



Wound Care Review

Best Practice Guidelines

Successful Wound Management Strategies : An Introduction

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Goals & Objectives

- The role and importance of wound care management
- Identify and document wounds based on CMS / ICD 9 / ICD 10 criteria
- Review and classify wound types based on their perspective classification
- Appropriately utilize major elements of wound assessment
- Understand role of pain assessment and documentation in wound care
- Review the importance of digital wound imaging in documentation
- Understand best practice guidelines and documentation of wounds

Overview

In today's home health care market, there is a need for increased awareness about the management, treatment and documentation of wounds. Inaccurate documentation and classification of the wounds leads to:

- Inappropriate treatment of the wounds
- Delayed healing of wounds
- Suboptimal Medicare reimbursement
- Decreased quality of care delivery by the agency
- Dissatisfied clients

Wound Care Litigation

Current statistics on Verdicts and Settlements

- Average Reported Award 2005-2010: \$4,154,592
- Highest Awards 2005-2010
- Dallas County, Texas: \$84,425,000
- Los Angeles County, California: \$48,493,140
- Cook County, Illinois: \$25,613,42



Cost of Treatment

Long Term Care Facilities/Hospitals

What it means to you per incident:

Pressure Ulcer

\$3,259 to \$52,930

Venous Stasis Ulcer

\$9,695 per patient

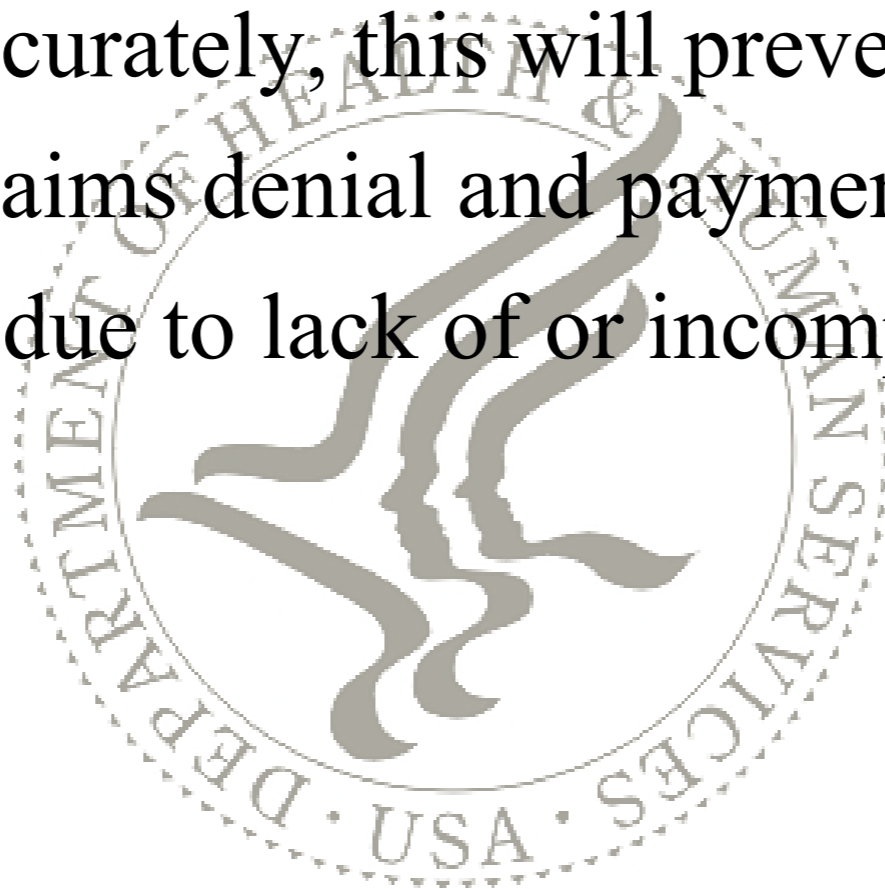
Neuropathic Ulcer

\$16,000 to \$28,000 per incident

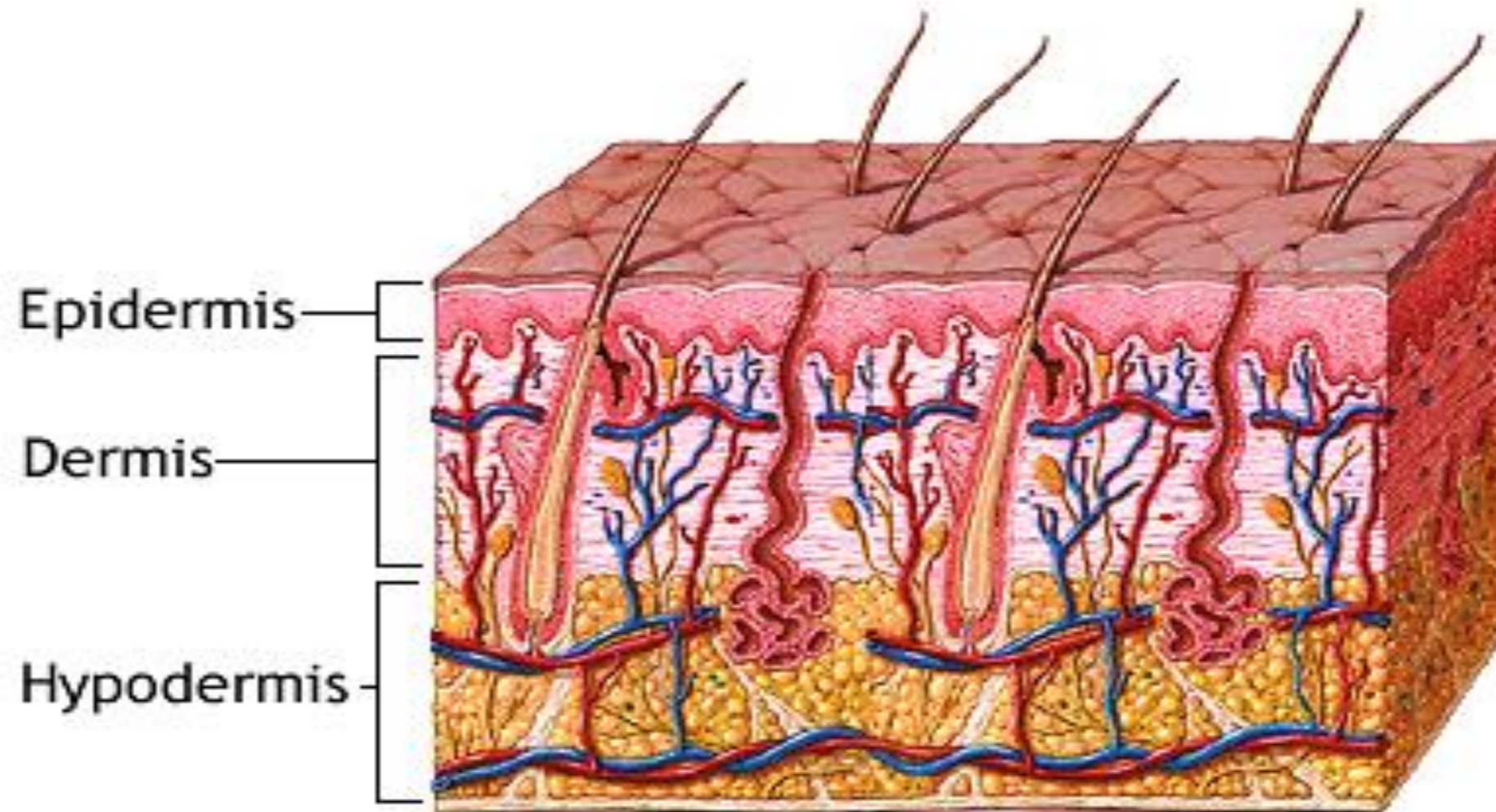
Source: WoundVision.com

Documentation

It is extremely important that all documentation is completed thoroughly and accurately, this will prevent inaccurate reimbursement, claims denial and payment refunds. 90% of denied claims are due to lack of or incomplete documentation.



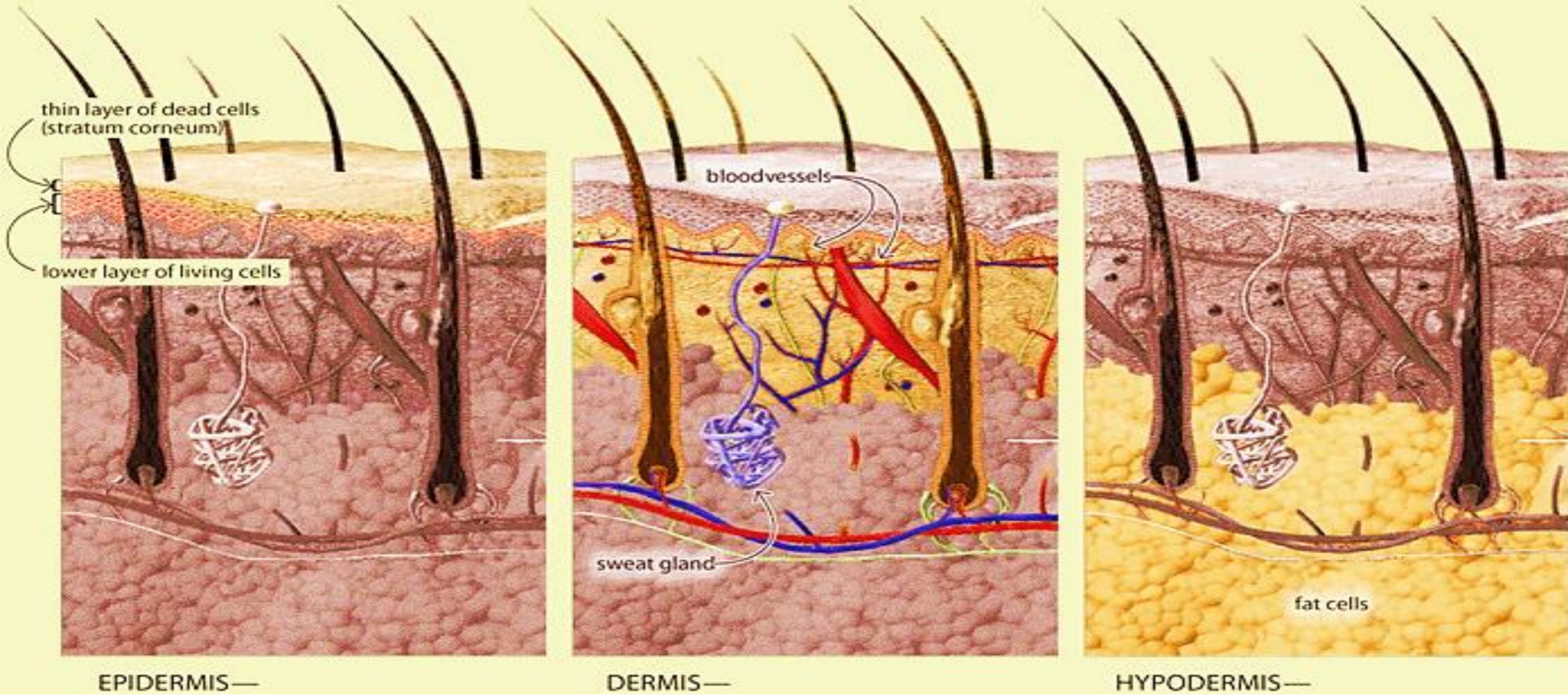
Normal Skin



Skin

- Skin is the largest organ of the body
- Skin is not just one static layer; it varies in thickness depending on on the location of the body. The thickest skin is found on the bottoms of the feet, while the thinnest is found around the eyes
- There are 3 layers of the Skin:
Epidermis, Dermis & Subcutaneous

Layers of the Skin



Type of Wounds

**IMPORTANT
ANNOUNCEMENT**

All wounds are not pressure ulcers !



Classification of Wounds

- Pressure Ulcers
- Diabetic / Neuropathic Ulcers
- Venous Stasis Ulcers
- Arterial / Ischemic Ulcers
- Surgical Wounds
- Atypical Wounds
- Fungating / Malignant Wounds
- Burns



