

WOUND OSTOMY AND CONTINENCE NURSES SOCIETY GUIDANCE ON OASIS SKIN AND WOUND STATUS M0 ITEMS

OVERVIEW AND BACKGROUND

As mandated by the Balanced Budget Act of 1997, Home Health Reimbursement shifted to a prospective payment system effective October 2000. Under this system, payment is based on the patient's clinical severity, functional status, and therapy requirements. The system for wound classification uses terms such as "nonhealing", "partially granulating", and "fully granulating"; these terms lack universal definition and clinicians have verbalized concerns that they may be interpreting these terms incorrectly. The WOCN Society has therefore developed the following guidelines for classification of wounds. These items were developed by consensus among the WOCN's panel of content experts.

M0445:	Does the patient have a Pressure Ulcer?
M0450:	Current number of Pressure Ulcers at Each Stage
M0460:	Stage of Most Problematic (Observable) Pressure Ulcer
	1 Stage I
	2 Stage II
	3 Stage III
	4 Stage IV
	NA No observable pressure ulcer

Definitions:

Pressure Ulcer: Any lesion caused by unrelieved pressure resulting in damage of underlying tissue. Shear and friction may be contributing factors. Pressure ulcers are usually located over bony prominences and are staged to classify the degree of tissue damage observed.

- Stage I: Non-blanchable erythema of intact skin, the heralding lesion of skin ulceration. In individuals with darker skin, discoloration of the skin, warmth, edema, induration, or hardness may also be indicators.
- State II: Partial thickness skin loss involving epidermis, dermis, or both. The ulcer is superficial and presents as an abrasion, blister, or shallow crater.
- Stage III: Full thickness skin loss involving damage to or necrosis of subcutaneous tissue that may extend down to, but not through, underlying fascia. The ulcer presents clinically as a deep crater with or without undermining of adjacent tissue.
- Stage IV: Full thickness skin loss with extensive destruction, tissue necrosis, or damage to muscle, bone, or supporting structures (e.g. tendon, joint capsule). Undermining and sinus tracts (tunnels) may also be associated with Stage IV pressure ulcers.
- Non-observable: Wound is unable to be visualized due to an orthopedic device, dressing, etc. A pressure ulcer cannot be accurately staged until the deepest viable tissue layer is visible; this means that wounds covered with eschar and/or slough cannot be staged, and should be documented as non-observable.

WOUND OSTOMY AND CONTINENCE NURSES SOCIETY GUIDANCE ON OASIS SKIN AND WOUND STATUS M0 ITEMS

M0464:	Status of Most Problematic (Observable) Pressure Ulcer
	1 Fully granulating
	2 Early/partial granulation
	3 Not healing
	NA No observable pressure ulcer

Definitions:

- Fully granulating:
 - wound bed filled with granulation tissue to the level of the surrounding skin or new epithelium
 - no dead space
 - no avascular tissue (eschar and/or slough)
 - no signs or symptoms of infection
 - wound edges are open
- Early/partial granulation:
 - $\geq 25\%$ of the wound bed is covered with granulation tissue
 - there is minimal avascular tissue (eschar and/or slough) (i.e., $< 25\%$ of the wound bed is covered with avascular tissue)
 - may have dead space
 - no signs or symptoms of infection
 - wound edges open
- Not healing:
 - wound with $\geq 25\%$ 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

Note: A new Stage 1 pressure ulcer is reported on OASIS as Not healing.

WOUND OSTOMY AND CONTINENCE NURSES SOCIETY GUIDANCE ON OASIS SKIN AND WOUND STATUS M0 ITEMS

- M0468:** Does the patient have a stasis ulcer?
M0470: Current number of Observable Stasis (Ulcer(s))
M0474: Does this patient have at least one Stasis Ulcer that cannot be observed?
M0476: Status of the Most Problematic (Observable) Stasis Ulcer
- | | |
|----|----------------------------|
| 1 | Fully granulating |
| 2 | Early/partial granulation |
| 3 | Not healing |
| NA | No observable stasis ulcer |

Definitions:

- Fully granulating:
 - wound bed filled with granulation tissue to the level of the surrounding skin or new epithelium
 - no dead space
 - no avascular tissue (eschar and/or slough)
 - no signs or symptoms of infection
 - wound edges are open.
- Early/partial granulation:
 - $\geq 25\%$ of the wound bed is covered with granulation tissue
 - there is minimal avascular tissue (eschar and/or slough) (i.e. $< 25\%$ of the wound bed is covered with avascular tissue)
 - may have dead space
 - no signs or symptoms of infection
 - wound edges open.
- Not healing:
 - wound with $\geq 25\%$ 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

