Part 4:
OASIS-C2 Accuracy

Presented by:
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For:
HealthCare Synergy

Let’s Review!
M2020/M2030 General Rules

- If a patient does not have the requisite knowledge of a drug’s dose and administration schedule to take the correct dose at the correct time (includes mental/emotional/cognitive ability):
  - Response 3, Unable to take medication (oral or injectable) unless administered by another person, is appropriate.

- If a medication (oral or injectable) is not in the home (whether currently due, due at a future point during the episode, or PRN):
  - Response 3, Unable to take medication (oral or injectable) unless administered by another person, is appropriate.

M2020/M2030 General Rules

- If medications are in the home but not needed or due at time of assessment, observe the patient’s ability based on asking patient to describe steps or simulate task.

- If patient requires assistance to walk to the place where medications are routinely stored or requires someone to retrieve medications for them:
  - Response 3, Unable to take medication (oral or injectable) unless administered by another person, is appropriate.
M2020 and M2030: Scenarios

- Patient got home from the hospital 2 days ago. Her meds include Lasix, Lisinopril, Digoxin, and an oral antibiotic. She is also on oxygen. She uses a pill planner set up by her daughter. Although she states she took yesterday’s meds, there is a Lasix tablet still in the box. She says she meant to take it but forgot.
  - How would you score M2020?

- Patient, a long time diabetic, is independent in administration of his insulin. At SOC, post left total knee replacement, the nurse assesses that he is unsafe ambulating without supervision and his wife must get his insulin from the refrigerator for him.
  - How would you score M2030?

Answers: M2020 and M2030

- Patient got home from the hospital 2 days ago. Her meds include Lasix, Lisinopril, Digoxin, and an oral antibiotic. She is also on oxygen. She uses a pill planner set up by her daughter. Although she states she took yesterday’s meds, there is a Lasix capsule still in the box. She says she meant to take it but forgot.
  - How would you score M2020?
    ✓ Response 3 - Unable to take medication unless administered by another person

- Patient, a long time diabetic, is independent in administration of his insulin. At SOC, following a total knee replacement, the nurse assesses that he is unsafe ambulating without supervision and his wife must get his insulin from the refrigerator for him.
  - How would you score M2030?
    ✓ Response 3 - Unable to take injectable medication unless administered by another person
Integumentary Status
M1300 – M1350

See WOCN Guidance on OASIS-C2 Integumentary Items

NPUAP Revised “Pressure Injury” Guidelines

In April 2016, the National Pressure Ulcer Advisory Panel (NPUAP) revised its’ guidelines for the purpose of improving assessment and documentation precision. These include:

- A change in terminology used by the system from “pressure ulcers” to “pressure injuries”
- A new definition for “pressure injury”
- Removal of term “suspected” from deep tissue pressure injury
- New/updated staging definitions including:
  - Use of Arabic numbers 1-4, instead of Roman numerals I-IV
  - 2 new definitions
    1. Medical device related pressure injury
    2. Mucosal membrane pressure injury
- New/updated illustrations
Pressure Injury Definition

- A pressure injury is localized damage to the skin and underlying soft tissue usually over a bony prominence or related to a medical or other device. The injury can present as intact skin or an open ulcer and may be painful. The injury occurs as a result of intense and/or prolonged pressure or pressure in combination with shear. The tolerance of soft tissue for pressure and shear may also be affected by microclimate, nutrition, perfusion, co-morbidities and condition of the soft tissue.

Types of Pressure Injuries

- Two kinds of pressure injuries:
  - Pressure injuries to intact skin
  - Pressure injuries that result in open ulcerations (skin not intact)

- Revised staging descriptions focus on the extent of tissue damage in assigning a stage rather than the depth of the injury.
Medical Device Related Pressure Injury (NPUAP 2016)

- **Medical Device Related Pressure Injury:**
  This describes an etiology.
  - Medical device related pressure injuries result from the use of devices designed and applied for diagnostic or therapeutic purposes. The resultant pressure injury generally conforms to the pattern or shape of the device. The injury should be staged using the staging system.

- **Mucosal Membrane Pressure Injury:**
  - Mucosal membrane pressure injury is found on mucous membranes with a history of a medical device in use at the location of the injury. Due to the anatomy of the tissue these ulcers *cannot* be staged.

(M1300)

- Identifies whether the home health agency care providers assessed the patient’s risk of developing pressure ulcers.

- May only respond NA in M2400e if *every standardized, validated* pressure ulcer risk assessment conducted *at or since the most recent SOC/ROC assessment* indicates the patient is *not* at risk of developing pressure ulcers.
  - The evaluation of clinical factors is *not* a standardized tool.
If assessed using a standardized, validated assessment tool, use the scoring parameters on the tool for determining the scoring response.

If the evaluation was based on clinical factors (without a standardized, validated screening tool) the agency or care provider may define what constitutes risk.

If both a standardized, validated screening tool AND an evaluation of clinical factors are used, select response 1 - Yes, if either assessment is positive for risk.

<table>
<thead>
<tr>
<th>Braden Score</th>
<th>Risk Level</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>15 -18</td>
<td>At Risk</td>
<td>* If other major risk factors present, advance to next level of risk.</td>
</tr>
<tr>
<td>13 - 14</td>
<td>Moderate</td>
<td>* If other major risk factors present, advance to next level of risk.</td>
</tr>
<tr>
<td>10 – 12</td>
<td>High</td>
<td></td>
</tr>
<tr>
<td>9 or less</td>
<td>Very High</td>
<td></td>
</tr>
</tbody>
</table>

*Other major risk factors are defined by the Braden tool as: advanced age, fever, poor dietary intake of protein, diastolic pressure below 60, hemodynamic instability.

Source: Braden, Barbara, Protocols by Level of Risk
> Agencies may adopt the NPUAP guidelines in their clinical practice and documentation.

> Since CMS has adapted the NPUAP guidelines for OASIS purposes, the definitions do not perfectly align with each stage as described by NPUAP.

> When discrepancies exist between the NPUAP definitions and the OASIS scoring instructions provided in the OASIS Guidance Manual and CMS Q&As, providers should rely on the CMS OASIS instructions. **OASIS RULES!**

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**M1306: Guidance (cont.)**

> Pressure ulcers are defined as 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.

> If pressure is not the primary cause of the lesion, do not report the wound as a pressure ulcer.
  