OASIS : M1020/1022/1024

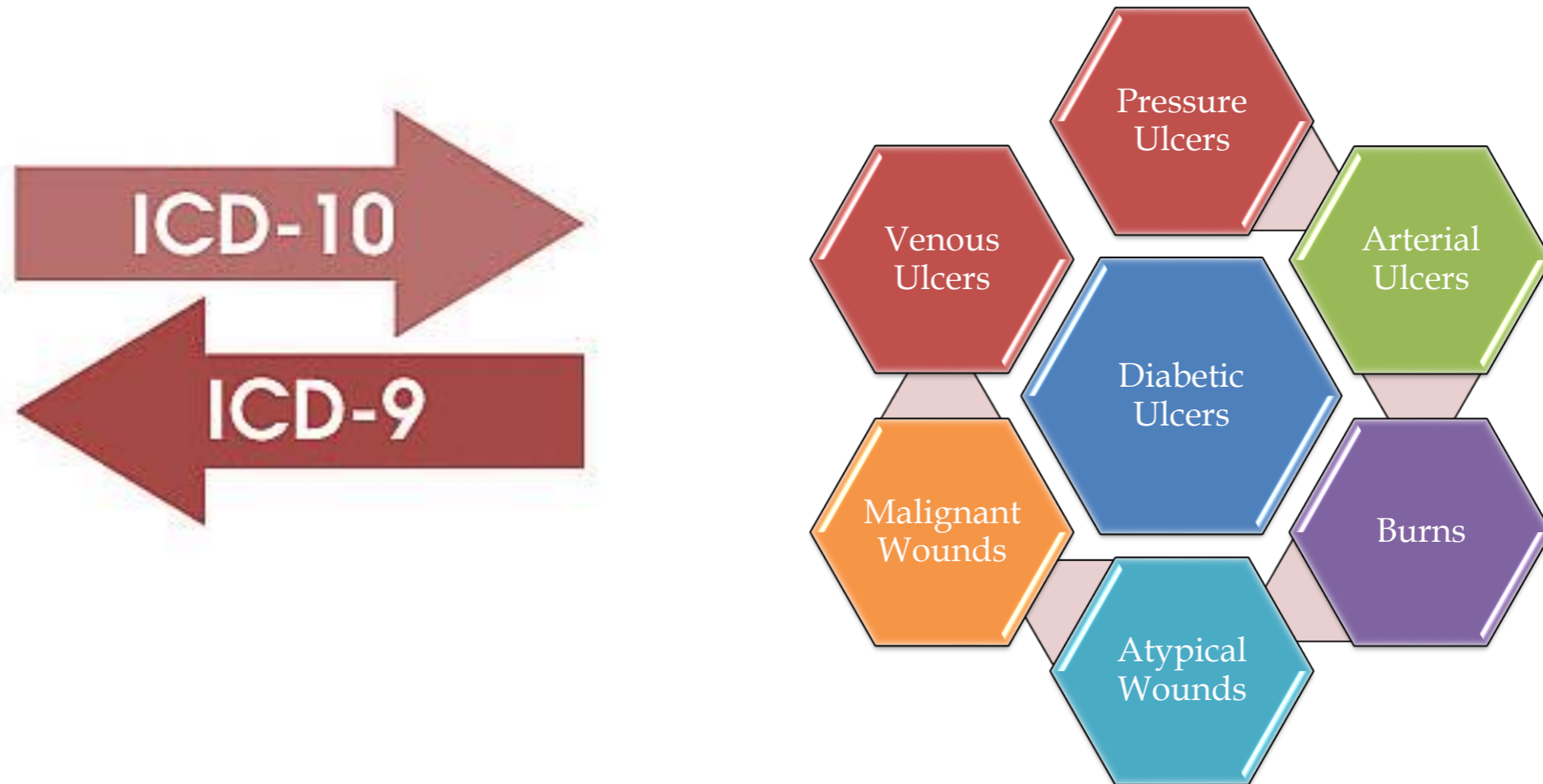
Diagnosis, Symptom Control, and Payment Diagnosis

- List each diagnosis for which the patient is receiving home care and enter its ICD-9-CM code at the level of highest specificity.
- Diagnoses are listed in the order that best reflect the seriousness of each condition and support the disciplines and services provided.

Are these sections filled out accurately ?

Documentation

Wounds must be appropriately documented based on CMS specified diagnoses criteria



Documentation

**Pressure Ulcer
STAGE I**
707.21

**Pressure Ulcer
STAGE II**
707.22

**Pressure Ulcer
STAGE-III**
707.23

Burns
940 - 948

Cellulitis
681 - 682

Gangrene
785.4

**Pressure Ulcer
Stage-IV**
707.24

**Pressure Ulcer
Un-Stageable**
707.20

**Pressure Ulcer
Deep Tissue Injury**
707.25

Osteomyelitis
730.07

**Non-Healing
Surgical Wound**
998.83

**Skin
Infection**
686.90

**Diabetic Foot
Ulcer**
707.13 - 707.19

**Disruption
Operation
Wound**
998.32

Trauma Wounds
870 - 897

Pyoderma
686.0

**Venous Leg
Ulcer**
459.81

Arterial Ulcer
440.23

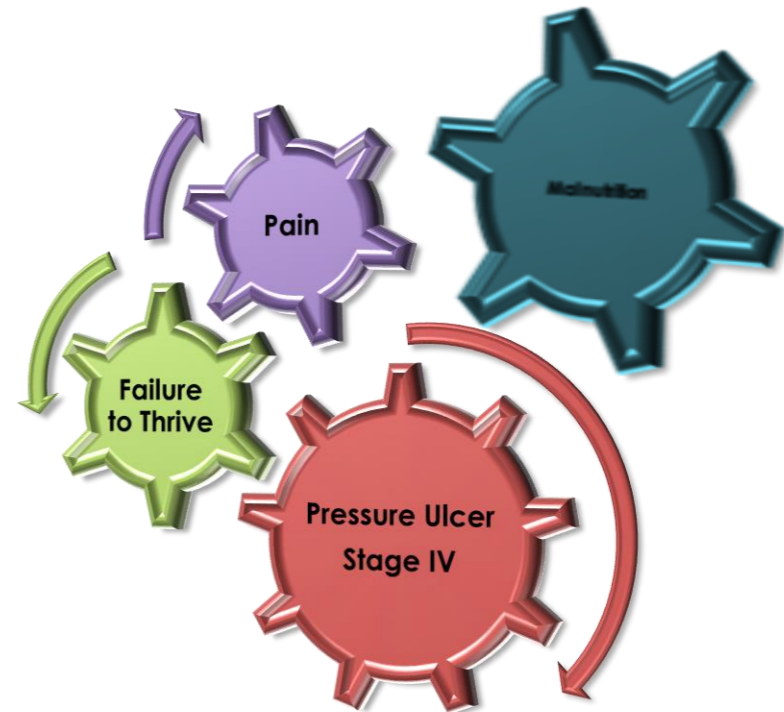
Calciphylaxis
275.49

**Contact
Dermatitis**
692.9

Documentation

OASIS Section M1020

Documentation should describe the patient's condition, using terminology which includes specific diagnoses as well as symptoms, problems, or reasons for the service. In addition, secondary codes must be documented that describe any coexisting conditions



