



DEPARTMENT OF HEALTH & HUMAN SERVICES  
Health Care Financing Administration

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REF: S&C 21

**DATE:** August 6, 2001

**FROM:** Director  
Survey and Certification Group  
Center for Medicaid and State Operations

**SUBJECT:** Wound Ostomy Continence Nurses Society (WOCN) Outcome and Assessment Information Set (OASIS) Guidance Document

**TO:** Associate Regional Administrators, DMSO  
State Survey Agency Directors

The purpose of this memorandum is to provide you with information and answers to questions about wound items on the OASIS. We are including them for your files.

The Centers for Medicare & Medicaid Services (CMS) (formerly the Health Care Financing Administration) are collaborating with clinical wound care experts from the WOCN to clarify the definitions for “fully granulating, early/partial granulation, and not healing” for OASIS wound items. The clarifications respond to numerous questions about wound status received by the OASIS Mailbox. The clarifications are intended to be helpful to home health agency (HHA) clinicians as they complete their patient assessments. For more information about the WOCN guidelines and for answers to questions about the WOCN guidelines, please contact the WOCN web site at [www.wocn.org](http://www.wocn.org).

HHA clinicians are encouraged to use the new guidance to assist with clinical assessments of patient wounds. HHAs are **not** required to correct previously encoded and transmitted assessments.

The WOCN OASIS Guidance Document is found in attachment A and on WOCN’s web site. A Question and Answer document is found in attachment B.

Note: The CMS OASIS team and clinical wound care experts from WOCN cannot offer definite answers to the classification of a specific wound, because we cannot visually assess the wound.

**Effective Date:** The guidance presented in this memorandum is effective on the date of issuance.

**Training:** This policy should be shared with all OASIS Educational and Automation coordinators, home health agency surveyors, their managers, the state/regional office training coordinator and home health providers.

If you have any question about this issue, please contact Mary Weakland at (410) 786-6835 or Tracey Mummert at (410) 786-3398.

/s/ Sandy Haydock for Steve  
Steven A. Pelovitz

Attachments: A & B

cc: Regional Office OASIS Coordinators  
State Agency OASIS Educational Coordinators  
State Agency OASIS Automation Coordinators

# WOCN GUIDANCE ON OASIS SKIN AND WOUND STATUS M0 ITEMS

## Attachment A

### 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.

**M0 445:**                    **Does the patient have a Pressure Ulcer?**  
**M0 450:**                    **Current number of Pressure Ulcers at Each Stage**  
**M0 460:**                    **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. 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.

**Stage 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 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.

**M0 464: Status of Most Problematic (Observable) Pressure Ulcer**

- 1 Fully granulating
- 2 Early/partial granulation
- 3 Not healing
- NA No observable pressure ulcer

- Fully Granulating: Wound bed filled with granulation tissue to the level of the surrounding skin or new epithelium; no dead space, no avascular tissue; 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 (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.
- Non-healing: Wound with  $\geq 25\%$  avascular tissue 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.

**M0 468: Does the patient have a stasis ulcer?**

**M0 470: Current number of Observable Stasis Ulcer(s)**

**M0 474: Does this patient have at least one Stasis Ulcer that cannot be observed?**

**M0 476: 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; 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 (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.

Non-healing: Wound with  $\geq 25\%$  avascular tissue 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.

**M0 482: Does the patient have a Surgical Wound?**  
**M0 484: Current number of (Observable) Surgical Wounds**  
**M0 486: Does the patient have at least one Surgical Wound that cannot be observed due to the presence of a non-removable dressing?**  
**M0 488: Status of the most problematic (Observable) Surgical Wound**

- 1 Fully granulating
- 2 Early/partial granulation
- 3 Not healing
- NA No observable surgical wound

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; healing ridge well defined
- Early/partial granulation: incision well-approximated but not completely epithelialized; no signs or symptoms of infection; healing ridge palpable but poorly defined
- Non-healing: incisional separation OR incisional necrosis OR signs or symptoms of infection OR no palpable healing ridge

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; 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 (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.
- Non-healing:** Wound with  $\geq 25\%$  avascular tissue 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.

## **GLOSSARY**

<b>Avascular:</b>	Lacking in blood supply; synonyms are dead, devitalized, necrotic, and nonviable. Specific types include slough and eschar.
<b>Clean Wound:</b>	Wound free of devitalized tissue, purulent drainage, foreign material or debris
<b>Closed Wound Edges:</b>	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).
<b>Dead Space:</b>	A defect or cavity
<b>Dehiscd/Dehiscence:</b>	Separation of surgical incision; loss of approximation of wound edges
<b>Epidermis:</b>	Outermost layer of skin
<b>Epithelialization:</b>	Regeneration of epidermis across a wound surface
<b>Eschar:</b>	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.
- Healing Ridge:** Palpatory finding indicative of new collagen synthesis. Palpation reveals induration beneath the skin that extends to approximately 1 cm on each side of the wound. Becomes evident between 5 and 9 days after wounding; typically persists till about 15 days post-wounding. This is an expected positive sign.
- 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.
- 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.

Attachment B

**Wound Ostomy Continence Nurses Society (WOCN) OASIS Guidance  
Questions and Answers**

Q1. (M0464) I have just admitted a patient with a trochanteric pressure ulcer. The ulcer was debrided while the patient was in the hospital and the patient also received IV antibiotics. On admission the ulcer measures 5 cm x 6 cm x 3 cm; there are no areas of tracking or tunneling. The entire wound bed is clean with exposed muscle, but there is no granulation tissue. There is a moderate amount of serous exudate; the surrounding skin is intact. How should I classify the status of this wound for the OASIS items?

