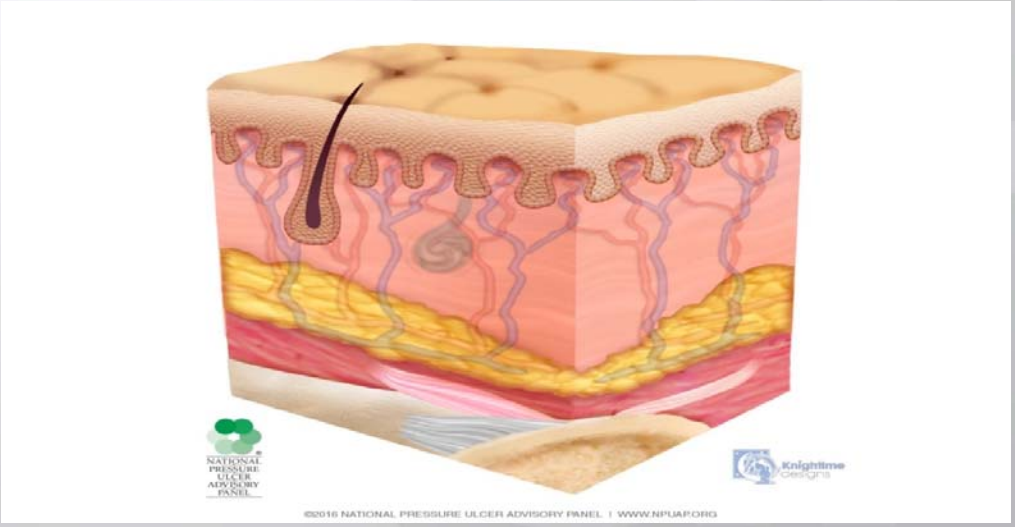
Pressure Ulcer or Pressure Injury? (Do you have skin in the game?)

Ann Rambusch, MSN, HCS-D, HCS-O, RN

June 28, 2016

DECISIONHEALTH

Understanding NPUAP's Revised Guidelines for the Staging of Pressure Injuries



NPUAP Staging System and Drawings, ©2016 used with permission of NPUAP.

DECISIONHEALTH

What's NPUAP?

- The **N**ational **P**ressure Ulcer **A**dvisory **P**anel **(NPUAP)** is the authoritative voice for improved patient outcomes in pressure ulcer prevention and treatment through public policy, education and research.
- The Advisory Panel works collaboratively with other organizations to develop new pressure ulcer prevention and treatment clinical guidelines.
- NPUAP appropriately responds to clinicians' needs for clarity when issuing new/revised guidelines.

NPUAP Releases Revised Pressure Injury Guidelines

- In April 2016, NPUAP announced:
  - An revised / updated staging system for pressure ulcers.
  - A change in terminology used by the system from "pressure ulcers" to "pressure injuries".
- New guidelines are consensus guidelines.
  - Consensus is a process to develop common understanding in areas where science cannot provide guidance or science is not yet available.
  - Guidelines, definitions, and illustrations were validated through interactive discussion and voting by a group of 400 NPUAP members.

What about NPUAP and WOCN?

- Wound Ostomy Continence Nurses Society (WOCN) is a professional nursing society, which supports its members by promoting educational, clinical and research opportunities to advance the practice and guide the delivery of expert health care to individuals with wounds, ostomies and incontinence.
- WOCN provides guidance to CMS on OASIS integumentary items (M1300 – M1350) based on recommendations of a panel of content experts.
- WOCN guidance is based on NPUAP guidance.

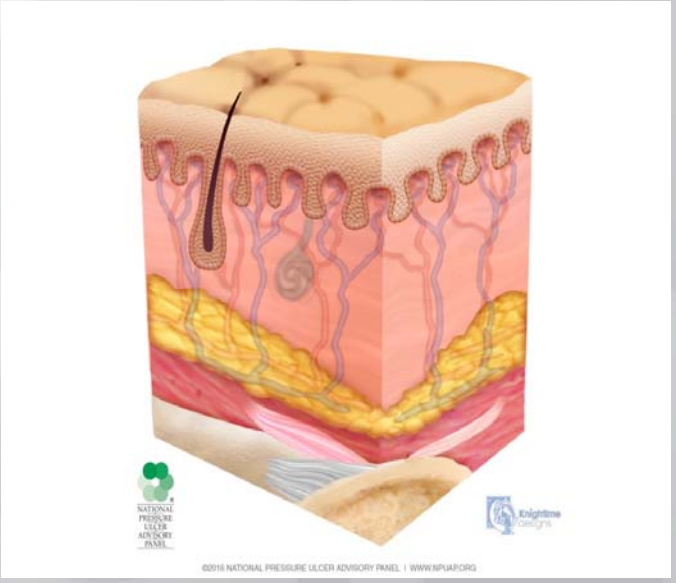
WOCN Supports NPUAP Guidance

- Announced full support of new guidance in May 2016. *(WOCN letter to NPUAP, 5/25/2016).*
- Will appoint a task force to develop a formal position statement in support of the new terminology.
- Will work to incorporate NPUAP changes as new or updated educational content is produced.

