# OASIS Alert

## Integumentary Items: Get the Latest Pressure Ulcer Advice from CMS

**Use clinical judgment when a scab obscures visualization.**

The OASIS pressure ulcer items are some of the most confusing to answer, so it's important to keep up with new guidance for selecting your response. Here are the latest answers from the **Centers for Medicare & Medicaid Services** on accurately reporting pressure ulcer data.

Know When a Pressure Ulcer is No Longer a Pressure Ulcer

**Question:** Our patient had a Stage 4 pressure ulcer. The post-op surgical report states it was surgically excised and closed without placement of a muscle flap. Should we report it as a Stage 4 pressure ulcer in M1306  Does this patient have at least one Unhealed Pressure Ulcer at Stage II or Higher or designated as "unstageable" or has it become a surgical wound that we should report in M1340  Does this patient have a Surgical Wound?

**Answer:** When all the tissue damaged by pressure is removed surgically, by amputation or surgical excision for example, the patient no longer has a pressure ulcer, CMS says in the July 2013 CMS Quarterly OASIS Q&As. Instead, the patient has a surgical wound  until it heals.

Don't Let a Scab Obscure Your M1308 Response

**Question:** Our patient has a Stage 3 pressure ulcer that we have been treating during the episode. At the reassessment, the pressure ulcer is covered with a scab. I know a pressure ulcer is unstageable if it has a non-removable dressing or is covered with eschar or slough, but how does a scab affect the staging for M1308  Current Number of Unhealed Pressure Ulcers at Each Stage?

**Answer:** When you can see bone, muscle or tendon in a pressure ulcer with full thickness tissue loss, you have a Stage 4 pressure ulcer. You should report this wound as a Stage 4 in M1308 regardless of the presence of eschar, slough or a scab, CMS advises in the Q&As.

But suppose you can't see any Stage 4 structures such as bone, muscle or tendon, and there is some degree of necrotic tissue (eschar or slough) or scabbing present. If you believe the necrotic tissue or scabbing may be obscuring the visualization of bone, muscle or tendon, then this pressure ulcer is unstageable.

On the other hand, suppose you can't see any bone, muscle or tendon in a full thickness pressure ulcer, but in your clinical judgment the amount and/or placement of any necrotic tissue or scabbing present could not be obscuring visualization of Stage 4 structures. In this situation, you should report the pressure ulcer as Stage 3, CMS advises.

**Bottom line:** For a patient to have an unstageable scabbed pressure ulcer is an unusual occurrence, but it can happen. When completing M1308 for such a patient, you should report the pressure ulcer in row d.2  Unstageable: Known or likely but unstageable due to coverage of wound bed by slough and/or eschar, CMS says. A scab is not slough or eschar, but due to the constraints of the OASIS data set, you'll have to report an unstageable scabbed pressure ulcer this way.

Make sure you describe the clinical findings in detail in the patient's medical record.

**Note:** Always refer to the **Wound Ostomy and Continence Nurses Society** (WOCN) for guidance on pressure ulcer staging. You can read the WOCN guidance here: http://c.ymcdn.com/sites/www.wocn.org/resource/resmgr/docs/guidanceoasis-c.pdf.

See How Scabs Impact Healing Status

**Question:** How do you define the healing status of a Stage IV pressure ulcer that has closed to the point it has a scab on the surface? It is not eschar or slough. How would we report this in M1320 – Status of Most Problematic (Observable) Pressure Ulcer?

**Answer:** You can't assign the status "0 – Newly epithelialized" if a scab is obscuring the wound bed, CMS says. This is because the wound bed is not completely covered by new epithelium. If the scab is raised and appears to be covering a wound that has filled with granulation to the same level as the surrounding skin surface, you would report "1 – Fully granulating" in M1320, CMS advises.

But you might not be able to assign the status "Fully granulating" if the scab keeps you from seeing whether the wound bed is filled with granulation tissue to the level of the surrounding skin.

If the scab is present in a wound bed that is sunken below the level of the surrounding skin, then you can't select "0 – Newly epithelialized" or "1 – Fully granulating," CMS says. If there are no signs or symptoms of infection and you can visualize that at least 25 percent of the wound bed is covered with granulation tissue, then you can select "2 – Early/partial granulation."

It's important to remember that a scab is not avascular tissue (eschar or slough), CMS reminds. So the requirement that greater than or equal to "25 percent of the wound bed is covered with avascular tissue" for "Early/partial granulation" healing status doesn't apply to a scab. So, if you can see any of the criteria for "3 – Not Healing" in a scab covered wound, this would be the correct response.

WOCN criteria for answering "3 – Not Healing" include:

- wound with greater than or equal to 25 percent avascular tissue (eschar and/or slough) or
- signs/symptoms of infection or
- clean but non-granulating wound bed or
- closed/hyperkeratotic wound edges or
- persistent failure to improve despite appropriate comprehensive wound management.

**Note:** The WOCN Guidance on OASIS-C Integumentary Items includes definitions of the healing status of pressure ulcers. Read it here: http://c.ymcdn.com/sites/www.wocn.org/resource/resmgr/docs/guidanceoasis-c.pdf.

Read all of the July 2013 CMS Quarterly OASIS Q&As here: https://www.qtso.com/download/hha/CMS_OAI_2nd_Qtr_2013_QAs_07_17_13_REVISED.pdf.