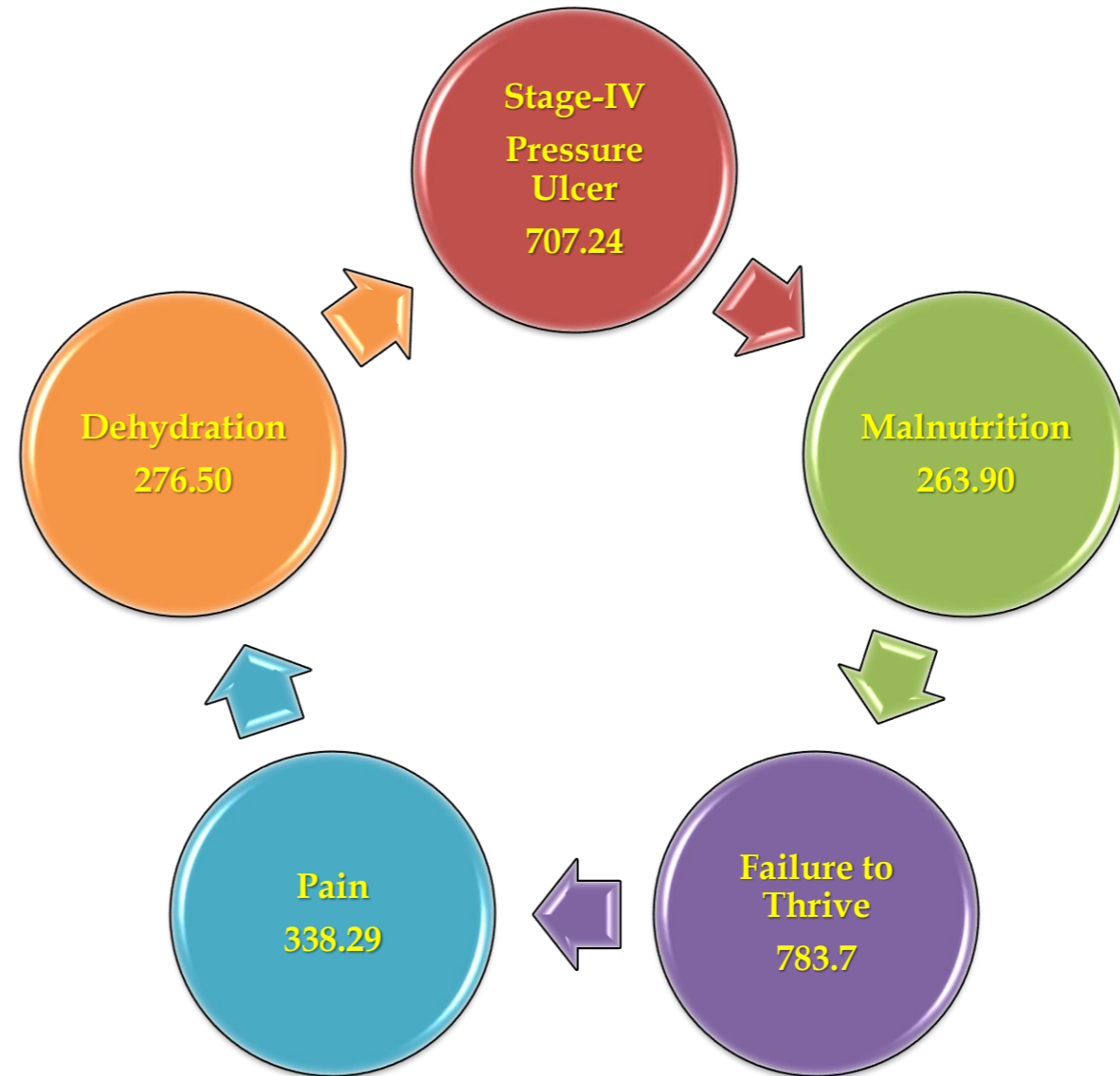
OASIS : M1032 ~ Risk for Hospitalization

Which of the following signs or symptoms characterize this patient as a risk for hospitalization?

- Recent decline in mental emotional, or behavioral status
- Multiple hospitalizations (2 or more) in the past 12 months
- History of falls (2 or more falls – or any fall with injury in the past year)
- Taking five or more medications
- Frailty indicators, e.g., weight loss, self-reported exhaustion
- Other ***Can Wounds cause hospitalizations?***

Documentation

DIAGNOSIS ASSOCIATION



Documentation

DIAGNOSIS ASSOCIATION

DIAGNOSIS

DIABETES MELLITUS	250.80
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DIAGNOSIS

NEUROPATHY	355.79 (8) (9)
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DIAGNOSIS

DIABETIC FOOT ULCER	707.13 – (19)
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Documentation

OASIS Section M1020

COLUMN 1	COLUMN 2	COLUMN 3	COLUMN 4
<p>Sequencing of diagnoses should reflect the seriousness of each condition and support the disciplines and services provided.</p> <p>(M1020) Primary Diagnosis</p>	<p>ICD-9-C M and symptom control rating for each condition. Note that the sequencing of these ratings may not match the sequencing of the diagnoses.</p> <p>ICD-9-C M/ Symptom Control Rating (V-codes are allowed)</p>	<p>Complete if a V-code is assigned under certain circumstances to Column 2 in place of a case mix diagnosis.</p> <p>(M1024) Description/ ICD-9-C M (V- or E-codes NOT allowed)</p>	<p>Complete only if the V-code in Column 2 is reported in place of a case mix diagnosis that is a multiple coding situation (e.g., a manifestation code).</p> <p>(M1024) Description/ ICD-9-C M (V- or E-codes NOT allowed)</p>
a. Diagnosis <input type="text" value="DMI oth nt st unc"/>	Code <input type="text" value="250.80"/>	a. <input type="text" value="Start Typing"/>	a. <input type="text" value="Start Typing"/>
Severity <input type="text" value="3"/>	O/E <input type="text" value="Onset"/>	Date <input type="text" value="06/11/2014"/>	
(M1022) Other Diagnoses			
b. Diagnosis <input type="text" value="Oth mononeur low"/>	Code <input type="text" value="355.79"/>	b. <input type="text" value="Start Typing"/>	b. <input type="text" value="Start Typing"/>
Severity <input type="text" value="4"/>	O/E <input type="text" value="Onset"/>	Date <input type="text" value="06/11/2014"/>	
c. Diagnosis <input type="text" value="Ulcer of ankle"/>	Code <input type="text" value="707.13"/>	c. <input type="text" value="Start Typing"/>	c. <input type="text" value="Start Typing"/>
Severity <input type="text" value="4"/>	O/E <input type="text" value="Onset"/>	Date <input type="text" value="06/11/2014"/>	
d. Diagnosis <input type="text" value="Start Typing"/>	Code <input type="text" value=""/>	d. <input type="text" value="Start Typing"/>	d. <input type="text" value="Start Typing"/>
Severity <input type="text" value=""/>	O/E <input type="text" value=""/>	Date <input type="text" value=""/>	

OASIS : M1034 ~ Overall Status

Which description best fits the patient's overall status? (Check one)

- 0 – The patient is stable with no heightened risk(s) for serious complications and death (beyond those typical of the patient's age).
- 1 – The patient is temporarily facing high health risk(s) but is likely to return to being stable without heightened risk(s) for serious complications and death (beyond those typical of patient's age).
- 2 – The patient is likely to remain in fragile health and have ongoing high risk(s) of serious complications and death.
- 3 – The patient has serious progressive conditions that could lead to death within a year.