Note: Most recent guidance from WOCN: *WOCN Guidance on OASIS-C1 Integumentary Items, 2014.*

Highlights of the NPUAP Guidelines

- Change in terminology from pressure ulcer to pressure injury
- New definition for pressure injury
- New/updated staging definitions including:
  - Use of Arabic numerals
  - 2 new definitions
- New/updated illustrations



***Normal Caucasian Skin**, NPUAP 2016*

The *Old* Pressure *Ulcer* Definition

Before we visit the new definition, let's take a walk down memory lane . . .

Evolving Definition of Pressure Ulcer

- **2007 Pressure Ulcer:** A *pressure ulcer* is 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.
- **2009 Pressure Ulcer:** A *pressure ulcer* is 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.
  - Note the deletion of friction as a cause of pressure ulcers.

"Friction" and Pressure Injuries

Since friction is not considered a direct cause of pressure ulcers, the term "friction" was deleted from the NPUAP pressure ulcer definition in 2009.

- Per NPUAP: Friction is a risk factor that may contribute to or exacerbate a pressure injury due to the shear it creates. *(NPUAP White Paper: Friction Induced Skin Injuries, 2012)*
- WOCN OASIS-C1 guidance, updated in 2014, no longer references friction as a direct cause of pressure ulcers.
  - But . . . M1306 Item-Specific Instructions (Oct 2015) continued to list "shear and/or friction" as a cause of pressure ulcers.

OASIS Guidance: Blisters Due to Friction

- **Question:** How should we assess a serum-filled blister that is caused by a shoe rubbing against the foot?
- **Answer:** If the cause of a wound is ***solely*** a friction force which leads to visible skin impairment, such as the serum filled blister cited in the scenario, it would NOT be categorized as a pressure ulcer. The 2009 International NPUAP-EPUAP Pressure Ulcer Prevention and Treatment Clinical Practice Guideline eliminated reference to friction as a factor in pressure ulcer development.

(CMS 4th Qtr Q&A #4, 01/16)

Blisters in ICD-10

- A serum-filled blister due solely to friction is a considered a superficial nonthermal skin injury. It is not categorized as a pressure injury.
- In the ICD-10 Alphabetic index, look up:

Blister (nonthermal)
foot (except toes (s) alone) S90.82-
toe – *See* Blister, toe
toe (s) S90.42-
great S90.42-

Key Elements of the Revised Staging System

NPUAP Staging System Changes in 2016

- Change in terminology from “pressure ulcer” to “pressure injury”.
  - Not all of the pressure injuries in the staging system are pressure ulcers. Some involve intact skin.
  - New terminology more accurately describes all 6 stages of pressure injuries.
- Revised staging definitions and created new illustrations.
  - Drawings now include non-Caucasian skin
- New definition of pressure injury reflecting revisions to staging system replaces old definition of pressure ulcer.

Key Elements of Revision

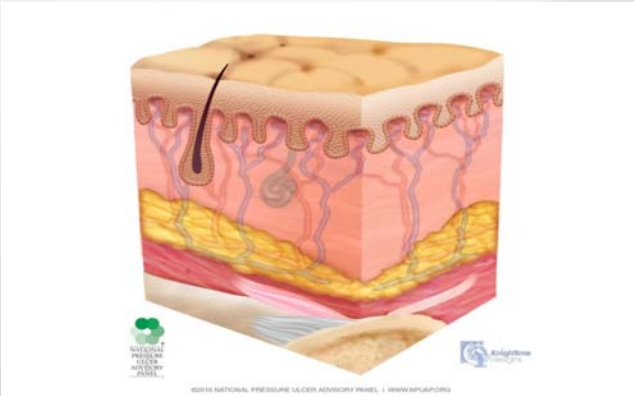
- Replaced Roman numerals (I,II,III,IV) with Arabic numbers (1,2,3,4) in diagnostic labels for stages.
  - Arabic numbers are consistent with ICD-10 labels.
- Deleted the term "suspected" from the Deep Tissue Injury diagnostic label.
  - Ability to diagnose deep tissue injury has improved.
  - "Suspected" can be added to any documentation of any stage.
- Added new definitions to the staging system:
  - Medical device related injury
  - Mucosal membrane pressure injury

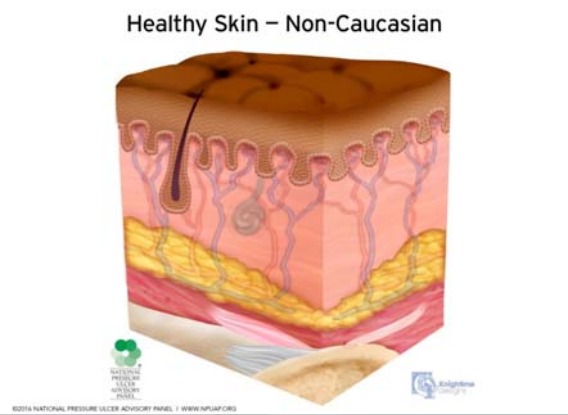
New Definition: Pressure Injury (2016)

- A pressure injury is localized damage to the skin and/or 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.

(NPUAP Press Release regarding change in terminology and updating of stages of pressure ulcer injuries, April 2016)

Pressure Injury Stages





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.

