

SECTION M: SKIN CONDITIONS

Intent: The items in this section document the risk, presence, appearance, and change of pressure ulcers. This section also notes other skin ulcers, wounds, or lesions, and documents some treatment categories related to skin injury or avoiding injury. It is important to recognize and evaluate each resident's risk factors and to identify and evaluate all areas at risk of constant pressure. A complete assessment of skin is essential to an effective pressure ulcer prevention and skin treatment program. Be certain to include in the assessment process, a holistic approach. It is imperative to determine the etiology of all wounds and lesions, as this will determine and direct the proper treatment and management of the wound.

M0100: Determination of Pressure Ulcer Risk

M0100. Determination of Pressure Ulcer Risk	
↓ Check all that apply	
<input type="checkbox"/>	A. Resident has a stage 1 or greater, a scar over bony prominence, or a non-removable dressing/device
<input type="checkbox"/>	B. Formal assessment instrument/tool (e.g., Braden, Norton, or other)
<input type="checkbox"/>	C. Clinical assessment
<input type="checkbox"/>	Z. None of the above

Item Rationale

Health-related Quality of Life

- Pressure ulcers occur when tissue is compressed between a bony prominence and an external surface. In addition to pressure, shear force, and friction are important contributors to pressure ulcer development.
- The underlying health of a resident's soft tissue affects how much pressure, shear force, or friction is needed to damage tissue. Skin and soft tissue changes associated with aging, illness, small blood vessel disease, and malnutrition increase vulnerability to pressure ulcers.
- Additional external factors, such as excess moisture, and tissue exposure to urine or feces, can increase risk.

Planning for Care

- The care planning process should include efforts to stabilize, reduce, or remove underlying risk factors; to monitor the impact of the interventions; and to modify the interventions as appropriate based on the individualized needs of the resident.
- Throughout this section, terminology referring to "healed" vs. "unhealed" ulcers refers to whether or not the ulcer is "closed" vs. "open." When considering this, recognize that Stage 1, Suspected Deep Tissue Injury (sDTI), and unstageable pressure ulcers although "closed," (i.e. may be covered with tissue, eschar, slough, etc.) would not be considered "healed."
- Facilities should be aware that the resident is at higher risk of having the area of a closed pressure ulcer open up due to damage, injury, or pressure, because of the loss of tensile strength of the overlying tissue. Tensile strength of the skin overlying a closed pressure ulcer is 80% of normal skin tensile strength. Facilities should put preventative measures in place that will mitigate the opening of a closed ulcer due to the fragility of the overlying tissue.

M0100: Determination of Pressure Ulcer Risk (cont.)

Steps for Assessment

1. Review the medical record, including skin care flow sheets or other skin tracking forms, nurses' notes, and pressure ulcer risk assessments.
2. Speak with the treatment nurse and direct care staff on all shifts to confirm conclusions from the medical record review and observations of the resident.
3. Examine the resident and determine whether any ulcers, scars, or non-removable dressings/devices are present. Assess key areas for pressure ulcer development (e.g., sacrum, coccyx, trochanters, ischial tuberosities, and heels). Also assess bony prominences (e.g., elbows and ankles) and skin that is under braces or subjected to pressure (e.g., ears from oxygen tubing).

Coding Instructions

For this item, check all that apply:

- **Check A if resident has a Stage 1 or greater pressure ulcer, a scar over bony prominence, or a non-removable dressing/device.** Review descriptions of pressure ulcer stages and information obtained during physical examination and medical record review. Examples of non-removable dressings/devices include a primary surgical dressing, a cast, or a brace.
- **Check B if a formal assessment has been completed.** An example of an established pressure ulcer risk tool is the *Braden Scale for Predicting Pressure Sore Risk*®. Other tools may be used.
- **Check C if the resident's risk for pressure ulcer development is based on clinical assessment.** A clinical assessment could include a head-to-toe physical examination of the skin and observation or medical record review of pressure ulcer risk factors. Examples of risk factors include the following:
 - impaired/decreased mobility and decreased functional ability
 - co-morbid conditions, such as end stage renal disease, thyroid disease, or diabetes mellitus;
 - drugs, such as steroids, that may affect wound healing;
 - impaired diffuse or localized blood flow (e.g., generalized atherosclerosis or lower extremity arterial insufficiency);

