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MDS Alert

MDS Coding: Improve Wound Coding To Heal Fiscal And Survey Sore Spots

Hint: Determine each wound's true etiology and capture those risk factors.

Talk about walking the coding tightrope: Facilities that undercode pressure ulcers pull the RUGs out from under their wound care program. Those that overcode go down with F tags.

You can master this balancing act by improving wound assessment and coding and capturing all of a resident's risk factors for pressure ulcers. That way your facility will have Medicare and Medicaid RUG money to invest in wound care, and can better target treatment to a wound's underlying cause. And you'll have the information to fend off F314 tags for what are really non-pressure wounds or unavoidable pressure ulcers.

Start by reviewing the revised MDS instructions for coding pressure-related wounds in Section M. Otherwise, you may code wounds as pressure ulcers that aren't really pressure-related, or vice versa.

To review the changes, see pp. 3-159-3-169 of the revised December 2002 RAI manual at www.cms.hhs.gov/medicaid/mds20/rai1202ch3.pdf.

For example, the August 2003 MDS update removed the word "injury" from the definition of a skin ulcer. "So if a skin tear is caused by injury -- for example, the resident fell and suffered a skin tear to his elbow -- then you don't code that as a pressure-related skin tear or a pressure ulcer," says **Christine Twombly, RN**, chief clinical consultant with **Reingruber & Company** in St. Petersburg, FL. But if the person has skin tears on the elbows caused by pushing himself up in the bed several times, code that as pressure-related, because "it's a sheering/pressure-related force," Twombly says.

In addition, a scab that results from an injury would not be staged in Section M1 or coded in M2, but should be coded in Section M4, Twombly adds.

Don't confuse eschar covering a pressure ulcer with a scab. If necrotic eschar prevents you from staging an ulcer, you code it as stage 4 until the wound can be debrided to allow staging, the revised Resident Assessment Instrument User's manual directs. "Yet you code a wound with a scab as a stage 2 ulcer rather than a stage 4," Twombly advises.

Twombly has, however, seen some nurses document eschar as a "black scab" on a wound, which the MDS coordinator then incorrectly codes as a stage 2 ulcer rather than a stage 4.

Identifying a stage 4 ulcer is important because residents with one stage 3 or 4 ulcer with treatment may be skilled on that basis alone, depending on their ADL score, notes **Darla Watson, RN**, vice president of beneficiary support for **Mariner Healthcare** in Atlanta.

Become a Wound Sleuth

All skin ulcers aren't pressure ulcers, contrary to what surveyors might like to surmise. "If an ulcer occurs in an area that's not a pressure point or over a bony prominence, try to figure out what might have caused the external pressure," suggests **Liza Ovington, PhD**, a certified wound care expert and principal of **Ovington & Associates** in Pittsburgh, PA. For example, "was it a restraint or the bedrail? If you can't figure it out, the ulcer may have been caused by ischemia due to a vascular problem or a thrombotic issue," she says.

A blister in the waist or leg band area of an incontinence brief most likely results from pressure and should be coded as a

pressure ulcer, says the **Oklahoma Foundation for Medical Quality**. However, if you can't identify a source of pressure, a blister may be evidence of perineal dermatitis caused by excessive urine or stool. If so, that's one less pressure ulcer to report.

Venous stasis ulcers typically develop in the "gaiter" region of the legs (approximately mid-calf to just below the medial and lateral malleoli). "Obesity is a risk factor for venous ulcers -- and you'll usually see these ulcers accompanied by lower extremity edema," Ovington explains.

Clinical Tidbit: "Bed-bound patients shouldn't develop a new venous stasis ulcer, because they won't have venous hypertension unless they are least getting up in a chair," notes Ovington.

Don't Take The Blame For This Wound: Some sacral ulcers may be what's known as the Kennedy terminal ulcer, which occurs in patients with end-stage disease. This wound appears very quickly -- and it is not avoidable. "The ulcer is typically butterfly shaped and while pressure is a component, the exact etiology is unknown," Ovington says.

For more information on the Kennedy terminal wound, including how to treat it, go to www.kennedyterminalulcer.com.

Document, Code Risk Adjustors

Make sure to assess risk factors for pressure ulcers, which can affect whether a resident flags as high- or low-risk on the quality indicators used by surveyors to target the survey. Residents with pressure ulcers will fall into the high-risk category on the quality indicators if they have one or more of the following conditions:

1. Impaired transfer or bed mobility (G1a(A) or G1b(B) = 3 or 4; or
2. Comatose (B1 = 1); or
3. Malnutrition I3a-3 = ICD-9 CM 260, 261, 262, 263.0, 263.1, 263.2, 263.8, or 263.9; or
4. End stage disease (J5c = 1).

Beware: A resident without any of the above risk factors flags on the low-risk pressure ulcer QI, which is a sentinel event. If that happens, recheck your MDS coding. For example, "the ADL scores may be higher than what's being recorded, which means the resident isn't really low-risk at all," notes Twombly.

Also document the resident's other known risk factors for pressure ulcers, including a previous stage 3 or 4 pressure ulcer. "The MDS 2.0 requires staff to downstage a wound, but a stage 4 is still a stage 4 when it gets smaller and when healed, it's a healed stage 4 wound," notes **Nathan Lake, RN, MSHA**, an MDS expert in Seattle, WA. "And that area of the skin will always be more vulnerable to breaking down again than it would have been if it had been a stage 2 ulcer."

Check out the covariates and exclusions for the new pressure ulcer quality measures at www.cms.hhs.gov/quality/nhqi/Snapshot.pdf. While the QMs aren't part of the survey protocol (unlike the quality indicators), any surveyor worth his salt probably checks them out before a survey.

Make Your Case With Surveyors

You may have to educate surveyors about a wound's true etiology. "Otherwise, surveyors will say, 'Look at all these pressure ulcers' when they aren't even pressure ulcers," notes **Mary Foot, RN, CNS**, a wound care specialist and principal of **Wound Care on Wheels** in Naperville, IL. "But unless you know what the so-called wound really is, the facility will end up with a potentially serious deficiency and a serious financial penalty, Foot cautions. And that, of course, means less money for wound prevention and treatment, which creates a vicious cycle that can lead to a downward spiral.

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