  > For example, blister on the heel due to rubbing of a new shoe

> Terminology referring to “healed” vs. “unhealed” ulcers can refer to whether the ulcer is “closed” vs. “open.”
  
  > Stage 1 pressure ulcers and Suspected Deep Tissue Injury (sDTI), although closed (intact skin), would not be considered healed.
  
  > Unstageable pressure ulcers, whether covered with a non-removable dressing or eschar or slough, would not be considered healed.
**M1306: Guidance** (cont.)

- Stage 2 (partial thickness) pressure ulcers heal through the process of regeneration of epidermis across the wound surface, known as “re-epithelialization.”
  - Stage 2 ulcers do **not** granulate and are reported as unhealed until they have epithelialized.
  - Eschar and/or slough are **not** present in a Stage 2 ulcer (would be a Stage 3 or 4).
  - Newly epithelialized Stage 2 ulcers are **not** reported or counted.

- Unstageable pressure ulcers are **not** considered healed. Included are:
  - Suspected Deep Tissue Injuries (sDTIs);
  - Known (documented in record) pressure ulcers covered with a nonremovable dressing.
  - Known pressure ulcers where eschar or slough is obscuring visualization of Stage 4 structure – bone, tendon, muscle, or joint capsule.

**M1306: Guidance** (cont.)

- Stage 3 and 4 (full thickness) pressure ulcers heal through a process of granulation (filling of the wound with connective/scar tissue), contraction (wound margins contract and pull together), and re-epithelialization (covers with epithelial tissue from within wound bed and/or from wound margins).

Once (a Stage 3 or 4) pressure ulcer has fully granulated and the wound surface is completely covered with new epithelial tissue, the wound is considered closed, and will continue to remodel and increase in tensile strength.

For the purposes of scoring the OASIS, **the wound is considered healed at this point, and should no longer be reported as an unhealed pressure ulcer**.
Healthy Skin
(NPUAP 2016)

Stage 1 Pressure Injury
(NPUAP 2016)

- Stage 1 Pressure Injury: Non-blanchable erythema of intact skin
  - Intact skin with a localized area of non-blanchable erythema, which may appear differently in darkly pigmented skin. Presence of blanchable erythema or changes in sensation, temperature, or firmness may precede visual changes. Color changes do not include purple or maroon discoloration. These may indicate deep tissue pressure injury.
Stage 2 Pressure Injury
(NPUAP 2016)

- **Stage 2 Pressure Injury:** Partial-thickness skin loss with exposed dermis
  - Partial-thickness loss of skin with exposed dermis. The wound bed is viable, pink or red, moist, and may also present as an intact or ruptured serum-filled blister. Adipose (fat) is *not* visible and deeper tissues are *not* visible. **Granulation tissue, slough and eschar are not present.** These injuries commonly result from adverse microclimate and shear in the skin over the pelvis and shear in the heel. This stage should not be used to describe moisture associated skin damage (MASD) including incontinence associated dermatitis (IAD), intertriginous dermatitis (ITD), medical adhesive related skin injury (MARSIs), or traumatic wounds (skin tears, burns, abrasions).
Stage 3 Pressure Injury
(NPUAP 2016)

- **Stage 3 Pressure Injury: Full-thickness skin loss**
  - Full-thickness loss of skin, in which adipose (fat) is visible in the ulcer and granulation tissue and epibole (rolled wound edges) are often present. Slough and/or eschar may be visible. The depth of tissue damage varies by anatomical location; areas of significant adiposity can develop deep wounds. Undermining and tunneling may occur. Fascia, muscle, tendon, ligament, cartilage and/or bone are not exposed. If slough or eschar obscures the extent of tissue loss this is an Unstageable Pressure Injury.

Stage 4 Pressure Injury
(NPUAP 2016)

- **Stage 4 Pressure Injury: Full-thickness skin and tissue loss**
  - Full-thickness skin and tissue loss with exposed or directly palpable fascia, muscle, tendon, ligament, cartilage or bone in the ulcer. Slough and/or eschar may be visible. Epibole (rolled edges), undermining and/or tunneling often occur. Depth varies by anatomical location. If slough or eschar obscures the extent of tissue loss this is an Unstageable Pressure Injury.
Unstageable Pressure Injury
(NPUAP 2016)

- **Unstageable Pressure Injury: Obscured full-thickness skin and tissue loss**
  - Full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because it is obscured by slough or eschar. If slough or eschar is removed, a Stage 3 or Stage 4 pressure injury will be revealed. Stable eschar (i.e. dry, adherent, intact without erythema or fluctuance) on the heel or ischemic limb should not be softened or removed.

Deep Tissue Injury
(NPUAP 2016)

- **Deep Tissue Pressure Injury: Persistent non-blanchable deep red, maroon or purple discoloration**
  - Intact or non-intact skin with localized area of persistent non-blanchable deep red, maroon, purple discoloration or epidermal separation revealing a dark wound bed or blood filled blister. Pain and temperature change often precede skin color changes. Discoloration may appear differently in darkly pigmented skin. This injury results from intense and/or prolonged pressure and shear forces at the bone-muscle interface. The wound may evolve rapidly to reveal the actual extent of tissue injury, or may resolve without tissue loss. If necrotic tissue, subcutaneous tissue, granulation tissue, fascia, muscle or other underlying structures are visible, this indicates a full thickness pressure injury (Unstageable, Stage 3 or Stage 4). Do not use DTPI to describe vascular, traumatic, neuropathic, or dermatologic conditions.
Medical Device Related Pressure Injury
(NPUAP 2016)

 Medical Device Related Pressure Injury:
This describes an etiology.
• Medical device related pressure injuries result from the use of devices designed and applied for diagnostic or therapeutic purposes. The resultant pressure injury generally conforms to the pattern or shape of the device. The injury should be staged using the staging system.

 Mucosal Membrane Pressure Injury:
• Mucosal membrane pressure injury is found on mucous membranes with a history of a medical device in use at the location of the injury. Due to the anatomy of the tissue these ulcers cannot be staged.

(M1307)

- The intent of this item is to:
  a) Identify the oldest Stage 2 pressure ulcer that is present at the time of discharge and is not fully epithelialized (healed);
  b) Assess the length of time this ulcer remained unhealed while the patient received care from the home health agency; and
  c) Identify patients who develop Stage 2 pressure ulcers while under the care of the agency.