DEFINITIONS

PRESSURE ULCER RISK FACTOR

Examples of risk factors include immobility and decreased functional ability; co-morbid conditions such as end-stage renal disease, thyroid disease, or diabetes; drugs such as steroids; impaired diffuse or localized blood flow; resident refusal of care and treatment; cognitive impairment; exposure of skin to urinary and fecal incontinence; under nutrition, malnutrition, and hydration deficits; and a healed ulcer.

PRESSURE ULCER RISK TOOLS

Screening tools that are designed to help identify residents who might develop a pressure ulcer. A common risk assessment tool is the Braden Scale for Predicting Pressure Sore Risk®.

M0100: Determination of Pressure Ulcer Risk (cont.)

- resident refusal of some aspects of care and treatment;
- cognitive impairment;
- urinary and fecal incontinence;
- under nutrition, malnutrition, and hydration deficits; and
- healed pressure ulcers, especially Stage 3 or 4 which are more likely to have recurrent breakdown.

- **Check Z if none of the above apply.**

M0150: Risk of Pressure Ulcers

M0150. Risk of Pressure Ulcers	
Enter Code <input type="checkbox"/>	Is this resident at risk of developing pressure ulcers? 0. No 1. Yes

Item Rationale

Health-related Quality of Life

- It is important to recognize and evaluate each resident's risk factors and to identify and evaluate all areas at risk of constant pressure.

Planning for Care

- The care process should include efforts to stabilize, reduce, or remove underlying risk factors; to monitor the impact of the interventions; and to modify the interventions as appropriate.

Steps for Assessment

1. Based on the item(s) reviewed for M0100, determine if the resident is at risk for developing a pressure ulcer.
2. If the medical record reveals that the resident currently has a Stage 1 or greater pressure ulcer, a scar over a bony prominence, or a non-removable dressing or device, the resident is at risk for worsening or new pressure ulcers.
3. Review formal risk assessment tools to determine the resident's "risk score."
4. Review the components of the clinical assessment conducted for evidence of pressure ulcer risk.

Coding Instructions

- **Code 0, no:** if the resident is not at risk for developing pressure ulcers based on a review of information gathered for M0100.
- **Code 1, yes:** if the resident is at risk for developing pressure ulcers based on a review of information gathered for M0100.

M0210: Unhealed Pressure Ulcer(s)

M0210. Unhealed Pressure Ulcer(s)	
Enter Code <input type="checkbox"/>	<p>Does this resident have one or more unhealed pressure ulcer(s) at Stage 1 or higher?</p> <p>0. No → Skip to M0900, Healed Pressure Ulcers</p> <p>1. Yes → Continue to M0300, Current Number of Unhealed Pressure Ulcers at Each Stage</p>

Item Rationale

Health-related Quality of Life

- Pressure ulcers and other wounds or lesions affect quality of life for residents because they may limit activity, may be painful, and may require time-consuming treatments and dressing changes.

Planning for Care

- The pressure ulcer definitions used in the RAI Manual have been adapted from those recommended by the National Pressure Ulcer Advisory Panel (NPUAP) 2007 Pressure Ulcer Stages.
- An existing pressure ulcer identifies residents at risk for further complications or skin injury. Risk factors described in M0100 should be addressed.
- For MDS assessment, initial numerical staging of pressure ulcers and the initial numerical staging of ulcers after debridement, or sDTI that declares itself, should be coded in terms of what is assessed (seen or palpated, i.e. visible tissue, palpable bone) during the look-back period. Nursing homes may adopt the NPUAP guidelines in their clinical practice and nursing documentation. However, since CMS has adapted the NPUAP guidelines for MDS purposes, the definitions do not perfectly correlate with each stage as described by NPUAP. Therefore, you cannot use the NPUAP definitions to code the MDS. You must code the MDS according to the instructions in this manual.
- Pressure ulcer staging is an assessment system that provides a description and classification based on anatomic depth of soft tissue damage. This tissue damage can be visible or palpable in the ulcer bed. Pressure ulcer staging also informs expectations for healing times.