A1. (M0464) According to the guidelines published by the WOCN, the evidence described above indicates that the status of this wound may be non-healing because there is no granulation tissue present in the wound bed. The OASIS Team and clinical wound care experts from WOCN are not able to fully assess a specific wound status without actually seeing the wound. For more information about the WOCN guidelines, please contact the WOCN web site at [www.wocn.org](http://www.wocn.org).

Q2. (M0464) This patient has an ischial pressure ulcer that measures 4 cm x 6 cm x 2 cm; there is a tract/tunnel at 4 o'clock that is 3 cm in depth. The wound bed has a small amount of stringy yellow tissue (about 20%) but is beginning to granulate (about 25% of the wound bed is covered with healthy red tissue that has a "bumpy" surface that looks a lot like raspberries). The edges of the wound are open. There are no signs of infection. How should I classify the status of this wound for the OASIS items?

A2. (M0464) According to the description presented above, the status of this wound may be classified as early/partial granulation because < 25% of the wound bed is covered with avascular tissue, at least 25% of the wound is granulating, the wound edges are open, and there are no signs of infection. There is dead space (a sinus tract) but that does not mean the wound is not healing. The OASIS Team and clinical wound care experts from WOCN are not able to assess a specific wound status without actually seeing the wound. Please contact the WOCN web site at [www.wocn.org](http://www.wocn.org) for further clarification about their guidelines regarding wound healing.

Q3. (M0464) My patient was admitted with a pressure ulcer 7 weeks ago and was initially showing progress. We debrided the wound and treated the infection and he began to granulate. Four to six weeks ago his wound measured 6 cm x 7 cm x 2 cm and he had 40% granulation tissue and no avascular tissue; we classified him as early/partial granulation. However, over the past 4 weeks he has shown no progress even though we have maintained him on an air support surface and his caregivers are turning him regularly. We have also consulted the dietitian who has recommended nutritional

## **Attachment B**

supplements, but he has been unable to ingest the recommended amount due to persistent nausea. How should I classify the status of this wound for the OASIS items?

A3. (M0464) According to the description presented in the question, the status of this wound appeared to have been correctly classified as early/partial granulation 4-6 weeks ago, but it may now be classified as non-healing due to persistent failure to progress despite appropriate management. The patient should be referred for medical management of his nutritional compromise since this is a key component of a comprehensive wound management program.

The OASIS Team and clinical wound care experts from WOCN are not able to assess a specific wound status without actually seeing the wound. Please contact the WOCN web site at [www.wocn.org](http://www.wocn.org) for further clarification about their guidelines regarding wound healing

Q4. (M0464) This patient was admitted with a Stage 4 pressure ulcer over the trochanter. The wound has now granulated to the surface and currently measures 5 cm x 4 cm; no sinus tracts and no measurable depth. The drainage is serous, and there are no signs of infection. The wound edges are open along most of the wound though there is an area at the inferior aspect where they appear to be closed/curled under. How should I classify the status of this wound for the OASIS items?

A4. (M0464) From the description provided, the status of this wound may be classified as fully granulating because it has granulated to the surface, there is no dead space and no signs of infection, and most of the wound edges are open. The OASIS Team and clinical wound care experts from WOCN are not able to assess a specific wound status without actually seeing the wound. Please contact the WOCN web site at [www.wocn.org](http://www.wocn.org) for further clarification about their guidelines regarding wound healing

Q5. (M0476) My patient has a venous stasis ulcer that measures 3 cm x 4 cm x 0.5 cm; the wound bed has a mix of adherent yellow tissue (40%) and pale, edematous granulation tissue (60%). There is a large volume of yellow-green exudate and a halo of erythema around the wound; the patient is afebrile. How should I classify the status of this wound for the OASIS items?

A5. (M0476) According to the descriptions provided in the question, the status of this wound may be classified as non-healing for two reasons:

- 1) The wound bed has more than 25% avascular tissue; and
- 2) There are signs/symptoms of infection (large amount of yellow-green exudate and halo of erythema).

The OASIS Team and clinical wound care experts from WOCN are not able to assess a specific wound status without actually seeing the wound. Please contact the WOCN web site at [www.wocn.org](http://www.wocn.org) for further clarification about their guidelines regarding wound healing.

Q6. (M0488) This patient has a surgical incision from an abdominal procedure 7 days ago. There is slight incisional separation along the middle portion of the incision; there is a small amount of serous drainage but no signs of infection; there is no palpable healing ridge. How should I classify the status of this wound for the OASIS items?

**A6. (M0488) According to the description of the wound presented in the question, the status of this may be classified as non-healing for two reasons:**

- 1) There is incisional separation; and
- 2) There is no palpable healing ridge.

The OASIS Team and clinical wound care experts from WOCN are not able to assess a specific wound status without actually seeing the wound. Please contact the WOCN web site at [www.wocn.org](http://www.wocn.org) for further clarification about their guidelines regarding wound healing.

Q7. (M0488) My patient is post-op CABG. The sternal incision is well-approximated, and there is new pink skin covering the entire incision. There is a well-defined healing ridge and no signs of infection though there is very mild erythema along the wound borders. How should I classify the status of this wound for the OASIS items?

A7. (M0488) According to the description presented in the question, the status of this wound may be classified as fully granulating, because the incision has completely epithelialized, there are no signs of infection, and there is a well-defined healing ridge. The OASIS Team and clinical wound care experts from WOCN are not able to assess a specific wound status without actually seeing the wound. Please contact the WOCN web site at [www.wocn.org](http://www.wocn.org) for further clarification about their guidelines regarding wound healing.