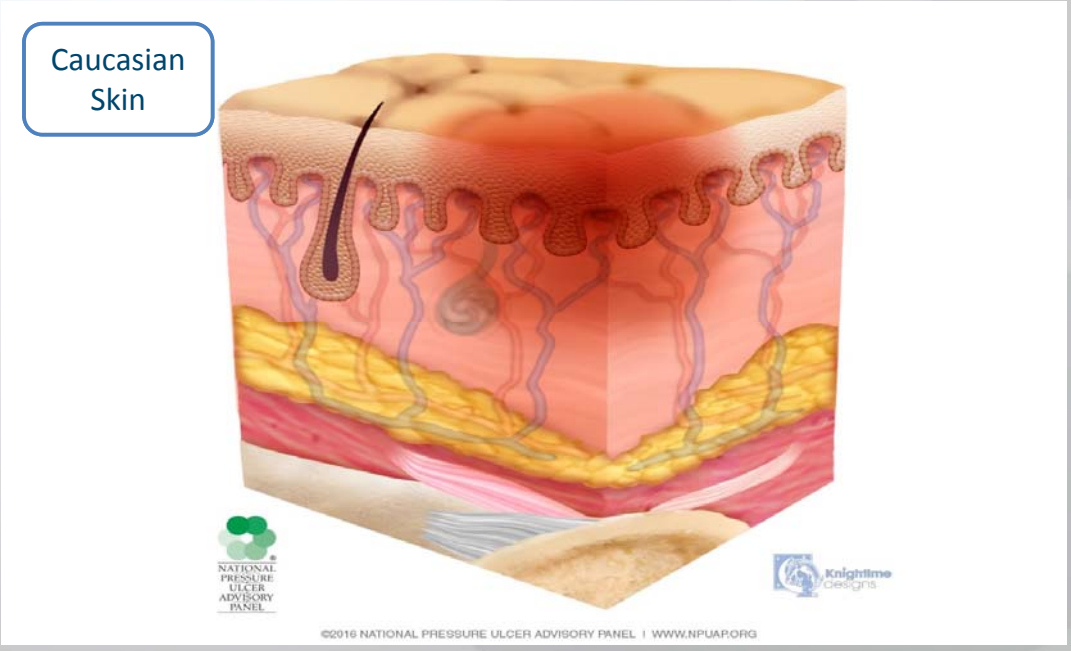
Pressure Injuries Involving Intact Skin

- **Stage 1 Pressure Injury:** Non-blanchable erythema of intact skin
- **Deep Tissue Pressure Injury:** Persistent non-blanchable deep red, maroon or purple discoloration
  - Injury involving intact or non-intact skin

Pressure Injuries involving Open Ulcerations (skin not intact)

- **Stage 2 Pressure Injury:** Partial-thickness skin loss with exposed dermis
- **Stage 3 Pressure Injury:** Full-thickness skin loss
- **Stage 4 Pressure Injury:** Full-thickness skin and tissue loss
- **Unstageable Pressure Injury:** (Obscured full-thickness skin and tissue loss)

