



Traumatic wound

Definition: Wound caused by injury (from accident or violence)

1. **Open wound, uncomplicated:** Wounds classified as lacerations, puncture wounds, cuts, animal bites, avulsions, and traumatic amputations
2. **Open wound, complicated:** Traumatic wound with presence of infection, foreign body in wound, or delayed healing
3. **Superficial wounds:** Traumatic wound classified as skin tears, partial thickness wounds, abrasions, friction burns, blisters, nonvenomous insect bites, superficial foreign body (e.g. splinter)

Documentation of external cause of the trauma wound is helpful. This is not a requirement, but it will help to paint the picture of how the patient sustained the injury and will help support the necessity of the care your agency is providing.

Important coding information: The care of superficial injuries is not typically a covered skill under Medicare. There are certain circumstances where a skin tear may be coded as an open wound. Please check our blog post [**Documenting and Coding Superficial Skin Tears**](#)

Ulcer

Definition: Wound caused by pressure and various disease processes

1. Pressure ulcers are coded according to **location** and **stage** (Stage I-IV and Unstageable)

Important coding information: Reverse staging is not an appropriate clinical practice (always document the pressure ulcer at its worst stage). Stage III and IV (full thickness) pressure ulcers close through a process of granulation, contraction, and epithelialization. They can never be considered “fully healed” but may be considered closed. Closed Stage III and IV ulcers should continue to be monitored, reported, and coded due to potential for reopening.

2. Venous stasis ulcers
3. Diabetic ulcers
4. Arterial ulcers

Important coding information: Clinician should document the specific location, laterality and severity of non-pressure ulcers (example: skin breakdown only, exposed fat layer, muscle necrosis or bone necrosis) for coders to accurately capture the specific ICD 10 codes. The severity of the ulcer may be determined and coded based upon nursing documentation, but confirmation of necrosis of bone should be obtained by diagnostic testing such as MRI (cannot determine through visualization alone).

Surgical wound

Definition: Wound created by surgical procedure

Important information: A surgical wound is reported on the OASIS until it has been completely epithelialized for 30 days or more with no S/S of infection and no evidence of complications.

OASIS guidelines define the following as surgical wounds:

- Orthopedic pin sites
- Abscess treated with incision and drain **only** if a drain had been placed
- Central line sites, Mediport sites, and implanted venous access device even if the implantation site has healed. Device does not need to be functional or accessed.
- Implanted infusion device (even if not presently functional)
- Peritoneal dialysis catheter, AV shunt
- Muscle flap, skin advancement flap, or rotational flap to surgically replace a pressure ulcer
- Shave, punch, or excisional biopsy to remove/diagnose lesions
- Skin graft **donor** site
- Surgical procedure performed via arthroscopy
- Paracentesis site (if drain placed)
- Wound created when ostomy is reversed or taken down
- I&D **only** if there was excision of necrotic mass, mesh, or other appliances or structures (beyond simple I&D)
- Surgical repair of traumatic injury such as ruptured organs, torn tendons, ligaments, or muscles, and fractures (beyond simple suture of traumatic laceration)
- LVAD exit site
- Incision or “cut down” created to perform procedure per femoral sheath

The following are **NOT** considered surgical wounds per OASIS guidelines:

- All ostomies
- An ostomy site closing on its own (without surgical reversal)
- The surgical line around a fresh ostomy stoma (the peristomal or mucocutaneous suture line)
- Debridement (does not change a burn, pressure ulcer, stasis ulcer, or traumatic wound into a surgical wound)
- Simple I&D
- Cardiac catheterization performed via needle puncture (even if stent placed)
- PICCs (even if insertion required fluoroscopy)
- Implanted pacemakers/internal defibrillators (after original incision has healed)
- External infusion device infusing meds SQ
- Arthrocentesis, thoracentesis, and paracentesis sites utilized for simple aspiration of fluid
- Chest tube site with or without a drain/tube
- Peripheral IVs sutured in place
- Pressure ulcer sutured shut
- Sutured traumatic lacerations
- Cataract surgery
- Gynecological surgery via vaginal approach
- Skin graft **recipient** site
- Enterocutaneous fistula
- Pressure ulcers treated with skin graft or surgical debridement
- Abscess that has been incised/drained without placement of drain
- Surgeries to mucous membranes
- VP shunt after original incision heals
- Removal of callus
- Removal or simple excision of toenail

Important information: In uncomplicated cases, most surgical wounds in home health will be represented by an Aftercare code. If surgical wound has **physician documented** complication such as infection, dehiscence, or delayed healing, a complication code will be used instead of an Aftercare code.

**Sources: OASIS C Best Practice Manual, Wound Ostomy and Continence Nurse Society, and CMS Quarterly Q&As*