DEFINITION

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.

Steps for Assessment

- Review the medical record, including skin care flow sheets or other skin tracking forms.
- Speak with direct care staff and the treatment nurse to confirm conclusions from the medical record review.
- Examine the resident and determine whether any skin ulcers are present.
 - Key areas for pressure ulcer development include the sacrum, coccyx, trochanters, ischial tuberosities, and heels. Other areas, such as bony deformities, skin under braces, and skin subjected to excess pressure, shear or friction, are also at risk for pressure ulcers.
 - Without a full body skin assessment, a pressure ulcer can be missed.
 - Examine the resident in a well-lit room. Adequate lighting is important for detecting skin changes. For any pressure ulcers identified, measure and record the deepest anatomical stage.
- Identify any known or likely unstageable pressure ulcers.

M0210: Unhealed Pressure Ulcer(s) (cont.)

Coding Instructions

Code based on the presence of any pressure ulcer (regardless of stage) in the past 7 days.

- **Code 0, no:** if the resident did not have a pressure ulcer in the 7-day look-back period. Then skip Items M0300–M0800.
- **Code 1, yes:** if the resident had any pressure ulcer (Stage 1, 2, 3, 4, or unstageable) in the 7-day look-back period. Proceed to **Current Number of Unhealed Pressure Ulcers at Each Stage** item (M0300).

Coding Tips

- If an ulcer arises from a combination of factors which are primarily caused by pressure, then the ulcer should be included in this section as a pressure ulcer.
- Oral Mucosal ulcers caused by pressure should not be coded in Section M. These ulcers are captured in item **L0200C, Abnormal mouth tissue**. Mucosal ulcers are not staged using the skin pressure ulcer staging system because anatomical tissue comparisons cannot be made.
- If a pressure ulcer is surgically closed with a flap or graft, it should be coded as a surgical wound and not as a pressure ulcer. If the flap or graft fails, continue to code it as a surgical wound until healed.
- Residents with diabetes mellitus (DM) can have a pressure, venous, arterial, or diabetic neuropathic ulcer. The primary etiology should be considered when coding whether the diabetic has an ulcer that is caused by pressure or other factors.
- If a resident with DM has a heel ulcer from pressure and the ulcer is present in the 7-day look-back period, **code 1** and proceed to code items M0300–M0900 as appropriate for the pressure ulcer.
- If a resident with DM has an ulcer on the plantar (bottom) surface of the foot closer to the metatarsal and the ulcer is present in the 7-day look-back period, **code 0** and proceed to M1040 to code the ulcer as a diabetic foot ulcer.
- Scabs and eschar are different both physically and chemically. Eschar is a collection of dead tissue within the wound that is flush with the surface of the wound. A scab is made up of dried blood cells and serum, sits on the top of the skin, and forms over exposed wounds such as wounds with granulating surfaces (like pressure ulcers, lacerations, evulsions, etc.). A scab is evidence of wound healing. A pressure ulcer that was staged as a 2 and now has a scab indicates it is a healing stage 2, and therefore, staging should not change. Eschar characteristics and the level of damage it causes to tissues is what makes it easy to distinguish from a scab. It is extremely important to have staff who are trained in wound assessment and who are able to distinguish scabs from eschar.
- If a resident had a pressure ulcer on the last assessment and it is now healed, complete **Healed Pressure Ulcers** item (M0900).
- If a pressure ulcer healed during the look-back period, and was not present on prior assessment, **code 0**.