Stage 1 Pressure Injury: Non-blanchable Erythema of Intact Skin

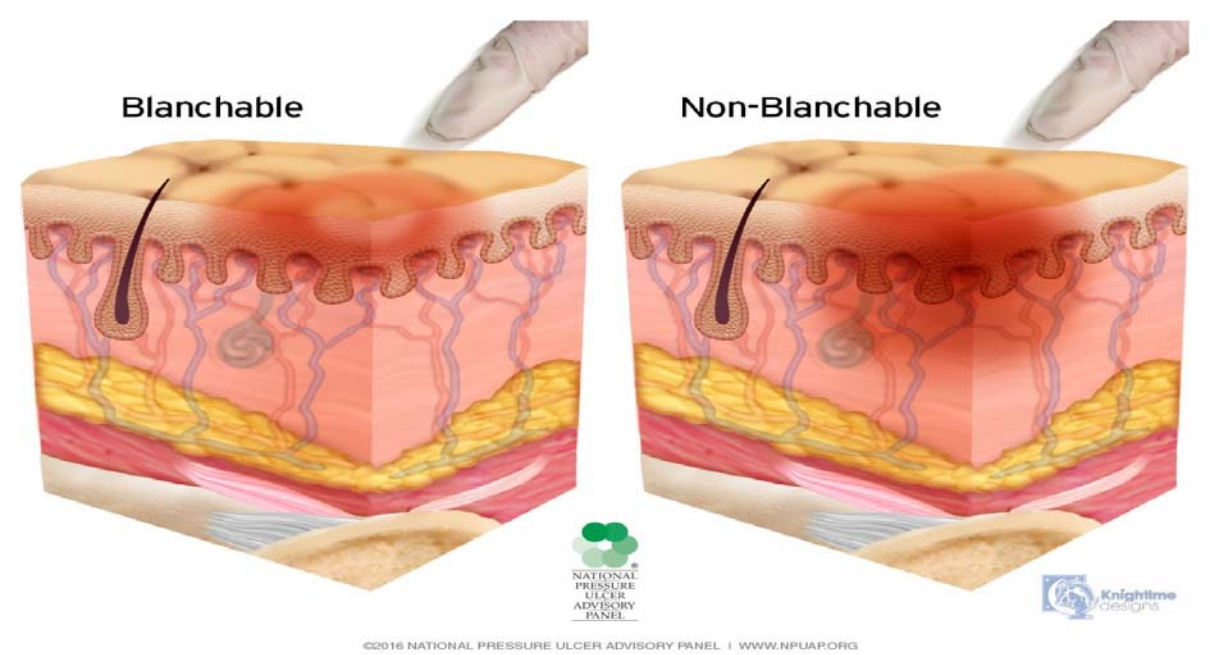


Stage 1 Pressure Injury: Non-blanchable Erythema of Intact Skin

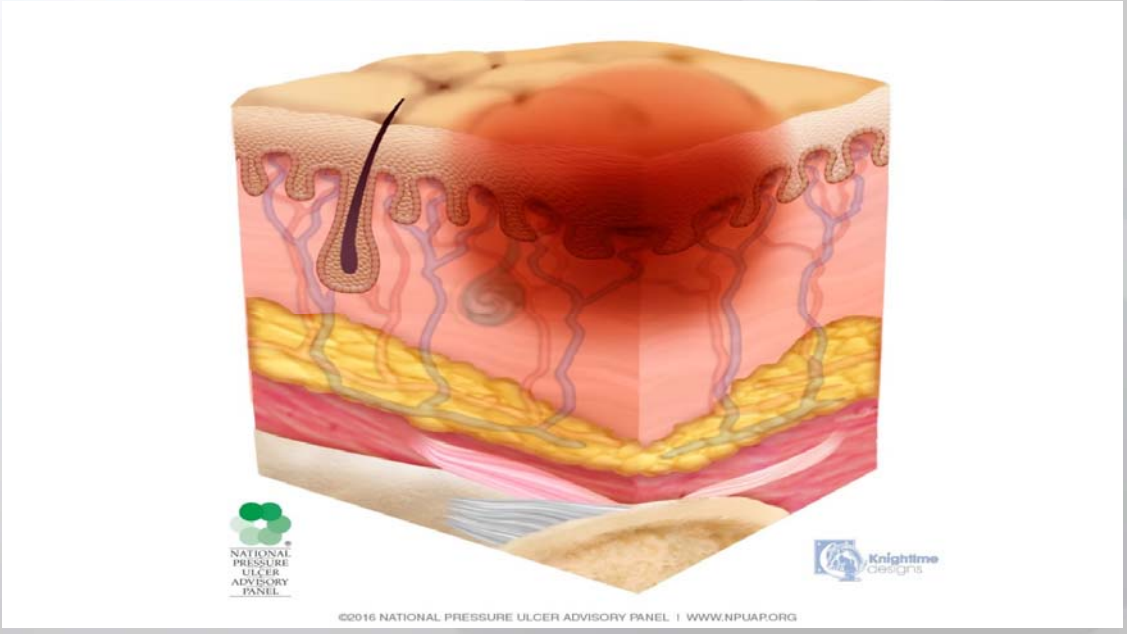
- Intact skin with a localized area of non-blanchable erythema, which may appear differently in darkly pigmented skin.
- Presence of blanchable erythema or changes in sensation, temperature, or firmness may precede visual changes.
- ***New in 2016:*** Color changes do not include purple or maroon discoloration; these may indicate deep tissue pressure injury.

(NPUAP, 2016)

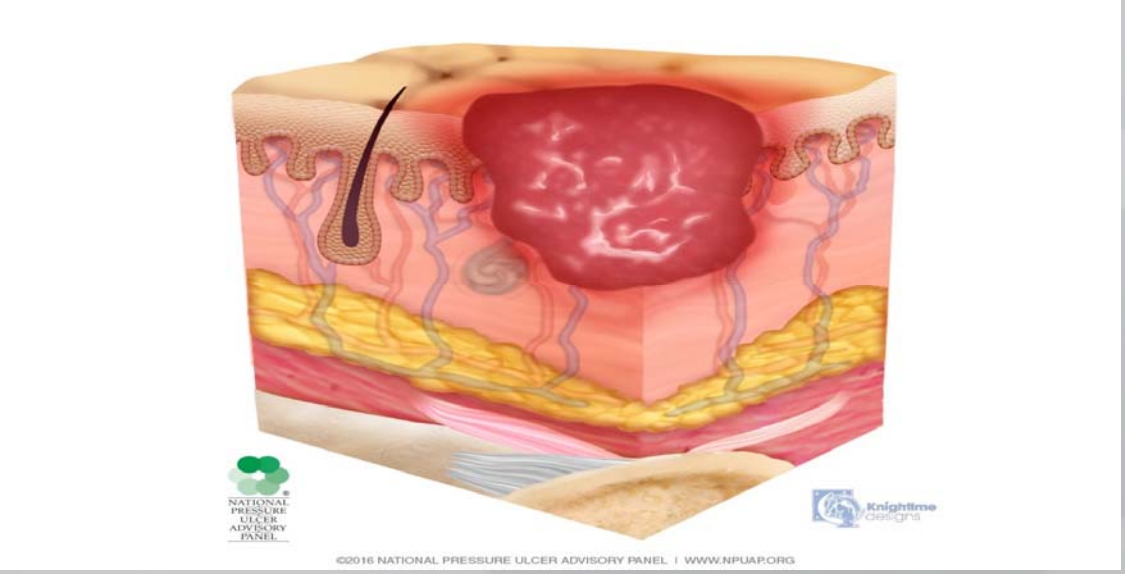
Blanchable vs. Non-Blanchable



Stage 1 Pressure Injury (Edema)



