MDS Alert

Resident Assessment: Revisit Wound Dx And Coding - Or Your Facility Will Be Nursing Survey Wounds Of Its Own

Follow this formula to heal non-pressure wounds and prevent F309 tags.

An ulcer might "walk and talk" like a decubitus at first glance, but look closely: It just might be a wound of a different feather.

And with a tough new "zero tolerance" stance for pressure ulcers under revised survey guidance at F314, you don't want to code a wound as a pressure ulcer at M2a if it really has another etiology - and requires a different plan to heal.

Rule of thumb: Pressure ulcers usually occur over a bony prominence or you can tell they were caused by some outside pressure, such as a catheter tubing, bedpan or something in the bed, says **Karen Lou Kennedy-Evans, RN**, a wound care specialist in Tucson, AZ.

But just because a wound appears to have a non-pressure etiology doesn't get the facility off the hook. Revised survey guidance for pressure ulcers adds new language to define non-pressure wounds under F309 (the OBRA catch-all quality of care tag).

And shortfalls in diagnosing and treating arterial, venous insufficiency and diabetic neuropathic ulcers can land your facility with an F309 tag - and "tag along" tags spelled out by the guidance for related care planning, comprehensive assessment, professional standards and staffing shortages, etc., warns **Karen Merk, RN**, a clinical consultant with **Briggs Corporation** headquartered in West Des Moines, IA.

Recognize Double-Edged Sword

The revised guidance offers a glass that the industry can view as half full. "We've been trying to get CMS for years to recognize that all ulcers aren't caused by pressure," comments attorney **John Lessner** with **Ober/Kaler** in Baltimore. The guidance can also help facilities win appeals for citations at F314 when they can show a wound wasn't really a pressure ulcer, adds **Joseph Bianculli**, an attorney in Arlington, VA.

Even so, the new language at F309 also puts the onus on facilities to obtain the appropriate diagnostic studies and surgical consults for vascular wounds. "Facilities must also use interventions to mitigate diabetes-related wounds, such as better diabetic control, and venous insufficiency ulcers," Lessner advises.

For example, venous insufficiency ulcers (previously known as stasis ulcers) may be caused by venous hypertension associated with inactivity, paralysis, obesity, a malignancy or deep vein thrombosis, according to the revised F309 definitions. Thus, a weight-reduction plan might help heal an obese resident's venous insufficiency ulcer, if the resident agrees to a calorie-restricted diet.

5 Strategies for Success

Fine-tune your wound-care program to detect, code and treat non-pressure ulcers from the get-go. Here's how:

1. Do thorough nursing assessment and documentation of the wound's characteristics and a resident's risk factors for various types of wounds, suggests DON **Lisa Conrad** with **Broadview Multi-Care Center Rosepoint Pavilion** in Parma, OH. "Then give that information to the physician."

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Location of the wound is key: "If a wound is on the ... bottom part of the calf, that should be a major clue to have the physician do a more in-depth work-up," advises **Beth Klitch**, a survey consultant in Columbus, OH.

Coding tip: To diagnose a diabetic neuropathic ulcer, the resident must be diagnosed with diabetes mellitus and have peripheral neuropathy, according to the revised F314/F309 survey guidance. Code diabetes mellitus by marking the checkbox at I1a.

Because the MDS doesn't have a checkbox to code peripheral neuropathy, record a specific ICD-9-CM code in Section I3, says **Christy Riekeberg, RN**, director of Medicare and therapy services at **Loch Haven Nursing Home** in Macon, MO.

Clinical assessment heads-up: A diabetic neuropathic ulcer typically occurs "on the foot, e.g., at midfoot, at the ball of the foot over the metatarsal heads, or on the top of toes with Charcot deformity," according to the revised survey guidance.
Review the definitions of non-pressure related wounds (pp. 2 and 3 of the pdf) at www.cms.hhs.gov/manuals/pm_trans/R4SOM.pdf.

2. Make sure attending physicians, physician extenders and the medical director are up to speed on wound diagnosis. Also get appropriate diagnostic services lined up to confirm the etiology of certain wounds. "Doppler studies are required to diagnose arterial wounds, for example," Merk notes.

Take advantage of Part B-covered consults for patients with the optional insurance who might benefit from expert diagnosis for vascular wounds and/or surgical intervention.

3. Reassess the etiology of nonhealing wounds. For example, always consider cancer when a wound doesn't heal, advised Daniel Berlowitz, MD, in a CMS-sponsored Aug. 3, 2004 Webcast on pressure ulcers (view the Webcast at www.cms.internetstreaming.com).

4. Recognize a Kennedy Terminal Ulcer. "These ulcers come on suddenly and look like they have been there for a week," says Kennedy-Evans, who is credited with identifying the characteristic wound decades ago. "The wounds are red, yellow and black with irregular borders - and if the wound is on the sacrum, may be shaped like a pear," she notes.

The Kennedy terminal ulcers typically occur in people very near the end of life and are largely considered to be unavoidable.

For more information, go to www.kennedyterminalulcer.com.

5. Be prepared to show surveyors documentation to substantiate the types of wounds in your building. For example, Broadview has gone to reporting all open wounds to surveyors - "and if a wound isn't pressure related, then we make sure we have all the documentation to show its etiology," says Conrad.

Editor's note: For an in-depth look at pressure ulcer and risk assessment coding tips with the revised survey guidance in mind, see the March 2005 MDS Alert.

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