Can Wounds increase the risks & complications ?

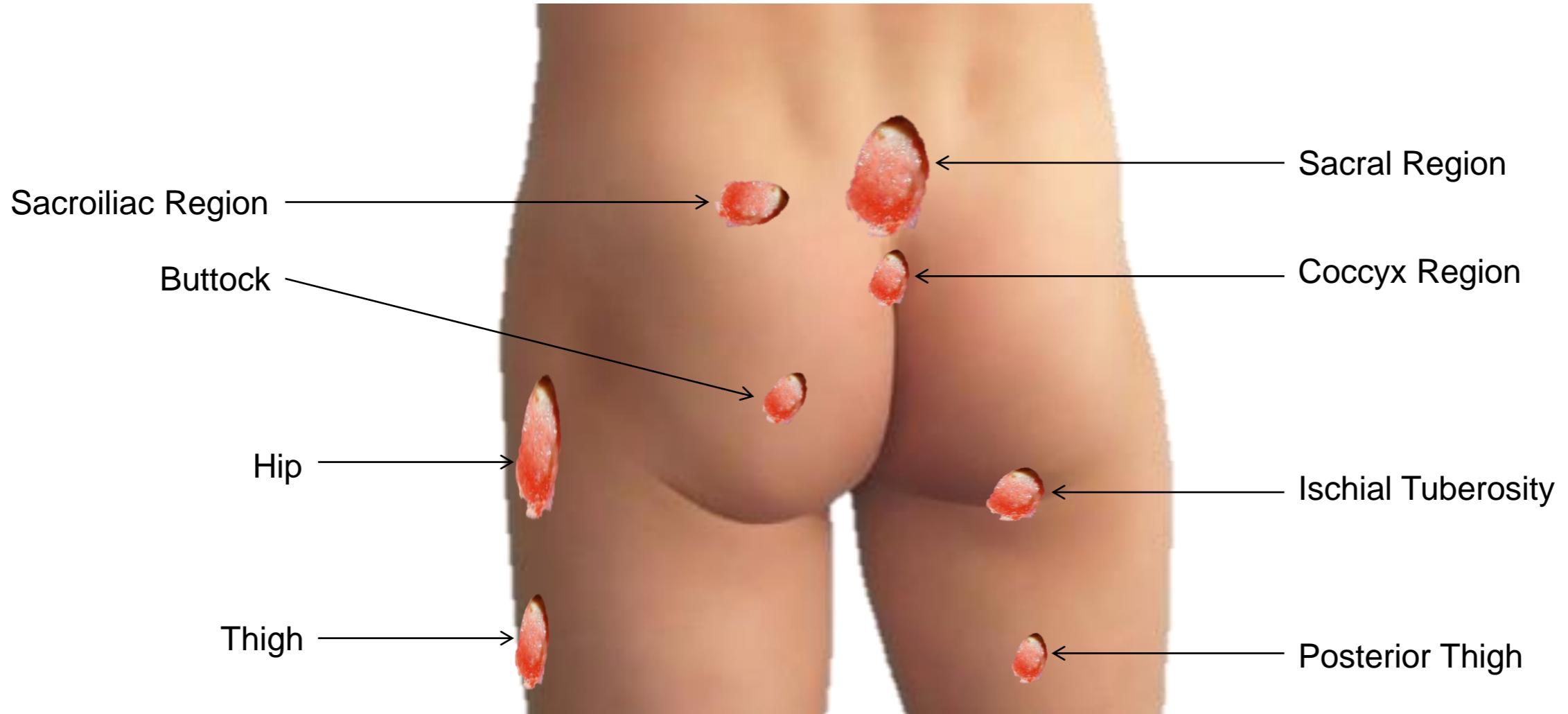
Elements of Wound Documentation

LOCATION OF WOUND



Elements of Wound Documentation

LOCATION OF WOUND



Elements of Wound Documentation

WOUND MEASUREMENT

It is extremely important to measure the wound periodically since it shows the actual progress of the wound. (Length x Width x Depth)