Stage 2 Pressure Injury: Partial-thickness Skin Loss with Exposed Dermis



Stage 2 Pressure Injury

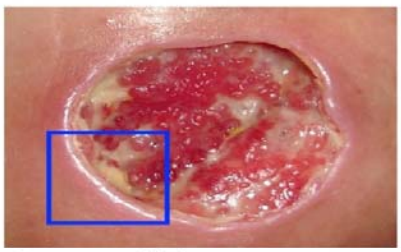
- Partial-thickness loss of skin with exposed dermis.
- The wound bed is viable, pink or red, moist, and may also present as an intact or ruptured serum-filled blister. *(References to "shallow open ulcer" were deleted.)*
- ***New:*** Adipose (fat) is not visible and deeper tissues are not visible.
- ***New:*** Granulation tissue, slough and eschar are not present.
- ***New:*** Stage 2 injuries commonly result from adverse microclimate and shear in the skin over the pelvis and shear in the heel. *(NPUAP, 2016)*

Stage 2 Pressure Injury (cont.)

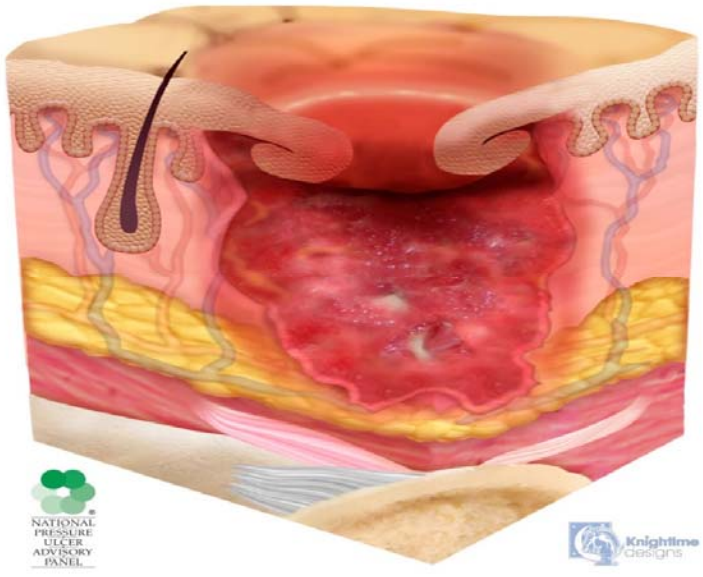
- ***New:*** Stage 2 Pressure Injury should not be used to describe moisture associated skin damage (MASD) including:
  - Incontinence associated dermatitis (IAD) – diaper rash *(ICD-10 code = L22)*
  - Intertriginous dermatitis (ITD) - inflammatory condition of skin folds *(ICD-10 code = L30.9)*
  - Medical adhesive related skin injury (MARSI) or
  - Traumatic wounds (skin tears, burns, abrasions).

(NPUAP, 2016)

Stage 3 Pressure Injury – with Epibole



Area of Focus



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.

(NPUAP, 2016)

Stage 3 Pressure Injury: Full-thickness skin loss (cont.)

- 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.

(NPUAP, 2016)

✓ **Clinical note:** *Focus on the extent of tissue damage (injury) to underlying tissues not the depth of the injury to assign correct stage.*

Staging Correctly Can Make a Difference in Supply Payments

- 65 year old patient admitted for management of systolic heart failure and a pressure injury on the right hip. At SOC the SN is not sure if the pressure injury is a Stage 2 or a Stage 3. The patient is malnourished and is extremely thin. The pressure injury on the right hip appears very shallow.

✓ *Staging the injury correctly impacts the agency's supply reimbursement.* *(See NRS Worksheet, CY2016 – included in handouts)*