M0300: Current Number of Unhealed Pressure Ulcers at Each Stage

Steps for completing M0300A–G

Step 1: Determine Deepest Anatomical Stage

For each pressure ulcer, determine the deepest anatomical stage. Do not reverse or back stage. Consider current and historical levels of tissue involvement.

1. Observe and palpate the base of any identified pressure ulcers present to determine the anatomic depth of soft tissue damage involved.
2. Ulcer staging should be based on the ulcer's deepest anatomic soft tissue damage that is visible or palpable. If a pressure ulcer's tissues are obscured such that the depth of soft tissue damage cannot be observed, it is considered to be unstageable (see Step 2 below). Review the history of each pressure ulcer in the medical record. If the pressure ulcer has ever been classified at a higher numerical stage than what is observed now, it should continue to be classified at the higher numerical stage. Nursing homes that carefully document and track pressure ulcers will be able to more accurately code this item.

Step 2: Identify Unstageable Pressure Ulcers

1. Visualization of the wound bed is necessary for accurate staging.
2. Pressure ulcers that have eschar (tan, black, or brown) or slough (yellow, tan, gray, green or brown) tissue present such that the anatomic depth of soft tissue damage cannot be visualized or palpated in the wound bed, should be classified as unstageable, as illustrated at <http://www.npuap.org/wp-content/uploads/2012/03/NPUAP-Unstage2.jpg>
3. If the wound bed is only partially covered by eschar or slough, and the anatomical depth of tissue damage can be visualized or palpated, numerically stage the ulcer, and do not code this as unstageable.
4. A pressure ulcer with intact skin that is a suspected deep tissue injury (sDTI) should not be coded as a Stage 1 pressure ulcer. It should be coded as unstageable, as illustrated at <http://www.npuap.org/images/NPUAP-SuspectDTI.jpg>
5. Known pressure ulcers covered by a non-removable dressing/device (e.g., primary surgical dressing, cast) should be coded as unstageable.

M0300: Current Number of Unhealed Pressure Ulcers at Each Stage (cont.)

Step 3: Determine “Present on Admission”

*For **each** pressure ulcer, determine if the pressure ulcer was present at the time of admission/entry or reentry and **not** acquired while the resident was in the care of the nursing home. Consider current and historical levels of tissue involvement.*

DEFINITION

ON ADMISSION

As close to the actual time of admission as possible.

1. Review the medical record for the history of the ulcer.
2. Review for location and stage at the time of admission/entry or reentry. If the pressure ulcer was present on admission/entry or reentry and subsequently increased in numerical stage during the resident's stay, the pressure ulcer is coded at that higher stage, and that higher stage **should not be considered as “present on admission.”**
3. If the pressure ulcer was unstageable on admission/entry or reentry, but becomes numerically stageable later, it should be considered as “present on admission” at the stage at which it first becomes numerically stageable. If it subsequently increases in numerical stage, that higher stage **should not be considered “present on admission.”**
4. If a resident who has a pressure ulcer is hospitalized and returns with that pressure ulcer at the same numerical stage, the pressure ulcer **should not be coded as “present on admission”** because it was present at the facility prior to the hospitalization.
5. If a current pressure ulcer increases in numerical stage during a hospitalization, it is coded at the higher stage upon reentry and **should be coded as “present on admission.”**

M0300A: Number of Stage 1 Pressure Ulcers

M0300. Current Number of Unhealed Pressure Ulcers at Each Stage	
Enter Number <input type="text"/>	A. Number of Stage 1 pressure ulcers Stage 1: Intact skin with non-blanchable redness of a localized area usually over a bony prominence. Darkly pigmented skin may not have a visible blanching; in dark skin tones only it may appear with persistent blue or purple hues

Item Rationale

Health-related Quality of Care

- Stage 1 pressure ulcers may deteriorate to more severe pressure ulcers without adequate intervention; as such, they are an important risk factor for further tissue damage.

Planning for Care

- Development of a Stage 1 pressure ulcer should be one of multiple factors that initiate pressure ulcer prevention interventions.

M0300A: Number of Stage 1 Pressure Ulcers (cont.)