- Note: Multiple episodes may span between SOC/ROC and DC.
**M1307: Guidance**

- Stage 2 (partial thickness) pressure ulcers heal through the process of regeneration of the epidermis across a wound surface called “re-epithelialization.”

- Do not reverse stage pressure ulcers as a way to document healing as it does not accurately characterize what is physiologically occurring as the ulcer heals.
  - For example, over time, even though a Stage 4 pressure ulcer has been healing and contracting such that it is less deep, wide, and long, the tissues that were lost (muscle, fat, dermis) will never be replaced with the same type of tissue. Clinical standards require that this ulcer continue to be documented as a Stage 4 pressure ulcer until it has healed.

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**M1307: Guidance (cont.)**

- If more than one Stage 2 pressure ulcer is present at discharge, refer to the oldest one.

- If no pressure ulcer existed at the SOC, then a Stage 1 pressure ulcer developed, which progressed to a Stage 2 by discharge, enter Response 2, and specify the date that the pressure ulcer was first identified as a Stage 2 ulcer.

- An ulcer that is suspected of being a Stage 2, but is Unstageable due to non-removable dressing/device at the time of discharge, should not be identified as the “oldest Stage 2 pressure ulcer.”

- Enter “NA” if the patient has no Stage 2 pressure ulcers at the time of discharge, or all previous Stage 2 pressure ulcers have healed.
Replaces M1308

$\textbf{(M1311)}$

<table>
<thead>
<tr>
<th>(M1311) Current Number of Unhealed Pressure Ulcers at Each Stage</th>
<th>Enter Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>A1. Stage 2: Partial thickness loss of dermis presenting as a shallow open ulcer with red pink wound bed, without slough. May also present as an intact or open/ruptured blister.</td>
<td>[ \text{Number of Stage 2 pressure ulcers} ] [If 0 at FUDC Go to M1311B1]</td>
</tr>
<tr>
<td>A2. Number of \textit{these} Stage 2 pressure ulcers that were present at most recent SOC/ROC</td>
<td>[ \text{– enter how many were noted at the time of most recent SOC/ROC} ]</td>
</tr>
<tr>
<td>B1. Stage 3: Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon, or muscle is not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling.</td>
<td>[ \text{Number of Stage 3 pressure ulcers} ] [If 0 at FUDC Go to M1311C1]</td>
</tr>
<tr>
<td>B2. Number of \textit{these} Stage 3 pressure ulcers that were present at most recent SOC/ROC</td>
<td>[ \text{– enter how many were noted at the time of most recent SOC/ROC} ]</td>
</tr>
<tr>
<td>C1. Stage 4: Full thickness tissue loss with exposed bone, tendon, or muscle. Slough or eschar may be present on some parts of the wound bed. Often includes undermining and tunneling.</td>
<td>[ \text{Number of Stage 4 pressure ulcers} ] [If 0 at FUDC Go to M1311D1]</td>
</tr>
<tr>
<td>C2. Number of \textit{these} Stage 4 pressure ulcers that were present at most recent SOC/ROC</td>
<td>[ \text{– enter how many were noted at the time of most recent SOC/ROC} ]</td>
</tr>
</tbody>
</table>

$\$\$\textbf{M1311} = 2\text{ or more Stage 3 or 4}$

\[ (\textbf{M1311})...\text{continued} \]

<table>
<thead>
<tr>
<th>(M1311) Current Number of Unhealed Pressure Ulcers at Each Stage</th>
<th>Enter Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>D1. Unstageable: Non-removable dressing: Known but not stageable due to non-removable dressing/device</td>
<td>[ \text{Number of unstageable pressure ulcers due to non-removable dressing/device} ] [If 0 at FUDC Go to M1311E1]</td>
</tr>
<tr>
<td>D2. Number of \textit{these} unstageable pressure ulcers that were present at most recent SOC/ROC</td>
<td>[ \text{– enter how many were noted at the time of most recent SOC/ROC} ]</td>
</tr>
<tr>
<td>E1. Unstageable: Slough and/or eschar; Known but not stageable due to coverage of wound bed by slough and/or eschar</td>
<td>[ \text{Number of unstageable pressure ulcers due to coverage of wound bed by slough and/or eschar} ] [If 0 at FUDC Go to M1311F1]</td>
</tr>
<tr>
<td>E2. Number of \textit{these} unstageable pressure ulcers that were present at most recent SOC/ROC</td>
<td>[ \text{– enter how many were noted at the time of most recent SOC/ROC} ]</td>
</tr>
<tr>
<td>F1. Unstageable: Deep tissue injury: Suspected deep tissue injury in evolution</td>
<td>[ \text{Number of unstageable pressure ulcers with suspected deep tissue injury in evolution} ] [If 0 - Go to M1322 (at Follow up), Go to M1313 (at Discharge)]</td>
</tr>
<tr>
<td>F2. Number of \textit{these} unstageable pressure ulcers that were present at most recent SOC/ROC</td>
<td>[ \text{– enter how many were noted at the time of most recent SOC/ROC} ]</td>
</tr>
</tbody>
</table>

\[ \text{(Omit "A2, B2, C2, D2, E2 and F2" on SOC/ROC)} \]
**M1311: Guidance**

- Counts all current Stage 2, Stage 3, Stage 4, and unstageable pressure ulcers at all time points.

- 2-line format for reporting current pressure ulcers:
  - **Line 1 (Completed at all time points):** Number of current pressure ulcers at a given stage.
    - A1 (Stage 2); B1 (Stage 3); C1 (Stage 4); D1 (Unstageable due to non-removable dressing); E1 (Unstageable due to eschar/slough); F1 (Unstageable due to suspected DTI)
    - *If no pressure ulcer at a given stage at FU and DC, skip Line 2.*
  - **Line 2 (Completed at Follow-up and Discharge only):** Number of these ulcers at a given stage that were present at most recent SOC/ROC.
    - A2 (Stage 2); B2 (Stage 3); C2 (Stage 4); D2 (Unstageable due to non-removable dressing); E2 (Unstageable due to eschar/slough); F2 (Unstageable w/suspected DTI)
  
  *Interpretation: Was the current stage present AT THE SAME STAGE at the most recent SOC/ROC assessment?*

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**M1311 at SOC**

- At SOC, patient has Stage 4 pressure ulcer on his left heel.