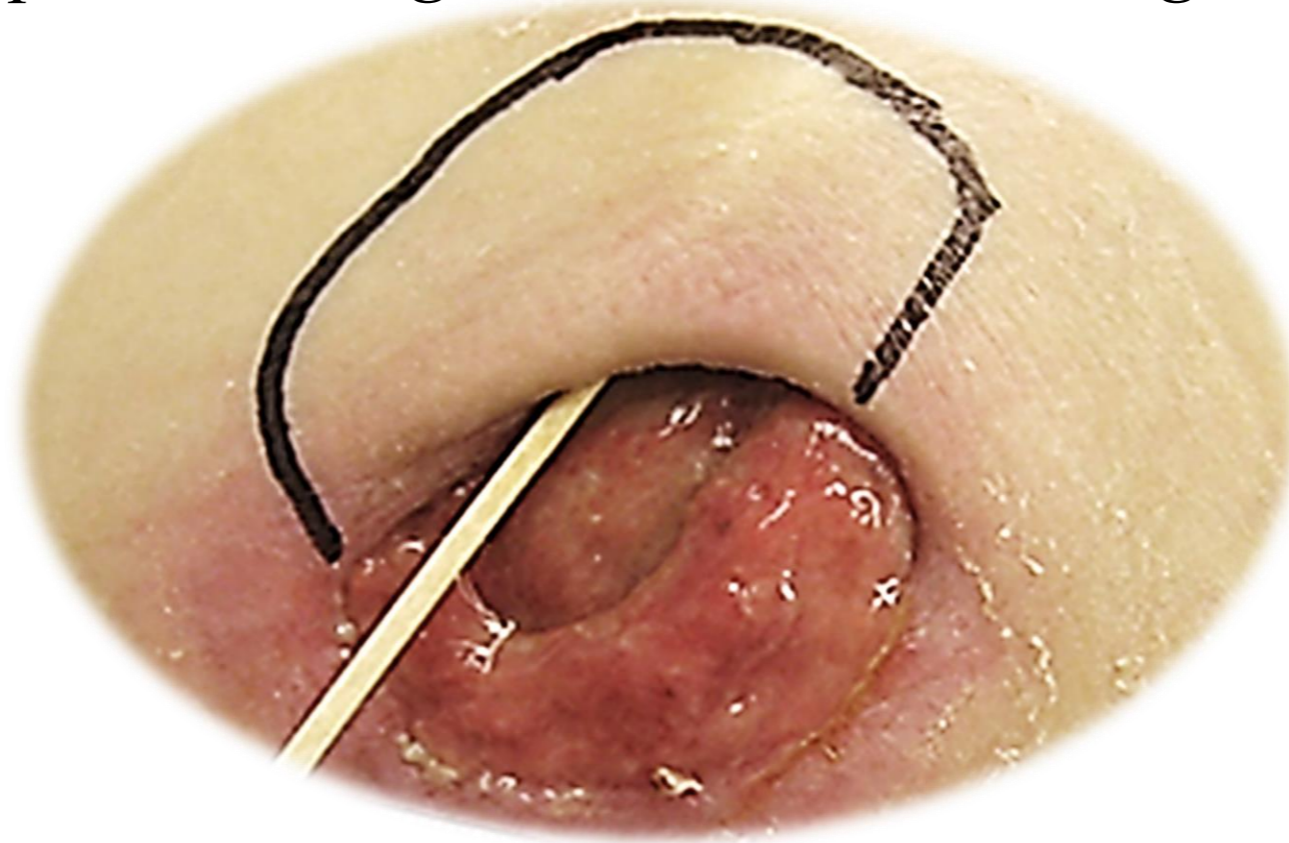


Elements of Wound Documentation

WOUND MEASUREMENT

Tunneling Channel that runs from the wound edge through to other tissue

“deepest tunneling at 9 o’clock, measuring 3 cm long”

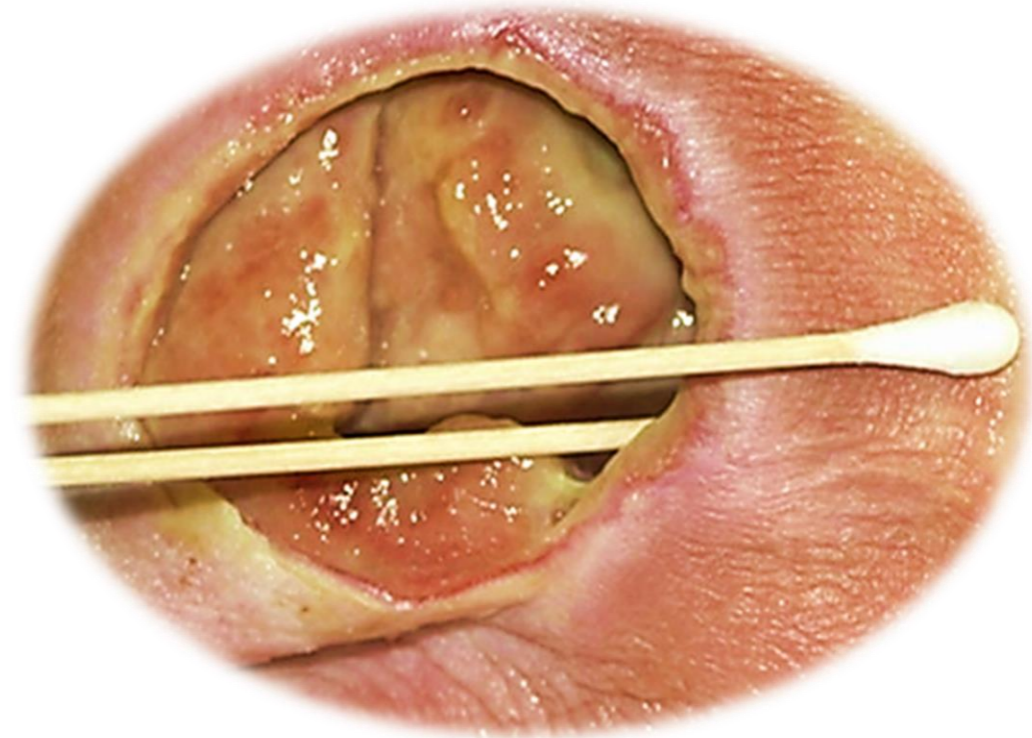
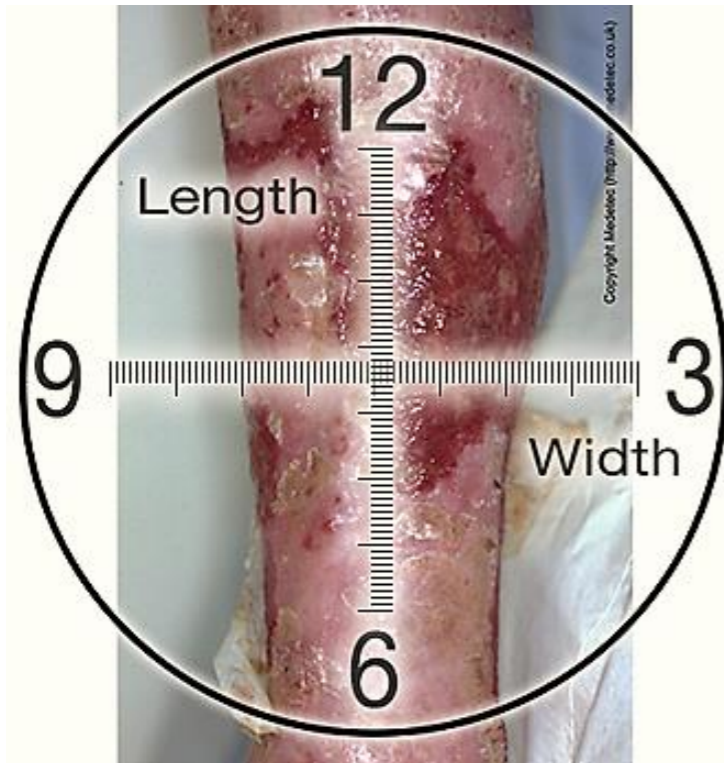


Elements of Wound Documentation

WOUND MEASUREMENT

Undermining is a separation of tissue from the surface under the edge of the wound. Describe by clock face with patients head at 12