Staging Correctly Makes a Difference in Supply Payments

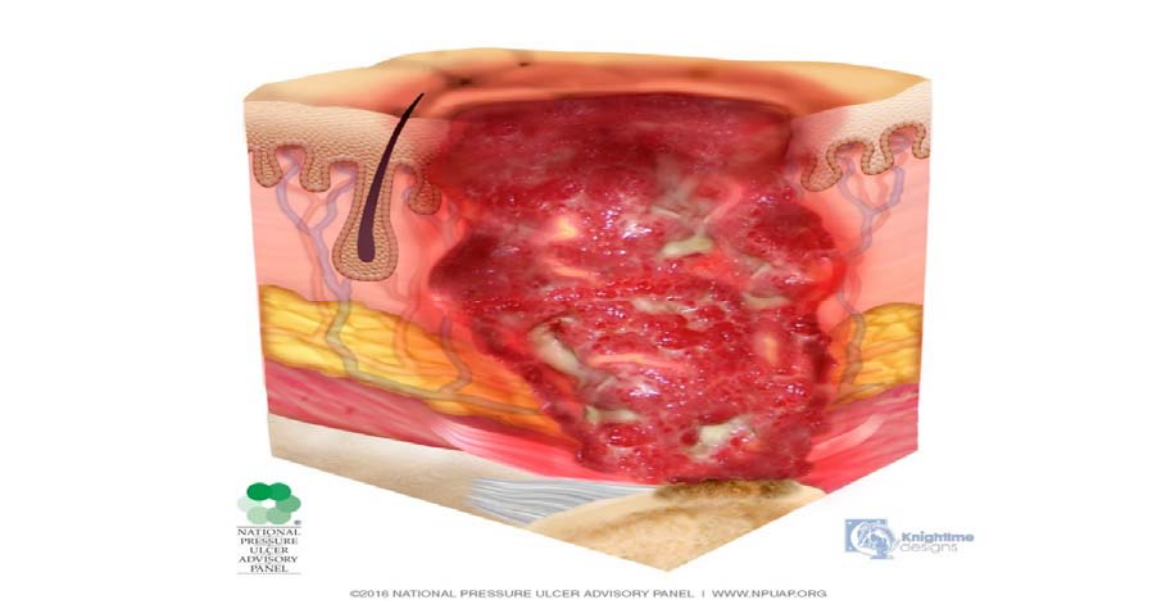
Patient has a pressure injury on right hip and no other wounds or lesions. If injury is assessed in M1308:

- As a Stage 2 pressure injury = 14 NRS points (line 22)
  $51.35 NRS payment
- As a Stage 3 pressure injury = 29 points (line 26)
  $209.18 NRS payment

Difference in supply reimbursement = $157.83

(Remember: Stage based on tissue injury/damage not the depth.)

Stage 4 Pressure Injury: Full-thickness Skin and Tissue Loss



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.

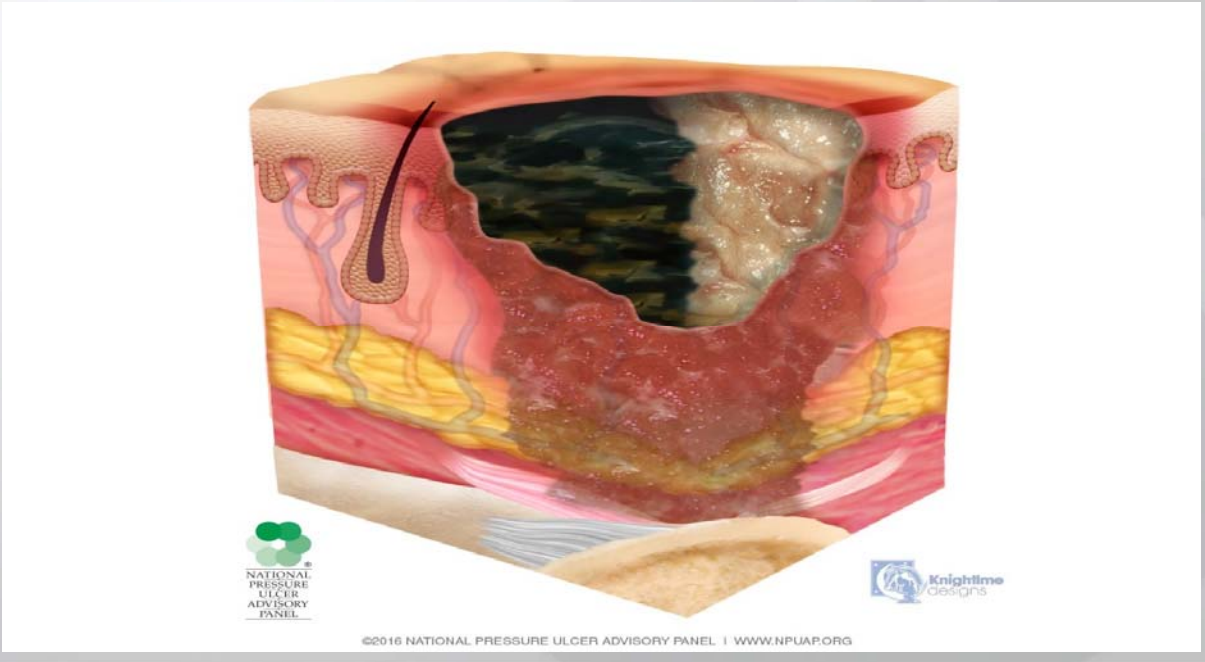
(NPUAP, 2016)

Stage 4 Pressure Injury: Full-thickness Skin and Tissue Loss

- Depth varies by anatomical location.
- If slough or eschar obscures the extent of tissue loss this is an Unstageable Pressure Injury.