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<table>
<thead>
<tr>
<th>B1. Stage 2: Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon, or muscle is not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling. Number of Stage 3 pressure ulcers</th>
<th>0</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not answered at SOC/ROC</td>
<td></td>
</tr>
<tr>
<td>B2. Number of these Stage 3 pressure ulcers that were present at most recent SOC/ROC</td>
<td>0</td>
</tr>
<tr>
<td>Not answered at SOC/ROC</td>
<td></td>
</tr>
<tr>
<td>C1. Stage 4: Full thickness tissue loss with exposed bone, tendon, or muscle. Slough or eschar may be present on some parts of the wound bed. Often includes undermining and tunneling. Number of Stage 4 pressure ulcers</td>
<td>0</td>
</tr>
<tr>
<td>Not answered at SOC/ROC</td>
<td></td>
</tr>
<tr>
<td>C2. Number of these Stage 4 pressure ulcers that were present at most recent SOC/ROC</td>
<td>0</td>
</tr>
<tr>
<td>Not answered at SOC/ROC</td>
<td></td>
</tr>
</tbody>
</table>
M1311 at Discharge

- At discharge, patient still has a Stage 4 pressure ulcer on his left heel.

M1311: Guidance

- Identifies the number of Stage 2 or higher pressure ulcers at each stage present at the time of assessment.
- **NOT** reported are:
  - Stage 1 pressure ulcers; and
  - Ulcers that have healed.
- **NOT** considered healed are:
  - Stage 1 pressure ulcers;
  - Stage 2 pressure ulcers;
  - Suspected Deep Tissue Injury; and
  - Unstageable pressure ulcers, whether covered with a non-removable dressing or eschar or slough.

Do not reverse stage pressure ulcers!
Present on Admission = Present at SOC/ROC

- For each pressure ulcer, determine whether the pressure ulcer was present at the time of the most recent SOC/ROC, and did not form during this home health quality episode.

- If a pressure ulcer that is identified on the SOC date increases in numerical stage (worsens) within the assessment time frame (5 days at SOC, 2 days at ROC), the initial stage of the pressure ulcer would be reported.
  - Do not change the stage on the SOC/ROC assessment.

Let’s take a look...

- A SOC assessment is done on Tuesday. The patient has a Stage 2 pressure ulcer on her coccyx.

- On Saturday, the nurse noted that the pressure ulcer had worsened to a Stage 3.

  ➢ If a pressure ulcer worsens during the assessment time period, the initial stage at SOC is reported.
Same patient...

- The patient was admitted to the hospital with pneumonia. At ROC, the pressure ulcer was marked as a Stage 3.

| B1. Stage 3: Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon, or muscle is not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling. Number of Stage 3 pressure ulcers [If 0 at FUDC Go to M1311C1] | 1 |
| B2. Number of these Stage 3 pressure ulcers that were present at most recent SOC/ROC — enter how many were noted at the time of most recent SOC/ROC | 1 |

- The patient went to a SNF and was discharged from the agency. The pressure ulcer remained a Stage 3.

| B1. Stage 3: Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon, or muscle is not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling. Number of Stage 3 pressure ulcers [If 0 at FUDC Go to M1311C1] | 1 |
| B2. Number of these Stage 3 pressure ulcers that were present at most recent SOC/ROC — enter how many were noted at the time of most recent SOC/ROC | 1 |

➤ If the patient had not been hospitalized and a ROC done, how would M1311 have been scored at discharge?

Unstageable Pressure Ulcer at SOC/ROC

- If a pressure ulcer was unstageable at SOC/ROC, but becomes numerically stageable later, when completing the Discharge assessment, its “Present on Admission” stage should be considered the stage at which it first becomes numerically stageable.

- If the ulcer subsequently increases in numerical stage, do not report the higher stage ulcer as being “present at SOC/ROC” when completing the Discharge assessment.
M1311: Scenario

- At SOC, patient had a pressure ulcer on his right hip that was covered with slough and eschar. Two days later, the physician debrided it and staged it as a 3. It progressed to a Stage 4 and a Stage 2 developed on his left hip, prior to being discharged to a nursing home.

- The pressure ulcer was unstageable at SOC. This is not changed, if the status changes within the assessment time period (5 days at SOC).

- If a pressure ulcer was unstageable at SOC/ROC, but becomes numerically stageable later, when completing the Discharge, its “Present on Admission” stage should be considered the stage at which it first becomes numerically stageable – Stage 3.

- If the ulcer worsens, do not report the higher stage at Discharge.
M1311: Guidance (cont.)

- A previously closed Stage 3 or Stage 4 pressure ulcer that re-opens should be reported at its worst stage.
- The clinician should make every effort to contact previous providers (including patient’s physician) to determine the stage of the wound at its worst.
- A pressure ulcer that has been surgically debrided remains a pressure ulcer and should *not* be reported as a surgical wound on M1340.
- Pressure ulcers sutured closed are still considered pressure ulcers, *not* surgical wounds.
  - Report these ulcers in M1311 as: D1 (unstageable due to a non-removable dressing or device).

M1311: Guidance (cont.)

- A muscle flap, skin advancement flap, or rotational flap graft performed to surgically replace a pressure ulcer is *not* a pressure ulcer. It is a surgical wound and is *not* reported in M1311.
- A pressure ulcer treated with a skin graft (defined as transplantation of skin to another site) should *not* be reported as a pressure ulcer and, until the graft edges completely heal, should be reported as a surgical wound on M1340.
Your turn!

- Patient was admitted with a Stage 3 pressure ulcer on her right hip.
- At follow-up (recertification), the ulcer was assessed as unstageable due to eschar and slough.
- She was discharged 3 weeks later because she was moving to live with her daughter in another state. Prior to discharge, the ulcer was debrided and assessed as a Stage 3.
- There is a new Stage 2 pressure ulcer on her left hip.

How should M1311 be answered at SOC, Follow-up, and Discharge?
This item documents the number of pressure ulcers present at Discharge that were not present (are new) or have “worsened” (increased in numerical stage) since the most recent SOC/ROC assessment.
M1313: Guidance

- Compare the current stage at Discharge to past stages to determine whether any pressure ulcer currently present is new or at an increased numerical stage (worsened) when compared to the most recent SOC/ROC.