Steps for Assessment

1. Perform head-to-toe assessment. Conduct a full body skin assessment focusing on bony prominences and pressure-bearing areas (sacrum, buttocks, heels, ankles, etc).
2. For the purposes of coding, determine that the lesion being assessed is **primarily** related to pressure and that other conditions have been ruled out. If pressure is **not** the **primary** cause, do **not** code here.
3. Reliance on only one descriptor is inadequate to determine the staging of the pressure ulcer between Stage 1 and suspected deep tissue ulcers. The descriptors are similar for these two types of ulcers (e.g., temperature (warmth or coolness); tissue consistency (firm or boggy)).
4. Check any reddened areas for ability to blanch by firmly pressing a finger into the reddened tissues and then removing it. In non-blanchable reddened areas, there is no loss of skin color or pressure-induced pallor at the compressed site.
5. Search for other areas of skin that differ from surrounding tissue that may be painful, firm, soft, warmer, or cooler compared to adjacent tissue. Stage 1 may be difficult to detect in individuals with dark skin tones. Visible blanching may not be readily apparent in darker skin tones. Look for temperature or color changes.

Coding Instructions for M0300A

- **Enter the number** of Stage 1 pressure ulcers that are currently present.
- **Enter 0** if no Stage 1 pressure ulcers are present.

Coding Tips

- If a resident had a pressure ulcer on the last assessment and it is now healed, complete **Healed Pressure Ulcers** item (M0900).
- If a pressure ulcer healed during the look-back period, and was not present on prior assessment, **code 0**.

DEFINITIONS

STAGE 1 PRESSURE ULCER

An observable, pressure-related alteration of intact skin, whose indicators as compared to an adjacent or opposite area on the body may include changes in one or more of the following parameters: skin temperature (warmth or coolness); tissue consistency (firm or boggy); sensation (pain, itching); and/or a defined area of persistent redness in lightly pigmented skin, whereas in darker skin tones, the ulcer may appear with persistent red, blue, or purple hues.

NON-BLANCHABLE

Reddened areas of tissue that do not turn white or pale when pressed firmly with a finger or device.

M0300B: Stage 2 Pressure Ulcers

B. Stage 2: Partial thickness loss of dermis presenting as a shallow open ulcer with a red or pink wound bed, without slough. May also present as an intact or open/ruptured blister

- Number of Stage 2 pressure ulcers** - If 0 → Skip to M0300C, Stage 3
- Number of these Stage 2 pressure ulcers that were present upon admission/entry or reentry** - enter how many were noted at the time of admission/entry or reentry
- Date of oldest Stage 2 pressure ulcer** - Enter dashes if date is unknown:

-

-

Month
Day
Year

Item Rationale

Health-related Quality of Life

- Stage 2 pressure ulcers may worsen without proper interventions.
- These residents are at risk for further complications or skin injury.

Planning for Care

- **Most Stage 2** pressure ulcers should heal in a reasonable time frame (e.g., 60 days).
 - If a pressure ulcer fails to show some evidence toward healing within 14 days, the pressure ulcer (including potential complications) and the patient's overall clinical condition should be reassessed.
 - Stage 2 pressure ulcers are often related to friction and/or shearing force, and the care plan should incorporate efforts to limit these forces on the skin and tissues.
 - Stage 2 pressure ulcers may be more likely to heal with treatment than higher stage pressure ulcers.
 - The care plan should include individualized interventions and evidence that the interventions have been monitored and modified as appropriate.
- without slough.
May also present as an intact or open/ ruptured blister.

DEFINITION

STAGE 2 PRESSURE ULCER

Partial thickness loss of dermis presenting as a shallow open ulcer with a red-pink wound bed, without slough.

May also present as an intact or open/ ruptured blister.

Steps for Assessment

1. Perform head-to-toe assessment. Conduct a full body skin assessment focusing on bony prominences and pressure-bearing areas (sacrum, buttocks, heels, ankles, etc).
2. For the purposes of coding, determine that the lesion being assessed is primarily related to pressure and that other conditions have been ruled out. If pressure is **not** the primary cause, do **not** code here.