“undermining is 1 cm from 12 to 4 o’clock”



Elements of Wound Documentation

WOUND CHARACTERISTICS

Wounds shall be documented by percentage of each type of tissue in the wound bed

Granulation Tissue

red or pink color with cobblestone like appearance (healing, filling in)

Necrotic / Non-Viable

Slough-yellow, tan dead tissue (devitalized)

Eschar-black/brown necrotic tissue, can be hard or soft

Elements of Wound Documentation

WOUND CHARACTERISTICS

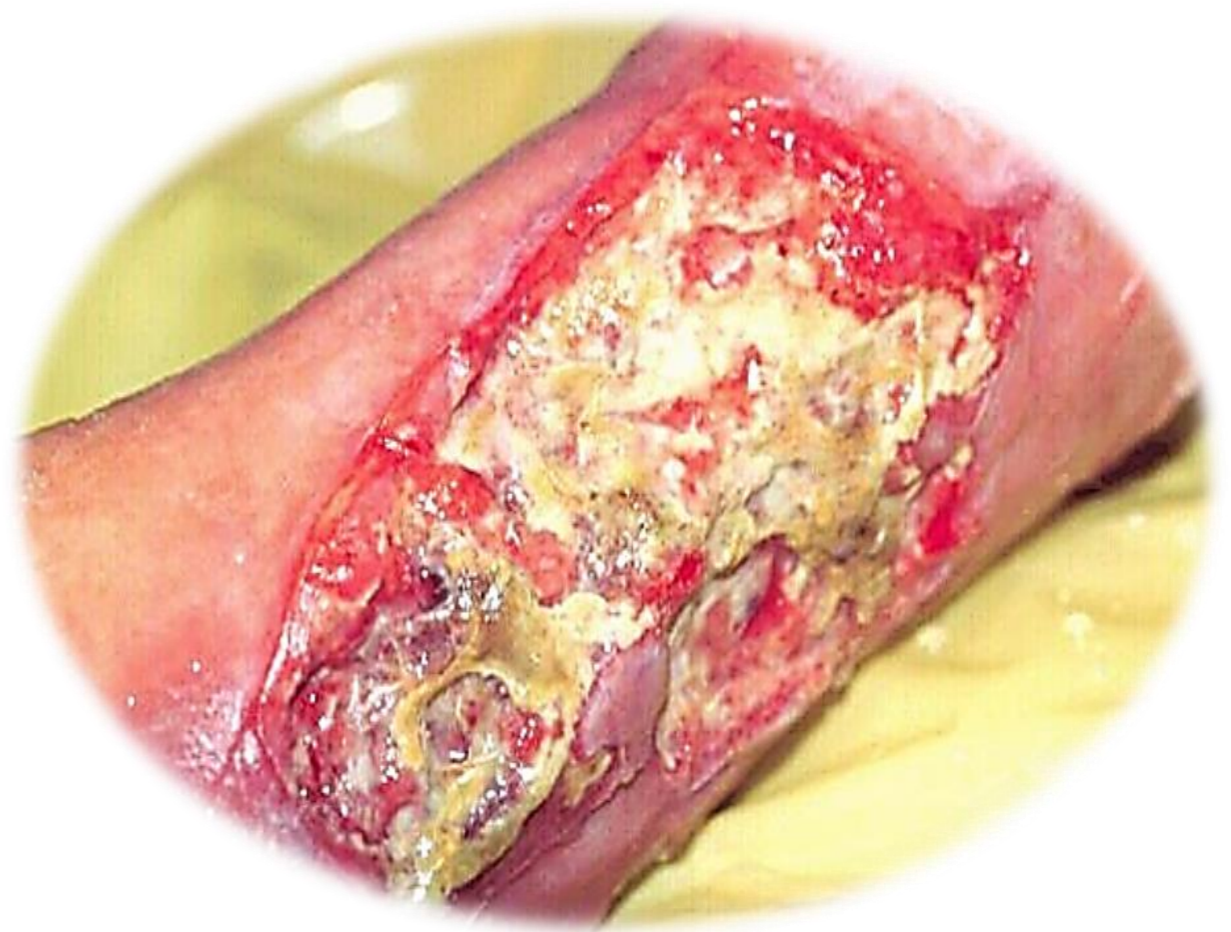
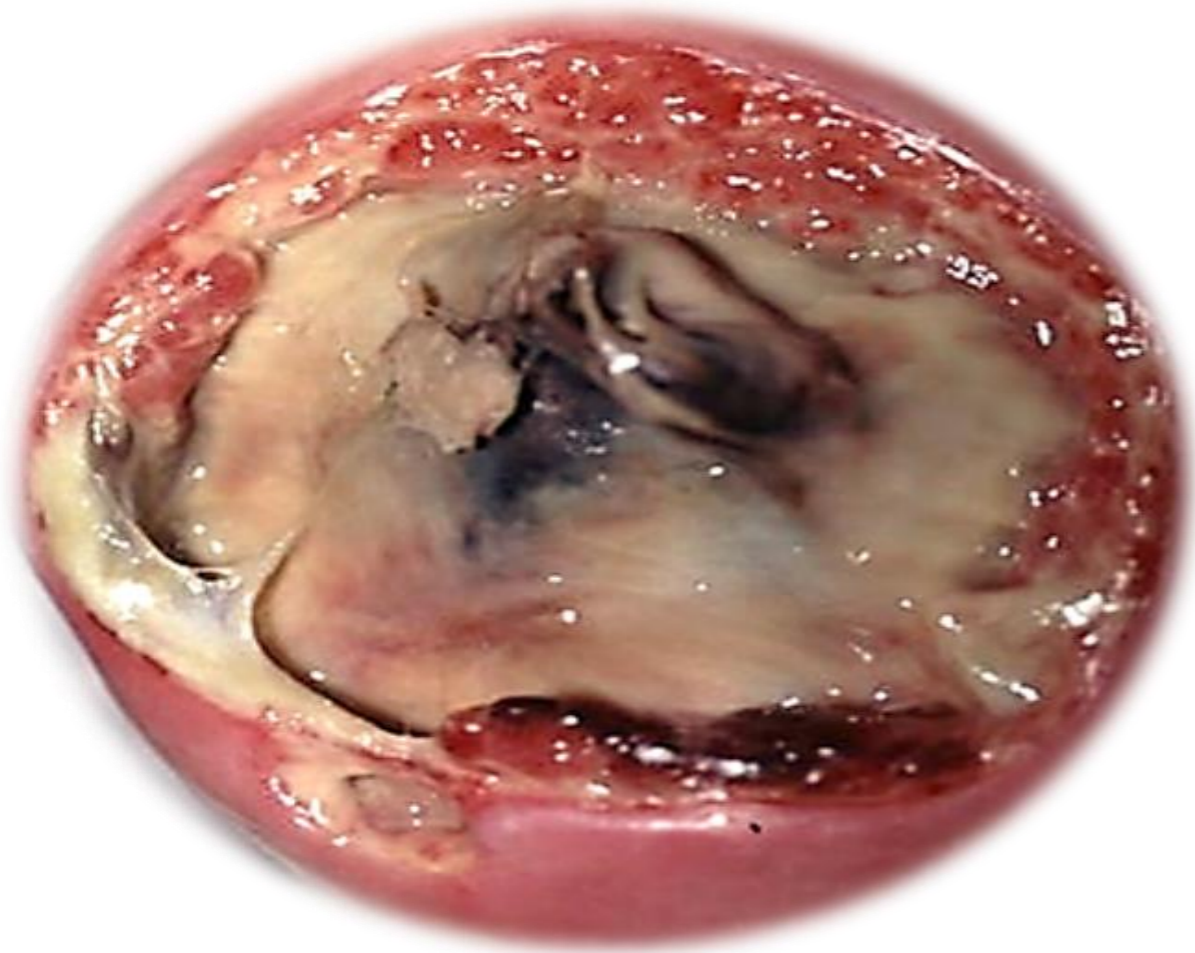
Granulation Tissue