- Count the number of current pressure ulcers that are new or have increased in numerical stage since the last SOC/ROC was completed.

- A pressure ulcer increased in numerical stage from SOC/ROC to Discharge, is considered worsened.

- For pressure ulcers that are currently Stage 2, 3, or 4, “worsening” refers to a pressure ulcer that has progressed to a deeper level of tissue damage and is, therefore, staged at a higher number using a numerical scale of 1-4 at the time of discharge in comparison to the most recent SOC/ROC assessment.

M1313: Guidance (cont.)

- For pressure ulcers that are currently Stage 2, 3 or 4:
  - Mark a response for each row of this item: a, b, and c. If at Discharge there are currently NO ulcers at a given stage, enter “0” for that stage/row.
  - Report the number of current pressure ulcers at each stage that are new or have worsened since the most recent SOC/ROC assessment.

- If the pressure ulcer was unstageable for any reason at the most recent SOC/ROC, do not consider it new or worsened, if at some point between SOC/ROC and Discharge it became stageable and remained at that same stage at Discharge.

- If the pressure ulcer was unstageable at SOC/ROC, then was stageable on a routine visit and/or Follow-Up assessment, and by Discharge the pressure ulcer had increased in numerical stage, is should be considered worsened at Discharge.
M1313: Guidance (cont.)

- If a previously stageable pressure ulcer becomes unstageable, then was debrided sufficiently to be restaged by Discharge, compare its stage before and after it was deemed unstageable. If the pressure ulcer’s stage has increased in numerical staging, report this as worsened.
- Pressure ulcers that are Unstageable at Discharge due to a dressing/device, such as a cast that cannot be removed to assess the skin underneath, cannot be reported as new or worsened unless no pressure ulcer existed at that site at the most recent SOC/ROC.
- A dash (–) value is a valid response for this item.

(M1313) Reporting Algorithm

<table>
<thead>
<tr>
<th>CURRENT STAGE at Discharge</th>
<th>Look back to most recent SOC/ROC</th>
<th>PRIOR STAGE at most recent SOC/ROC</th>
<th>REPORT AS NEW OR WORSENED?</th>
</tr>
</thead>
</table>
| a. Stage 2 at Discharge   | If some pressure ulcer at most recent SOC/ROC was: | • Not present  
• Stage 1  
• Covered with a non-removable dressing/device, then documented as a Stage 1 at any home visit or follow-Up assessment(s) | YES |
|                           |                                  | • Stage 2  
• Stage 3  
• Stage 4 | NO  
NA (Stage 3 or 4 could not become a Stage 2) |
|                           | If some pressure ulcer at most recent SOC/ROC was: | • Not present  
• Stage 1  
• Stage 2  
• Unstageable with documented Stage 1 and/or 2 at any home visit or follow-Up assessment(s) | YES |
|                           |                                  | • Stage 3  
• Stage 4 | NO  
NA (Stage 4 could not become a Stage 3) |
### (M1313) Reporting Algorithm (cont.)

#### c. Stage 4 at Discharge

- If same pressure ulcer at most recent SOC/ROC was:
  - Not present
  - Stage 1
  - Stage 2
  - Stage 3
  - Unstable with documented Stage 1, 2, and/or 3 at any home visit or follow-up

- Report as new or worsened?
  - Yes

#### d. Unstable due to non-removable dressing at Discharge

- If same pressure ulcer at most recent SOC/ROC was:
  - Not present

- Report as new or worsened?
  - Yes

#### (M1313) Reporting Algorithm (cont.)

#### e. Unstable due to slough and/or eschar at Discharge

- If same pressure ulcer at most recent SOC/ROC was:
  - Not present
  - Stage 1
  - Stage 2
  - Stage 3
  - Stage 4
  - Unstable

- Report as new or worsened?
  - Yes

#### f. Unstable - suspected deep tissue injury at Discharge

- If same pressure ulcer at most recent SOC/ROC was:
  - Not present
  - Stage 1
  - Stage 2
  - Stage 3
  - Unstable due to slough and/or eschar
  - Unstable – suspected DFI or due to a non-removable dressing/device

- Report as new or worsened?
  - Yes

- NA (Full thickness pressure ulcer could not become a DFI)
M1311 and M1313: Scenario

- Patient had a Stage 2 pressure ulcer on her left hip at SOC. Two weeks later she had an exacerbation of her CHF and was hospitalized for 5 days.
- At the ROC assessment, the pressure ulcer on her left hip had deteriorated to a Stage 3, and she had a new Stage 1 pressure ulcer on her right hip.
- At discharge, the Stage 3 pressure ulcer on her left hip was 80% granulated, and the Stage 1 pressure ulcer on her right hip had evolved to a stage 2 pressure ulcer.

➤ Complete M1311 at SOC and ROC and M1313 at DC.

M1311: Completed

- Stage 1 pressure ulcers are excluded from M1311.
- Line 2 completed at FU and DC only.
The Stage 1 pressure ulcer at ROC deteriorated to a Stage 2.

The Stage 3 pressure ulcer at ROC remained a Stage 3 and is, therefore, not reported at Discharge.

Identifies the degree of closure visible in the most problematic observable pressure ulcer, Stage 2 or higher.

Note: Stage 1 pressure ulcers and ulcers that have healed are not considered for this item.

Excludes pressure ulcer covered with a non-removable dressing/device.

“Most problematic” may be the largest, the most advanced stage, the most difficult to access for treatment, the most difficult to relieve pressure, etc.

Do not use Response 0. Newly epithelialized (healed) ulcers should not be reported.
Healing Status: WOCN Definitions
(WOCN Guidance on OASIS-C2 Integumentary Items 11/16)

- Newly epithelialized:
  - Wound bed completely covered with new epithelium; and
  - No exudate; and
  - No avascular tissue (eschar and/or slough); and
  - No signs or symptoms of infection.

- Fully granulating:
  - Wound bed filled with granulation tissue to the level of the surrounding skin; and
  - No dead space; and
  - No avascular tissue (eschar and/or slough); and
  - No signs or symptoms of infection; and
  - Wound edges are open.

- Early/partial granulation:
  - ≥ 25% of the wound bed is covered with granulation tissue; and
  - < 25% of the wound bed is covered with avascular tissue (eschar and/or slough); and
  - No signs or symptoms of infection; and
  - Wound edges are open.