M0300B: Stage 2 Pressure Ulcers (cont.)

3. **Examine the area adjacent to or surrounding an intact blister for evidence of tissue damage. If other conditions are ruled out and the tissue adjacent to, or surrounding the blister demonstrates signs of tissue damage, (e.g., color change, tenderness, boggy or firmness, warmth or coolness) these characteristics suggest a suspected deep tissue injury (sDTI) rather than a Stage 2 Pressure Ulcer.**
4. Stage 2 pressure ulcers will generally lack the surrounding characteristics found with a deep tissue injury.
5. Identify the number of these pressure ulcers that were present on admission/entry or reentry (see instructions on page M-6).
6. Identify the oldest Stage 2 pressure ulcer and the date it was first noted at that stage.

Coding Instructions for M0300B

- **Enter the number** of pressure ulcers that are currently present and whose deepest anatomical stage is Stage 2.
- **Enter 0** if no Stage 2 pressure ulcers are present and skip to **Current Number of Unhealed Pressure Ulcers at Each Stage** item (M0300C).
- **Enter the number** of Stage 2 pressure ulcers that were first noted at the time of admission/entry AND—for residents who are reentering the facility after a hospital stay, enter the number of Stage 2 pressure ulcers that were acquired during the hospitalization (i.e., the Stage 2 pressure ulcer was not acquired in the nursing facility prior to admission to the hospital).
- **Enter 0** if no Stage 2 pressure ulcers were first noted at the time of admission/entry or reentry.
- **Enter the date of the oldest Stage 2 pressure ulcer.** The facility should make every effort to determine the actual date that the Stage 2 pressure ulcer was first identified whether or not it was acquired in the facility. If the facility is unable to determine the actual date that the Stage 2 pressure ulcer was first identified (i.e., the date is unknown), enter a dash in every block. Do not leave any boxes blank. If the month or day contains only a single digit, fill the first box in with a "0." For example, January 2, 2012, should be entered as 01-02-2012.

Coding Tips

- A Stage 2 pressure ulcer presents as a shiny or dry shallow ulcer without slough or bruising.
- If the oldest Stage 2 pressure ulcer was present on admission/entry or reentry and the date it was first noted is unknown, enter a dash in every block.
- Do **not** code skin tears, tape burns, moisture associated skin damage, or excoriation here.
- When a pressure ulcer presents as an intact blister, examine the adjacent and surrounding area for signs of deep tissue injury. When a deep tissue injury **is** determined, do **not** code as a Stage 2.

M0300C: Stage 3 Pressure Ulcers

Enter Number <input type="text"/> Enter Number <input type="text"/>	<p>C. 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</p> <p>1. Number of Stage 3 pressure ulcers - If 0 → Skip to M0300D, Stage 4</p> <p>2. Number of <u>these</u> Stage 3 pressure ulcers that were present upon admission/entry or reentry - enter how many were noted at the time of admission/entry or reentry</p>
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Item Rationale

Health-related Quality of Life

- Pressure ulcers affect quality of life for residents because they may limit activity, may be painful, and may require time-consuming treatments and dressing changes.

Planning for Care

- Pressure ulcers at more advanced stages typically require more aggressive interventions, including more frequent repositioning, attention to nutritional status, and care that may be more time or staff intensive.
- An existing pressure ulcer may put residents at risk for further complications or skin injury.
- If a pressure ulcer fails to show some evidence toward healing within 14 days, the pressure ulcer (including potential complications) and the resident's overall clinical condition should be reassessed.

DEFINITION

STAGE 3 PRESSURE ULCER

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 or tunneling.

Steps for Assessment

- Perform head-to-toe assessment. Conduct a full body skin assessment focusing on bony prominences and pressure-bearing areas (sacrum, buttocks, heels, ankles, etc).
- For the purposes of coding, determine that the lesion being assessed is primarily related to pressure and that other conditions have been ruled out. If pressure is **not** the primary cause, do **not** code here.
- Identify all Stage 3 pressure ulcers currently present.
- Identify the number of **these** pressure ulcers that were present on admission/entry or reentry.