(NPUAP, 2016)

Unstageable Pressure Injury: due to Eschar/Slough

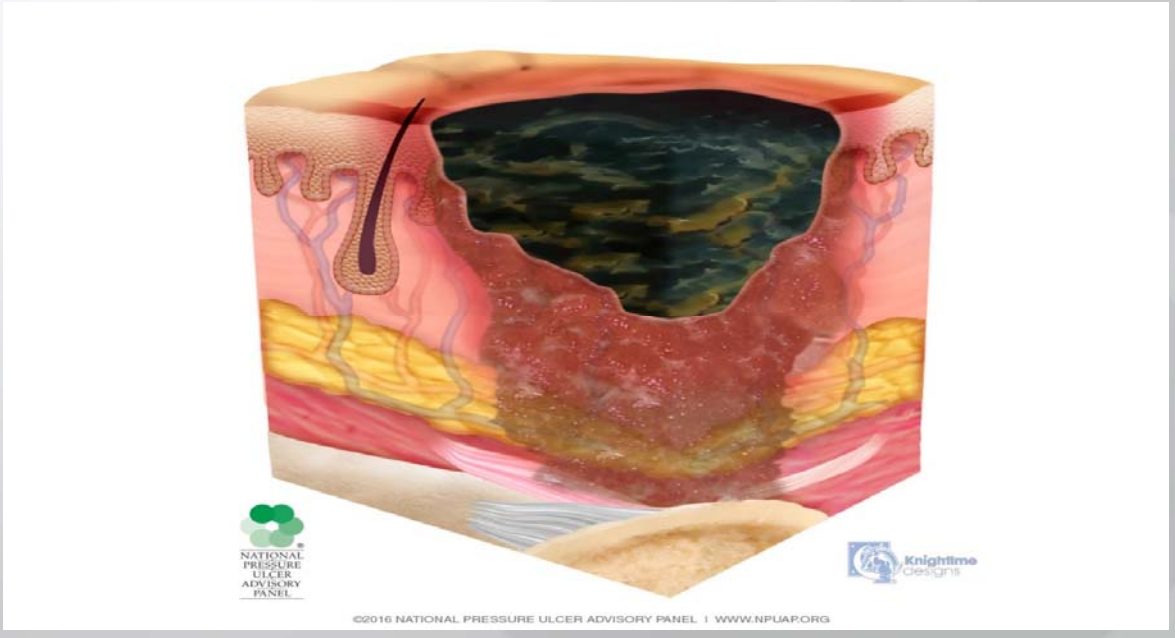


Unstageable Pressure Injury: Obscured full-thickness Skin and Tissue Loss

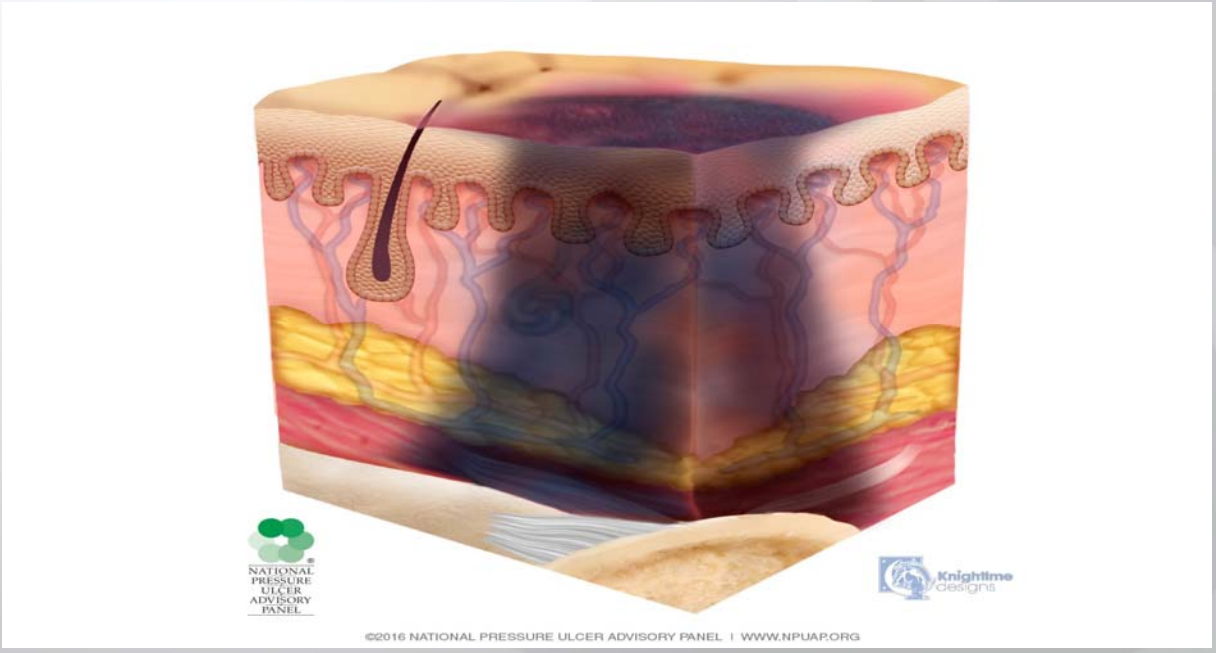
- Full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because it is obscured by slough or eschar.
- If slough or eschar is removed, a Stage 3 or Stage 4 pressure injury will be revealed.
- Stable eschar (i.e. dry, adherent, intact without erythema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

(NPUAP, 2016)

Unstageable due to Dark Eschar



Deep Tissue Injury



Deep Tissue Injury

(New, more complete description replaces old)

- 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. *(NPUAP, 2016)*

Deep Tissue Injury

(New, more complete description replaces old)

- 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.

(NPUAP, 2016)

Medical Device Related Pressure Injury:

(Label describes an etiology)

- Definition added to the 2016 NPUAP Staging guidance.
- Medical device related pressure injuries result from the use of devices designed and applied for diagnostic or therapeutic purposes.
- Resultant pressure injury generally conforms to the pattern or shape of the device.
- The injury should be staged using the staging system.