- Not healing:
  - Wound with ≥ 25% 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.
More M1320 Guidance

- Because Stage 2 ulcers do **not** granulate and newly epithelialized Stage 2 ulcers are **not** counted, the only appropriate response for a Stage 2 ulcer is 3 – Not Healing.

- Since a suspected Deep Tissue Injury in evolution does **not** granulate and would **not** be covered with new epithelial tissue, the only appropriate response for a suspected Deep Tissue Injury is 3 – Not Healing.

- The presence of necrotic tissue does NOT make the pressure ulcer “NA - No observable pressure ulcer.”

- A pressure ulcer with necrotic tissue (eschar/slough) obscuring the wound base **cannot** be staged, but its healing status is either:
  - Response 2 - Early/Partial Granulation, if necrotic or avascular tissue covers <25% of the wound bed; or
  - Response 3 - Not Healing, if the wound has ≥25% necrotic or avascular tissue.

### M1320: Status of Most Problematic (Observable) Pressure Ulcer

(Excluded: Stage 1 and Covered by Non-removable Dressing/Device)

<table>
<thead>
<tr>
<th>Pressure Ulcer Stages</th>
<th>Newly Epithelialized</th>
<th>Fully Granulated</th>
<th>Early/Partial Granulation</th>
<th>Not Healing</th>
<th>NA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stage 2</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>✔</td>
<td>No</td>
</tr>
<tr>
<td>Stage 3</td>
<td>No</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
<td>No</td>
</tr>
<tr>
<td>Stage 4</td>
<td>No</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
<td>No</td>
</tr>
<tr>
<td>PU covered with eschar or slough</td>
<td>No</td>
<td>No</td>
<td>✔ &lt; 25% granulation tissue</td>
<td>✔ ≥ 25% granulation tissue</td>
<td>No</td>
</tr>
<tr>
<td>Deep Tissue Injury (DTI)</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>✔</td>
<td>No</td>
</tr>
</tbody>
</table>
M1320: Scenario

- At SOC, the patient’s Stage 3 pressure ulcer was assessed to be partially granulated. At discharge, the Stage 3 ulcer is “hypergranulated.”

  > What is the healing status of this pressure ulcer in M1320?
  - Response 3 - Not healing
  - Hypergranulation is the growth of granulation tissue above the area of surrounding tissue (skin plane) in all or part of the wound bed. Hypergranulation results in delayed healing of a wound due to obstructed epithelialization.

  > Should it be reported in M1311/M1313 as worsened?
  - No - Worsening in M1311/M1313 refers to a pressure ulcer that has progressed to a deeper level of tissue damage and is therefore staged at a higher number.

What is the correct M1320 response?

- A Stage II pressure ulcer: __________
- A deep tissue injury: __________
- A pressure ulcer with 20% eschar: __________
- A closed Stage III pressure ulcer: __________
M1320: Answers

- A non-epithelialized Stage II pressure ulcer: **3 - Not healing**
- A deep tissue injury: **3 - Not healing**
- A pressure ulcer with 20% eschar: **2 - Early/partial granulation**
- A closed Stage III pressure ulcer: **None - no longer a pressure ulcer**

(M1322)

- NPUAP definition of Stage 1 pressure ulcer is used.
- Sentence added to item to address dark skin tones.
  - “Darkly pigmented skin may **not** have a visible blanching; in dark skin tones only it may appear with persistent blue or purple hues.”
Ulcers that have healed are **not** considered.

### M1324: Guidance

- Determine which pressure ulcer(s) are Stageable or Unstageable. A pressure ulcer is considered **Unstageable** if:
  - It is covered with a non-removable dressing/device, such as a cast, that cannot be removed;
  - It is a suspected deep tissue injury in evolution; or
  - The wound bed is obscured by some degree of necrotic tissue **AND no** bone, muscle, tendon, or joint capsule (Stage 4 structures) are visible. Note that if a Stage 4 structure is visible, the pressure ulcer is reportable as a Stage 4, even if slough or eschar is present.

- Enter “NA,” if the patient has **NO** pressure ulcers or only has pressure ulcers that are unstageable.

- If a pressure ulcer is Stage 4 at SOC and is granulating at the Follow-Up assessment, the ulcer remains a Stage 4.

*Reverse staging is NEVER allowed!***
Pressure Ulcer Scenario

- On admission to your agency, patient had a Stage 2 pressure ulcer on his (L) hip. After 7 weeks of care, the SN notes that the Stage 2 ulcer has epithelialized. At discharge, the sacral area is noted to be reddened and non-blanchable, with no break in skin, and there are no other skin lesions.

**How should the following OASIS items be answered?**

- M1306 – Does this patient have at least one Unhealed Pressure Ulcer at Stage II or Higher or designated as “unstageable”?
- M1320 – Status of Most Problematic Pressure Ulcer
- M1322 – Current Number of Stage 1 Pressure Ulcers
- M1324 – Stage of Most Problematic Unhealed Pressure Ulcer

Answers

- On admission to your agency, patient had a Stage 2 pressure ulcer on his (L) hip. After 7 weeks of care, the SN notes that the Stage 2 ulcer has epithelialized. At discharge, the sacral area is noted to be reddened and non-blanchable, with no break in skin, and there are no other lesions.

**How should the following OASIS items be answered at discharge?**

- M1306 – Does this patient have at least one Unhealed Pressure Ulcer at Stage II or Higher or designated as “unstageable”?
  - **Response 0** - No [Go to M1322]
- M1320 – Status of Most Problematic Pressure Ulcer
  - **M1320 is blank** - M1306 Response 0 (No) instructs to skip this item; Even if Response 1 (Yes), Stage 1 ulcers **not** included in M1320
- M1322 – Current Number of Stage 1 Pressure Ulcers
  - **Response 1** - Stage 1
- M1324 – Stage of Most Problematic Unhealed Pressure Ulcer
  - **Response 1** - Stage 1
(M1330)

- Report stasis ulcers ONLY – does not include:
  - Diabetic ulcers
  - Arterial lesions or arterial ulcers
    ➢ Note: Cannot make assumption between arteriosclerosis and arterial ulcer.
- If the wound is determined to be a venous stasis ulcer or a mixed arterial and venous ulcer, it should be noted in M1330.