Coding Instructions for M0300C

- Enter the number** of pressure ulcers that are currently present and whose deepest anatomical stage is Stage 3.
- Enter 0** if no Stage 3 pressure ulcers are present and skip to **Current Number of Unhealed Pressures Ulcers at Each Stage** item (M0300D).
- Enter the number** of Stage 3 pressure ulcers that were first noted at Stage 3 at the time of admission/entry AND—for residents who are reentering the facility after a hospital stay, enter the number of Stage 3 pressure ulcers that were acquired during the

M0300C: Stage 3 Pressure Ulcers (cont.)

hospitalization (i.e., the Stage 3 pressure ulcer was not acquired in the nursing facility prior to admission to the hospital).

- **Enter 0** if no Stage 3 pressure ulcers were first noted at the time of admission/entry or reentry.

Coding Tips

- The depth of a Stage 3 pressure ulcer varies by anatomical location. Stage 3 pressure ulcers can be shallow, particularly on areas that do not have subcutaneous tissue, such as the bridge of the nose, ear, occiput, and malleolus.
- In contrast, areas of significant adiposity can develop extremely deep Stage 3 pressure ulcers. Therefore, observation and assessment of skin folds should be part of overall skin assessment.
- Bone/tendon/muscle is not visible or directly palpable in a Stage 3 pressure ulcer.

Examples

1. A pressure ulcer described as a Stage 2 was noted and documented in the resident's medical record on admission. On a later assessment, the wound is noted to be a full thickness ulcer without exposed bone, tendon, or muscle, thus it is now a Stage 3 pressure ulcer.

Coding: The current Stage 3 pressure ulcer would be coded at **M0300C1 as Code 1, and at M0300C2 as 0, not present on admission/entry or reentry.**

Rationale: The designation of "present on admission" requires that the pressure ulcer be at the same location **and** not have increased in numerical stage. This pressure ulcer worsened after admission.

2. A resident develops a Stage 2 pressure ulcer while at the nursing facility. The resident is hospitalized due to pneumonia for 8 days and returns with a Stage 3 pressure ulcer in the same location.

Coding: The pressure ulcer would be coded at **M0300C1 as Code 1, and at M0300C2 as 1, present on admission/entry or reentry.**

Rationale: Even though the resident had a pressure ulcer in the same anatomical location prior to transfer, because the pressure ulcer increased in numerical stage to Stage 3 during hospitalization, it should be coded as a Stage 3, present on admission/entry or reentry.

M0300C: Stage 3 Pressure Ulcers (cont.)

3. On admission, the resident has three small Stage 2 pressure ulcers on her coccyx. Two weeks later, the coccyx is assessed. Two of the Stage 2 pressure ulcers have merged and the third has increased in numerical stage to a Stage 3 pressure ulcer.

Coding: The two merged pressure ulcers would be coded at **M0300B1 as 1, and at M0300B2 as 1, present on admission/entry or reentry.** The **Stage 3 pressure ulcer** would be **coded at M0300C1 as 1, and at M0300C2 as 0, not present on admission/entry or reentry.**

Rationale: Two of the pressure ulcers on the coccyx have merged, but have remained at the same stage as they were at the time of admission; the one that increased in numerical stage to a Stage 3 cannot be coded in M0300C2 as present on admission/entry or reentry since the Stage 3 ulcer was not present on admission/entry or reentry.

4. A resident developed two Stage 2 pressure ulcers during her stay; one on the coccyx and the other on the left lateral malleolus. At some point she is hospitalized and returns with two pressure ulcers. One is the previous Stage 2 on the coccyx, which has not changed; the other is a new Stage 3 on the left trochanter. The Stage 2 previously on the left lateral malleolus has healed.

