness); tissue consistency (firm or boggy); sensation (pain, itching); and/or a defined area of persistent redness in lightly pigmented skin, whereas in darker skin tones, the injury may appear with persistent red, blue, or purple hues." (M-11)

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." (M-12)

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 or tunneling." (M-14)

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." (M-18)

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." (M-19)

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." (M-19)

CPT® 2023 American Medical Association. All rights reserved.

Codify
BY AAPC

CPT® 2023 American Medical Association. All rights reserved.