WOUND OSTOMY AND CONTINENCE NURSES SOCIETY GUIDANCE ON OASIS SKIN AND WOUND STATUS M0 ITEMS

M0482:	Does the patient have a Surgical Wound?
M0484:	Current number of (Observable) Surgical Wounds
M0486:	Does the patient have at least one Surgical Wound that cannot be observed due to the presence of a non-removable dressing?
M0488:	Status of the most problematic (Observable) Surgical Wound
	1 Fully granulating
	2 Early/partial granulation
	3 Not healing
	NA No observable surgical wound

Definitions:

- Description/classification of wounds healing by primary intention (i.e. approximated incisions)
 - Fully granulating/healing:
 - incision well-approximated with complete epithelialization of incision
 - no signs or symptoms of infection
 - Early/partial granulation:
 - incision well-approximated but not completely epithelialized
 - no signs or symptoms of infection
 - Not healing:
 - incisional separation OR
 - incisional necrosis OR
 - signs or symptoms of infection
- Description/classification of wounds healing by secondary intention (i.e., healing of dehisced wound by granulation, contraction and epithelialization)
 - Fully granulating:
 - wound bed filled with granulation tissue to the level of the surrounding skin or new epithelium
 - no dead space
 - no avascular tissue (eschar and/or slough)
 - no signs or symptoms of infection
 - wound edges are open.
 - Early/partial granulation:
 - $\geq 25\%$ of the wound bed is covered with granulation tissue
 - there is minimal avascular tissue (eschar and/or slough) (i.e., $<25\%$ of the wound bed is covered with avascular tissue)
 - may have dead space
 - no signs or symptoms of infection
 - wound edges are open
 - Not healing:
 - wound with $\geq 25\%$ 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 comprehensive appropriate wound management

WOUND OSTOMY AND CONTINENCE NURSES SOCIETY GUIDANCE ON OASIS SKIN AND WOUND STATUS M0 ITEMS

GLOSSARY

Avascular:	Lacking in blood supply; synonyms are dead, devitalized, necrotic, and nonviable. Specific types include slough and eschar.
Clean Wound:	Wound free of devitalized tissue, purulent drainage, foreign material or debris
Closed Wound Edges:	Edges of top layers of epidermis have rolled down to cover lower edge of epidermis, including basement membrane, so that epithelial cells cannot migrate from wound edges; also described as epibole. Presents clinically as sealed edge of mature epithelium; may be hard/thickened; may be discolored (e.g., yellowish, gray, or white).
Dead Space:	A defect or cavity
Dehiscence/Dehiscence:	Separation of surgical incision; loss of approximation of wound edges
Epidermis:	Outermost layer of skin
Epithelialization:	Regeneration of epidermis across a wound surface
Eschar:	Black or brown necrotic, devitalized tissue; tissue can be loose or firmly adherent, hard, soft or soggy.
Full Thickness:	Tissue damage involving total loss of epidermis and dermis and extending into the subcutaneous tissue and possibly into the muscle or bone.
Granulation Tissue:	The pink/red, moist tissue comprised of new blood vessels, connective tissue, fibroblasts, and inflammatory cells, which fills an open wound when it starts to heal; typically appears deep pink or red with an irregular, “berry-like” surface
Healing:	A dynamic process involving synthesis of new tissue for repair of skin and soft tissue defects.
Hyperkeratosis:	Hard, white/gray tissue surrounding the wound
Infection:	The presence of bacteria or other microorganisms in sufficient quantity to damage tissue or impair healing. Wounds can be classified as infected when the wound tissue contains 10^5 (100,000) or greater microorganisms per gram of tissue. Typical signs and symptoms of infection include purulent exudate, odor, erythema, warmth, tenderness, edema, pain, fever, and elevated white cell count. However, clinical signs of infection may not be present, especially in the immunocompromised patient or the patient with poor perfusion.

WOUND OSTOMY AND CONTINENCE NURSES SOCIETY GUIDANCE ON OASIS SKIN AND WOUND STATUS M0 ITEMS

- Necrotic Tissue:** See avascular.
- Non-granulating:** Absence of granulation tissue; wound surface appears smooth as opposed to granular. For example, in a wound that is clean but non-granulating, the wound surface appears smooth and red as opposed to berry-like.
- Partial Thickness:** Confined to the skin layers; damage does not penetrate below the dermis and may be limited to the epidermal layers only
- Sinus Tract:** Course or path of tissue destruction occurring in any direction from the surface or edge of the wound; results in dead space with potential for abscess formation. Also sometimes called “tunneling”. (Can be distinguished from undermining by fact that sinus tract involves a small portion of the wound edge whereas undermining involves a significant portion of the wound edge.)
- Slough:** Soft moist avascular (devitalized) tissue; may be white, yellow, tan, or green; may be loose or firmly adherent
- Tunneling:** See sinus tract
- Undermining:** Area of tissue destruction extending under intact skin along the periphery of a wound; commonly seen in shear injuries. Can be distinguished from sinus tract by fact that undermining involves a significant portion of the wound edge, whereas sinus tract involves only a small portion of the wound edge.