OASIS Alert

Assessment: Know Your Ulcers to Bolster Reimbursement

Underestimate a Stage 3 and you're risking $162.

How confident are you when it comes to distinguishing between different kinds of ulcers? When your wound assessing accuracy slips, so will your agency's reimbursement.

Understand the Costs

Your OASIS accuracy is crucial to both patient outcomes and financial outcomes, says consultant **Lynda Laff** with Hilton Head, S.C.-based **Laff Associates**. "Since 2008 we have been paid for non-routine medical supplies (NRS) based upon the clinical assessment of the patient by the admitting clinician through the OASIS scoring and resultant case weights, HHRG and HIPPS codes," she explains.

Incorrectly stage a pressure ulcer, and you'll impact the NRS severity level whether negatively or positively, Laff says. That can result in more or fewer NRS dollars than your agency is rightfully due.

Real costs: Report a pressure ulcer as a Stage 2 when it is actually a Stage 3 and you could impact the NRS severity level in excess of $162.00 for that episode, Laff says.

Now suppose you incorrectly identify a pressure ulcer as a stasis ulcer. You'll lose additional reimbursement for this patient because pressure ulcers can earn more total NRS points than stasis ulcers depending upon the number and stage of the pressure ulcers, Laff says.

Patients with a primary diagnosis of diabetic ulcers automatically result in a NRS severity level of 3 or $144.16 plus the additional points received at M1020 □ Primary diagnosis, Laff points out. You can earn 13 case mix points for "non stasis/non-pressure ulcers" but you won't receive these points if you are already receiving points for a patient's diabetic ulcers.

Bottom line: You'll likely realize more revenue if the clinician codes an ulcer as the more specific diabetic ulcer rather than a "non-stasis/non-pressure" ulcer, Laff says. That's because a "non-stasis/non-pressure" ulcer diagnosis does not earn clinical case mix points □ only NRS case mix points.

But before you can accurately report an ulcer on the OASIS, you must make certain you've identified it correctly.

Be sure you know the difference between pressure ulcers, stasis ulcers, diabetic ulcers and arterial ulcers.

Know Your Ulcer Types

Knowing the characteristics of the different ulcer types will boost your accuracy with OASIS items M1306 through M1334:

1. Pressure ulcer. OASIS item M1306 □ Does this patient have at least one Unhealed Pressure Ulcer at Stage II or Higher or designated as unstageable defines a pressure ulcer as "a localized injury to the skin and/or underlying tissue usually over a bony prominence, as a result of pressure, or pressure in combination with shear and/or friction."

How to identify it: Examine your patient's skin for breakdown over bony prominences. With patients who are

bedridden or have had lengthy hospital stays, be sure to check the back of the head and the ear lobes.

Stage II: Patients with a Stage II pressure ulcer may display a partial thickness loss of dermis resulting in a shallow open ulcer with a red-pink wound bed without slough, according to the **Wound Ostomy Continence Nurses Society's** Guidance on OASIS-C Integumentary Items. Stage II pressure ulcers may also present as an intact, open, or ruptured serum-filled blister.

Stage III: You'll see full thickness tissue loss in a Stage III pressure ulcer. You may also be able to see subcutaneous fat but not bone, tendon, or muscle, the WOCN guidance says. There may be slough present, but it shouldn't obscure the depth of tissue loss. You may also see undermining and tunneling.

Stage IV: Full-thickness tissue loss with exposed bone, tendon, or muscle indicates a Stage IV pressure ulcer, according to the WOCN guidance. You may also see slough or eschar on some parts of the wound bed, as well as undermining and tunneling.

Don't forget: A debrided pressure ulcer is still a pressure ulcer, but if the ulcer is repaired with a muscle flap it becomes a surgical wound.

2. Stasis (venous) ulcer. M1330 Does this patient have a stasis ulcer? defines a stasis ulcer as one caused by inadequate venous circulation in the area affected (usually lower legs). This lesion is often associated with stasis dermatitis.

How to identify it: The ulcer may have a moist, granulating wound bed, be superficial and have minimal to copious serous drainage unless infected. If the patient has highly pigmented skin, look for a darker area around the wound. It may be painful if the leg is in a dependent position.

3. Arterial ulcer. An arterial ulcer or arterial wound is an ulceration that results from arterial occlusive disease. The area of tissue necrosis results from non-pressure related disruption of the arterial blood flow to an area.

How to identify it: An arterial ulcer occurs in the distal portion of the lower extremity. It may be over the ankle or bony areas of the foot (such as the top of the foot or toe, or outside edge of the foot). Look for a dry, pale wound bed with minimal or no exudate, experts say. Suspect an arterial ulcer if the patient has poor pedal pulses and the skin looks white and pale and lacks hair. Arterial ulcers are also painful, especially at night or when the leg is elevated. Report arterial ulcers in M1350 Does this patient have a Skin Lesion or Open Wound ... ? when they will receive clinical intervention.

4. Diabetic ulcer. Diabetic ulcers are not classified as pressure, stasis or arterial ulcers when answering OASIS items. They are usually found on any part of the leg, especially below the ankle and on the foot. The ulcer may not be painful if the patient suffers from neuropathy or paresthesia.

How to identify it: To have a diabetic ulcer, the patient must have a documented diagnosis of both diabetes and peripheral neuropathy. Ask the physician to clarify whether the ulcer is caused by pressure or by the diabetes. Then document that discussion in the record, experts advise. Report confirmed diabetic ulcers in M1350 Does this patient have a Skin Lesion or Open Wound ... ? when they will receive clinical intervention.

Training tip: If you find you need a complete review for your staff, consider consulting with a certified Wound Care Nurse. To locate someone near you, go to www.wocn.org and click on "Need a nurse?"

The WOCN's Clinical Fact Sheet for Quick Assessment of Leg Ulcers at the bottom of this page is another useful tool in assessing ulcers. The WOCN Guidance On OASIS-C Integumentary Items can be found at http://c.ymcdn.com/sites/www.wocn.org/resource/resmgr/docs/guidanceoasis-c.pdf.