(M1332)

- Includes only observable stasis ulcers.
- A scabbed stasis ulcer is considered observable.
- Excludes those covered with a nonremovable dressing or Unna boot.
Stasis Ulcers

- **Base:** Ruddy red
- **Depth:** Shallow
- **Margins:** Irregular
- **Exudate:** Mod to heavy
- **Pain:** \( \downarrow \) w/ elevation
- **Surrounding skin:**
  - Venous dermatitis
  - Hemosiderosis (brown staining of skin)
  - Temperature: normal to warm
  - Infection, cellulitis, inflammation

(Quick Assessment of Leg Ulcers, WOCN, 2009)

Arterial Ulcers

- **Base:** pale
- **Depth:** May be deep
- **Margins:** edges rolled
- **Exudate:** Minimal
- **Pain:** \( \uparrow \) w/ elevation/ activity
- **Surrounding skin:**
  - Pale on elevation
  - Temperature: decreased/cold
  - Shiny, taut, thin, dry
  - Hair loss over LE
  - Necrosis, gangrene, eschar, cellulitis

(Quick Assessment of Leg Ulcers, WOCN, 2009)
Once a stasis ulcer has completely epithelialized, it is considered healed and should not be reported as a current stasis ulcer.

\[
\text{M1334} = 2 \text{ or } 3
\]

---

**Quiz: M1330 – M1334**

- For M1330, a scabbed stasis ulcer is ____________.

- For M1332, if there are both arterial ulcers and stasis ulcers present, include only the ____________.

- For M1334, an infected stasis ulcer is ____________.

- Diabetic lower extremity ulcers are a type of stasis ulcer. True or False? ________
Answers: M1330 – M1334

- For M1330, a scabbed stasis ulcer is **observable**.

- For M1332, if there are both arterial ulcers and stasis ulcers present, count only the **stasis ulcers**.

- For M1334, an infected stasis ulcer is: **3 - Not healing**

- Diabetic lower extremity ulcers are a type of stasis ulcer. True or False? **FALSE**

---

(M1340)

**(M1340) Does this patient have a Surgical Wound?**

<table>
<thead>
<tr>
<th>Enter Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>No [At SOCR, go to M1350; At FUI/DC, go to M1400]</td>
</tr>
<tr>
<td>1</td>
<td>Yes, patient has at least one observable surgical wound</td>
</tr>
<tr>
<td>2</td>
<td>Surgical wound known but not observable due to non-removable dressing/device [At SOCROC, go to M1350; At FUI/DC, go to M1400]</td>
</tr>
</tbody>
</table>

- Select response 1, if both an observable and unobservable surgical wound are present.

- Select response 2, if covered by a dressing or device **not** to be removed **by MD order**.
**M1340: Surgical Wounds**

- Any implanted infusion or vascular access device until it is removed, including A-V fistulas or grafts
- Insulin pump and other implanted medication devices until removed
- Skin grafts to treat pressure ulcer
- Pacemaker, defibrillator, or left ventricular assist device insertion site until healed
- Muscle graft, skin advancement flap, or rotational flap to surgically replace a pressure ulcer
- Peritoneal dialysis catheter exit site
- Orthopedic pin sites
- Burr holes
- Laparoscopic surgery and arthroscopy until incision healed
- Central line sites, including if a PICC line catheter was used as a central catheter to a central site such as the internal jugular vein
- Shave, punch, or incisional biopsies
- Stapled, sutured or cemented incisions
- Ostomy take down
- “Cut down” approach to insert femoral catheter
- Excision of toenail, beyond simple excision
- Kyphoplasty through open incision
- Incision created to insert a balloon catheter until incision has healed
- Electrodesiccation and curettage

**M1340: NOT Surgical Wounds**

- External infusion device or pump infusing medication through SQ needle
- Ostomies, including an ostomy allowed to close on its own
  - Colostomy, ileostomy, Jejunostomy
  - Cystostomy
  - Gastrostomy
  - Tracheostomy
  - Thoracostomy
  - Urostomy
- Debridement of an ulcer or wound
- Surgical staple/suture insertion sites
- Trauma wound closed w/sutures
- Pressure ulcer closed w/sutures
- PICC line (tunneled or not)
- Re-epithelialized (more than 30 days) site of a pacemaker, defibrillator, or LVAD insertion
- Scar or keloid formation from a surgical wound
- Percutaneous (not open) kyphoplasty site
- Lesion due to freezing with liquid nitrogen (cryosurgery)
- Surgery via non-integumentary route:
  - Cataract surgery of the eye
  - Surgery to mucosal membranes (i.e., tooth extraction)
  - A gynecological procedure via a vaginal approach
  - Vascular approach (even with a stent placement)
Ulcer or Surgical Wound?

- Frequently, ulcers are covered by callus or fibrotic tissue. This makes the trimming of hyperkeratotic tissue important for comprehensive wound evaluation.
- Debridement is often done to remove all necrotic tissue and surrounding callus until there is a healthy bleeding edge.
- Would you be caring for an ulcer or a surgical wound?

$$$ (M1342)

- Includes all surgical wounds (as defined in M1340 guidance) that are not covered with a non-removable dressing/device, such as a cast.
- Skip this item, if the patient no longer has a surgical wound (M1340 = 0).

$$$ M1342 = 2 or 3
M1342: Guidance

- “Most problematic” surgical wound may be:
  - Largest
  - Persistent – slow healing
  - Complicated – infected or dehisced

- Openings in the skin, adjacent to the incision line, caused by staples or sutures are **not** to be considered part of the surgical wound when determining the healing status.

- Select Response “0” (Newly epithelialized) for implanted venous access and infusion devices when the insertion site is healed.

- WOCN wound guidance has specific criteria for surgical wounds healing by **primary** and **secondary** intention.

---

Healing by Primary Intention

- Incision may be closed with sutures, staples, or chemical bonding agents.

- Wound edges are approximated (no incisional separation).

- Generally, incisions are described as surgical wounds until **30 days after re-epithelialization** and then become a **scar**, and are **no longer a surgical wound**, if there is **no** evidence of a complication, such as dehiscence or infection.

- Re-epithelialization:
  - Is the regeneration of the epidermis across a wound surface
  - Per WOCN, usually takes place within a few hours to 3 days
Healing by Primary Intention (cont.)

- These incisions do not granulate.
  - Granulation tissue is usually pink/red moist tissue with an irregular, berry-like surface.

