Home Health Coding and OASIS Expert

Assessment: Bolster Your Wound Documentation for ICD-10

Look to the WOCN for training resources.

Accurately documenting ulcers is a challenge for many clinicians. But precise documentation of these and other wounds gains even greater importance under ICD-10. Do you need a refresher course to help improve your accuracy?

Problem: Listing the incorrect wound type is a common error. "We've seen the same wound referred to as a trauma wound, an arterial ulcer, and a diabetic ulcer all in the same record," said **Beth Johnson, MBA, BSN, RN, CRRN, HCS-D, HCS-O,** president of **Johnson, Richards & Associates,** in Brighton, Mich. Obviously, inaccuracies like these can lead to both coding and OASIS errors.

Solution: Be sure to describe the wound characteristics to the physician to help with accurate wound diagnosis, say **Sue Kennedy, BS, RN, CWOCN, FACCWS, COS-C,** and **Debbie Ritter, BSN, RN, CWOCN, FACCWS, COS-C, with RitKen and Associates,** a nationwide WOC Nurse consulting firm based in Ponchatoula, La.

Problem: Another area of common confusion is with pressure ulcer staging. For example, documenting that a pressure ulcer which was previously unstageable due to the presence of eschar or slough became a stage I pressure ulcer at a later date is impossible, Johnson said in a recent blog post. A stage I pressure ulcer is non-blanchable redness without any breakdown of the epidermal layer, making it impossible for an ulcer that was previously unstageable due to the presence of slough or eschar to be classified as stage I.

Solution: An unstageable ulcer, by definition, is one that is a suspected deep tissue injury (DTI) in evolution, one that is covered by a non-removable dressing, or one that is covered by eschar or slough to the extent that you cannot determine the depth of tissue injury. So, you could, theoretically have a stage I pressure ulcer that was previously called unstageable because it was covered by a non-removable dressing, but a pressure ulcer with slough or eschar present could never become a stage I, says Ritter.

Other frequent wound documentation errors include the following, say Kennedy and Ritter:

- Inconsistent wound location (left vs. right). Make certain wound location is documented accurately throughout the record.
- Describing a wound as partial thickness tissue loss when slough and/or granulation are present. The presence of slough or granulation actually indicates full thickness tissue damage or loss.
- Referring to a full thickness tissue damage pressure ulcer as a Stage II. Stage II pressure ulcers involve partial thickness tissue loss and are a result of unrelieved pressure.
- Lack of communication with the physician's team when there is no wound healing progress within two to three weeks of implementing a comprehensive wound management protocol.
- Improper documentation of implemented wound care interventions. For example: Providing wound care without orders. Or, simply including the statement "wound care provided per physician orders" in the documentation. Each skilled note must stand alone and "wound care provided per physician orders" is not acceptable documentation.

As you conduct the comprehensive patient assessment, you gather the details that promote accurate wound documentation, say Kennedy and Ritter. This includes the following areas.

Wound location: An accurate description of the wound's location communicates key characteristics that will assist physicians with determining wound etiology. For example, consider these different locations and common types of wounds found there.

- Bony prominence: pressure ulcer.
- Extremities: trauma or skin tear.
- Lower extremity: venous or arterial ulcers.
- Feet or toes: arterial or neuropathic ulcers.
- Perineum: Moisture Associated Skin Damage (MASD)

Medical Devices: The use of medical devices may contribute to pressure ulcers, Kennedy and Ritter say. The presence of unrelieved pressure contributes to compressed vessels and tissue ischemia. Watch for the following types of devices:

- Oxygen face mask: bridge of nose
- Oxygen cannula: ear cartilage
- Ventilator stabilizer
- Limb braces

Comorbidities: Having a thorough understanding of all of your patient's comorbidities may assist with identifying wound etiology. Take special note of these areas and the types of wounds to which they may contribute, Kennedy and Ritter say.

Age: Skin becomes more fragile

Recent surgery or immobility: Can create risk of pressure ulcers

Diabetes: At risk of neuropathic ulcers

Incontinence: Can lead to MASD

Autoimmune disorders: Greater risk of vasculitis, pyoderma gangrenosum, and other lesions

Cancer: Watch for malignant lesions

Renal disease: Potential calciphylaxis

Varicose veins, venous hypertension, thrombophlebitis, or deep vein thrombosis (DVT): Watch for venous stasis ulcers

Peripheral arterial disease (PAD) or peripheral vascular disease (PVD): Can lead to arterial ulcers

Medications: Meds may assist with identifying wound etiology. Be on the lookout for patients taking the following, Kennedy and Ritter say:

- Clopidogrel (Plavix): Consider possible arterial ulcer
- Warfarin (Coumadin): Possible venous stasis disease process
- Metformin (Glucophage) or insulin and wound(s) located on feet: Consider possibility of neuropathic ulcer
- Steroids (Prednisone): Side effect possibly resulting in increasingly fragile skin

Extent of tissue damage: Accurate assessment of the level of tissue damage ensures accurate diagnosis coding, Kennedy and Ritter say. Remember, while the physician determines the wound type and diagnosis, the clinician may determine the extent of tissue damage. Keep the following definitions in mind.

Partial thickness: through epidermis extending into dermis

Full thickness: through epidermis and dermis extending into subcutaneous tissue. Presence of fat, muscle, tendon, cartilage, or bone indicates full thickness tissue damage

Coming up: Watch for more ulcer coding challenges in ICD-10, which requires you to indicate the severity of stasis, arterial and diabetic ulcers. Severity is defined in 4 phases:

1) Limited to skin breakdown
2) Exposed fat layer
3) Necrosis of muscle
4) Necrosis of bone

Review of patient history: Knowing your patient's history can help you to identify conditions that could impact wound assessment. Watch for:

- Recent increased immobility
- Change in ambulation
- Environment that could promote wounds
- Age of wound

Nutritional status: This impacts wound appearance and healing. To keep an eye on this area, Kennedy and Ritter suggest considering whether to request the following lab values:

- Albumin level
- Pre-albumin level
- Ferritin and transferrin levels
- Blood glucose levels
- Complete Blood Count (CBC)

Don't Miss these Key Documentation Requirements

Accurate, detailed wound documentation should cover the following details, say Kennedy and Ritter. Be sure to record this information during each visit.

- Describe the wound bed. Indicate the presence of slough and/or granulation using percentages.
- Indicate the drainage amount including color and presence or absence of odor.
- Describe the surrounding wound margin (normal vs. erythema, vs. maceration).
- Describe the wound edge. Is it closed or open?
- Measure the wound weekly using centimeters. Include length (head to toe), width (perpendicular to length), depth (straight up and down at deepest area of the wound), as well as undermining and tunnels describing location using the numbers of a clock (12 o'clock being toward patient's head, 6 o'clock being toward patient's toes).

Try this: If your documentation already includes comprehensive wound assessments with accurate descriptions and measurements, you should have an easy time meeting the new ICD-10 requirements, Johnson said. But if the clinicians in your agency are struggling, now's the time to bring in a wound care professional for training in assessing, describing, documenting, and treating wounds. "If you don't have a wound-ostomy-continence certified nurse (WOCN) or similar expert on staff at your home health agency, look to your local hospital or WOCN society for resources," Johnson suggested.

Note: Read Johnsons' blog at http://jraconsultants.com/blog .