Elements of Wound Documentation

WOUND CHARACTERISTICS

Necrotic / Non-Viable Tissue



Elements of Wound Documentation

WOUND CHARACTERISTICS

Drainage & Odor

Exudate (Wound Drainage)

Document the amount, type and odor. Scant, Moderate, heavy. Drainage can be Serous/clear, sanguineous (bloody), serosanguineous (blood-tinged), purulent (cloudy, pus-yellow, green)

Odor

Most wounds have an odor. Be sure to clean wound well first before assessing odor (wound cleanser, saline) Describe foul odor as mild, moderate, or strong.

Elements of Wound Documentation

WOUND CHARACTERISTICS

Peri-Wound Skin Status

Viable, macerated, inflamed Color-erythema (purple appearance on dark skin),
pale

Texture-dry, moist, boggy (soft), macerated (white, soggy appearance), edema

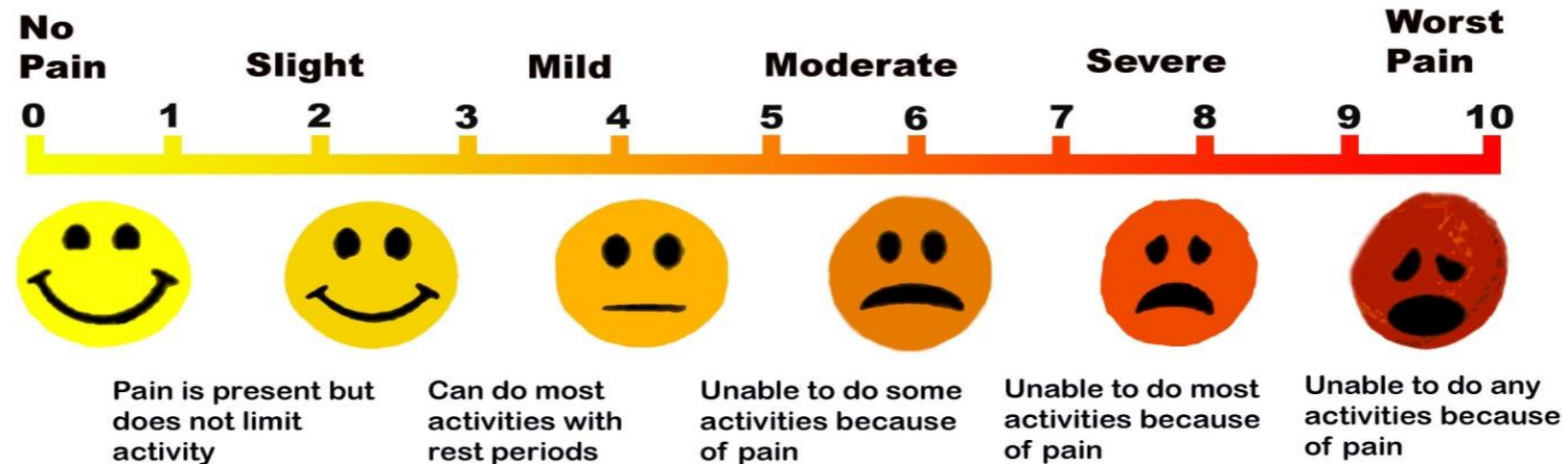
Temperature-cool, warm

Skin integrity- lesions, excoriation, maceration, denuded (loss of epidermis)

OASIS : M1240/M1242 ~ Pain

Pain related to wounds must be assessed and documented appropriately.

How is your Pain Today?



(The Wong-Baker FACES Pain Rating Scale)

www.cms.gov

Wound Care Digital Photo Documentation

A PICTURE CAN BE WORTH A THOUSAND WORDS

- Wound digital imaging improves the documentation which may protect the agency against a complaint or a lawsuit, improves coordination of care among clinicians and serve as a tool for patient and family education.
- Wound images taken consistently during the delivery of care can provide evidence that the wound was regularly assessed and monitored by the agency.
- Informed consent must be completed during the admission before wounds are photographed.
- A minimal of 14.0 megapixel digital camera is ideal for wound imaging.
- Weekly wound imaging is the recommended best practice.



Wound Care Best Practice Model

- Patients with skin problems or wounds or high risk for developing wounds shall be assessed by a Wound Care Nurse (WCN).
- Digital wound images must be implemented as an integral part of the care delivery.
- Weekly measurements of wounds shall be completed and documented in the medical records.
- Electronic medical record (EMR) must be able to accommodate the wound images.

References

- ❑ John A. Hartford Foundation, Institute for Geriatric Nursing:
<http://www.hartfordign.org/index.html>
- ❑ National Pressure Ulcer Advisory Panel:
<http://npuap.org/>
- ❑ Wound Care Nursing :
<http://www.woundcarenurses.org>
- ❑ Agency for Healthcare Research and Quality:
Clinical Practice Guidelines:
<http://www.ahrq.gov/clinic/cpgonline.htm>
- ❑ National Guideline Clearinghouse:
Guideline for prevention and management of pressure ulcers:
http://www.guideline.gov/summary/summary.aspx?ss=15&doc_id=3860&nbr=3071