- The only appropriate response to M1342 for these are:
  - 0 - Newly epithelialized or
  - 3 - Not healing.

- If there is not full epithelial re-surfacing, such as in the case of a scab adhering to the underlying tissue, the correct response would be “Not healing.”

- A scab does not automatically mean “not healing” – clinician must use judgment and assess for incisional separation (healing by secondary intention).

Healing by Secondary Intention

- Includes:
  - Surgical wounds intentionally left open to heal from wound base up
  - Dehisced (disrupted) surgical wounds

- Incisional separation, or disruption of wound edges, in a surgical wound healing initially by primary intention, results in a wound healing by secondary intention.

- Wounds healing by secondary intention do granulate.

- The healing status of these wounds may be assessed as:
  - 0 - Newly epithelialized
  - 1 - Fully granulating
  - 2 - Early/partial granulation
  - 3 - Not healing
Steps in Responding to M1342

- Determine if wound is healing by:
  - Primary intention (wound edges approximated)
  - Secondary intention (dehiscence or interruption)

- If by primary intention:
  - Observe incision for re-epithelialization
    - If complete = Newly epithelialized (Response 0)
    - If incomplete = Not healing (Response 3)

- If by secondary intention:
  - Assess for healing status – newly epithelialized, early/partial fully granulating, early/partial granulation, or not healing.

M1342 – Surgical Wound Healing Status

<table>
<thead>
<tr>
<th>M1342 Response</th>
<th>Status of Surgical Wound</th>
<th>Primary Intention</th>
<th>Secondary Intention</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>Newly epithelialized</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>1</td>
<td>Fully granulating</td>
<td>No</td>
<td>✓</td>
</tr>
<tr>
<td>2</td>
<td>Early/partial granulation</td>
<td>No</td>
<td>✓</td>
</tr>
<tr>
<td>3</td>
<td>Not healing</td>
<td>✓</td>
<td>✓</td>
</tr>
</tbody>
</table>
Scenario #1

- Patient’s surgical incision is mostly approximated, but it is open slightly in 2 areas with some serous drainage. Minimal avascular tissue is present and open wound bed areas are smooth and red.

- Is the wound healing by primary or secondary intention?

- How would you answer M1342 (Status of most problematic (observable) surgical wound)?
  - 0 - Newly epithelialized
  - 1 - Fully granulating
  - 2 - Early/partial granulation
  - 3 - Not healing

Answers

- Patient’s surgical incision is mostly approximated but it is open slightly in 2 areas with some serous drainage. Minimal avascular tissue is present and open wound bed areas are smooth and red.

- Is the wound healing by primary or secondary intention?
  - Secondary Intention

- How would you answer M1342?
  - Response 3 (Not healing) – smooth and red tissue is not granulation tissue
Scenario #2

- Patient is being discharged from home health because he’s no longer homebound. His abdominal incision was documented as re-epithelialized 2 weeks ago, and his physician removed the retention sutures 3 days ago. Four of the 16 former retention suture sites have become reddened, and two of them have purulent drainage. Several sites have scabs adhering to the underlying tissue. He is now on an antibiotic.

- How would you score M1342 (Healing status of most problematic (observable) surgical wound) on the Discharge OASIS?
  0 - Newly epithelialized
  1 - Fully granulating
  2 - Early/partial granulation
  3 - Not healing

Answer

- Patient is being discharged from home health because he’s no longer homebound. His abdominal incision was documented as re-epithelialized 2 weeks ago, and his physician removed the retention sutures 3 days ago. Four of the 16 former retention suture sites have become reddened, and two of them have purulent drainage. Several sites have scabs adhering to the underlying tissue. He is now on an antibiotic.

- How would you score M1342 (Healing status of most problematic (observable) surgical wound) on the Discharge OASIS?
  ✓ **Response 0 (Newly epithelialized)** – *Openings in the skin, adjacent to the incision line, caused by staples or sutures are not considered part of the surgical wound when determining the healing status.*
(M1350)

- Identifies the presence of a skin lesion or open wound NOT ALREADY ADDRESSED IN PREVIOUS ITEMS that is receiving *clinical assessment or intervention* from the home health agency.
- Clinical interventions include: cleansing, dressing changes, assessment, observation, teaching, etc.
- Documentation should support those interventions.

**M1350 Skin Lesion or Open Wound?**

- Types of skin lesions included but NOT described in detail by other specific OASIS items:

<table>
<thead>
<tr>
<th>Burns</th>
<th>Diabetic and arterial ulcers</th>
</tr>
</thead>
<tbody>
<tr>
<td>PICC lines and peripheral IV sites</td>
<td>Healed Stage 3 and 4 pressure ulcers</td>
</tr>
<tr>
<td>Trauma wounds and skin tears</td>
<td>Ostomies (excluding bowel), if care provided</td>
</tr>
<tr>
<td>Cellulitis and abscesses</td>
<td>Edema, rashes, peristomal breakdown, etc.</td>
</tr>
</tbody>
</table>

- Excluded from M1350 are:
  - Bowel ostomies
  - Tattoos, piercings, other skin alterations
  - Mucosal surface ulcers
  - Surgery for cataracts, mucosal surfaces, gyn procedures through vaginal approach.
Strategies for Getting Wounds Right

- Pay attention to item intent and skip patterns.
- Know what the guidance is:
  - Chapter 3 wound items
  - WOCN Guidance on OASIS-C2 Integumentary Items
  - CMS quarterly Q&As
- Use tools to ensure you know what to answer and how to answer it correctly.
- Re-educate yourself or others on wounds until you can ensure competency.

*Education must be ongoing!*

Resources

- WOCN Guidance on OASIS-C Integumentary Items
  [www.wocn.org](http://www.wocn.org)
- NPUAP Pressure Ulcer Staging System
  [www.npuap.org](http://www.npuap.org)
- Pressure Ulcer risk Assessment
Join me!

For Part 5:
Respiratory and Cardiac Status: M1400-M1510
Elimination Status: M1600-M1630
Neuro/Emotional/Behavioral Status: M1700-M1745
ADL/IADLs: M1800-M1910

Tuesday, December 13th
1:00 – 3:00 EST

Thank you for attending!

Sharon Molinari, RN, HCS-D, HCS-O
Home Health Consultant and Educator
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