(NPUAP, 2016)

Mucosal Membrane Pressure Injury

- Definition added to the NPUAP Staging information in 2016.
  - Guidance is similar to NPUAP White Paper on mucosal pressure ulcers published in 2008.
- 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 mucosal membrane pressure injuries cannot be staged.

NPUAP, 2016

Coding of Pressure Injury in ICD-10

(NPUAP Consensus Staging FAQs Answers, 5/31/16)

Question: How will we be paid for pressure injury since it is not in the current ICD-10 codes?

NPUAP Answer: The current ICD-10 coding system lists "pressure ulcer" and coders are supplied with synonyms for the condition including bed sore, decubitus ulcer, plaster ulcer, pressure area and pressure sore. The NPUAP is working with International Wound Organizations on the ICD- 10 *[sic]* to incorporate the term "pressure injury".

***Note:** Pressure ulcer is not currently a case-mix diagnosis code.*

NPUAP vs. ICD-10

NPUAP	ICD-10 Tabular
Stage 2 Pressure Injury - Sacrum 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.	**L89.152, Pressure ulcer of sacral region, stage 2** Pressure ulcer with abrasion, blister, partial thickness skin loss involving epidermis and/or dermis, sacral region

NPUAP vs. ICD-10

NPUAP	ICD-10 Tabular
Stage 3 Pressure Injury - Sacrum 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.	**L89.153, Pressure ulcer of sacral region, Stage 3** Pressure ulcer with full thickness skin loss involving damage or necrosis of subcutaneous tissue , sacral region

When will OASIS adopt new terminology?

- The NPUAP is responsible for using science to make needed changes combined with consensus to clarify or amplify the wording.
- The NPUAP has shared the changes with CMS and looks forward to working with them on an implementation plan.
- All the changes are aimed at improving assessment and documentation precision.

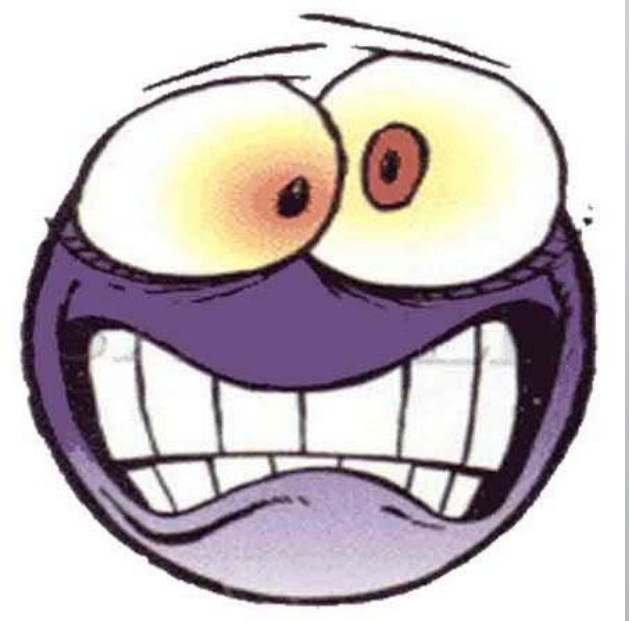
(NPUAP Consensus Staging FAQs, 5/31/16)

What do we know???

Issues Related to New System

- ICD-10 classification may take time to update.
  - Coding Clinic could be used as an interim solution.
- Pressure injury terminology in OASIS-C2 integumentary items has not been updated to reflect new system.
  - WOCN guidance for OASIS-C2 will require time and coordination with CMS to implement changes.
- Outcomes reporting categories and items may need to be revised to align with new terminology.
- Agencies will ultimately need to educate staff about new terminology and how they respond to these changes.

Got stress yet?



Benefits of Revised Staging System

- Revises/Refines the definition of pressure injury.
- Establishes universal terminology for assessing, staging, and labeling pressure injuries.
  - Includes pressure injuries to intact skin and open ulcers.
  - Definitions identify excluded types of lesions or injuries.
- Emphasizes that the etiology of pressure injuries is ***pressure***:
  - Prolonged pressure or
  - Pressure combined with shear or
  - Pressure related to medical device

Benefits of Revised Staging System

- Stresses that staging is based on extent of tissue damage, not depth of injury.
- Removes redundant, confusing, or obsolete terms from the definitions.
- End result of changes:
  - Improved communication, data collection, and research
  - Improved management of acute and chronic pressure injuries

Just Remember . . .

- *To be totally without stress is to be dead.*
- *Adopting the right attitude can convert a negative stress into a positive one.*

- Hans Selye

This is a beginning, not an end.

Questions?

Ann Rambusch, MSN, HCS-D, HCS-O, COS-C, RN
President, Rambusch3 Consulting
Member, Board of Medical Specialty Coding and Compliance
annrambusch@gmail.com

Web Resources

- NPUAP – *Press Release, FAQ Sheet, Illustrations*, etc.
  - www.NPUAP.org
- Wound Ostomy Continence Nurses Society (WOCN) – *Guidance on OASIS-C1 Integumentary Items, 2014*
  - www.WOCN.org