Coding: The **Stage 2** pressure ulcer would be coded at **M0300B1 as 1, and at M0300B2 as 0, not present on admission; the Stage 3** would be coded at **M0300C1 as 1, and at M0300C2 as 1, present on admission/entry or reentry.**

Rationale: The Stage 2 pressure ulcer on the coccyx was present prior to hospitalization; the Stage 3 pressure ulcer developed during hospitalization and is coded in M0300C2 as present on admission/entry or reentry. The Stage 2 pressure ulcer on the left lateral malleolus has healed and is therefore no longer coded here but in Item M0900, Healed Pressure Ulcers.

DEFINITION

STAGE 4 PRESSURE ULCER

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.

M0300D: Stage 4 Pressure Ulcers

Enter Number <input type="text"/> Enter Number <input type="text"/>	D. 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
	1. Number of Stage 4 pressure ulcers - If 0 → Skip to M0300E, Unstageable: Non-removable dressing 2. Number of these Stage 4 pressure ulcers that were present upon admission/entry or reentry - enter how many were noted at the time of admission/entry or reentry

Item Rationale

Health-related Quality of Life

- Pressure ulcers affect quality of life for residents because they may limit activity, may be painful, and may require time-consuming treatments and dressing changes.

M0300D: Stage 4 Pressure Ulcers (cont.)

Planning for Care

- Pressure ulcers at more advanced stages typically require more aggressive interventions, including more frequent repositioning, attention to nutritional status, more frequent dressing changes, and treatment that is more time-consuming than with routine preventive care.
- An existing pressure ulcer may put residents at risk for further complications or skin injury.
- If a pressure ulcer fails to show some evidence toward healing within 14 days, the pressure ulcer (including potential complications) and the resident's overall clinical condition should be reassessed.

Steps for Assessment

1. Perform head-to-toe assessment. Conduct a full body skin assessment focusing on bony prominences and pressure-bearing areas (sacrum, buttocks, heels, ankles, etc.).
2. For the purposes of coding, determine that the lesion being assessed is primarily related to pressure and that other conditions have been ruled out. If pressure is **not** the primary cause, do **not** code here.
3. Identify all Stage 4 pressure ulcers currently present.
4. Identify the number of **these** pressure ulcers that were present on admission/entry or reentry.

Coding Instructions for M0300D

- **Enter the number** of pressure ulcers that are currently present and whose deepest anatomical stage is Stage 4.
- **Enter 0** if no Stage 4 pressure ulcers are present and skip to **Current Number of Unhealed Pressure Ulcers at Each Stage** item (M0300E).
- **Enter the number** of Stage 4 pressure ulcers that were first noted at Stage 4 at the time of admission/entry AND—for residents who are reentering the facility after a hospital stay, enter the number of Stage 4 pressure ulcers that were acquired during the hospitalization (i.e., the Stage 4 pressure ulcer was not acquired in the nursing facility prior to admission to the hospital).
- **Enter 0** if no Stage 4 pressure ulcers were first noted at the time of admission/entry or reentry.

DEFINITIONS

TUNNELING

A passage way of tissue destruction under the skin surface that has an opening at the skin level from the edge of the wound.

UNDERMINING

The destruction of tissue or ulceration extending under the skin edges (margins) so that the pressure ulcer is larger at its base than at the skin surface.

M0300D: Stage 4 Pressure Ulcers (cont.)

Coding Tips

- The depth of a Stage 4 pressure ulcer varies by anatomical location. The bridge of the nose, ear, occiput, and malleolus do not have subcutaneous tissue, and these ulcers can be shallow.
- Stage 4 pressure ulcers can extend into muscle and/or supporting structures (e.g., fascia, tendon, or joint capsule) making osteomyelitis possible.
- Exposed bone/tendon/muscle is visible or directly palpable.
- Cartilage serves the same anatomical function as bone. Therefore, pressure ulcers that have exposed cartilage should be classified as a Stage 4.

M0300E: Unstageable Pressure Ulcers Related to Non-removable Dressing/Device

Enter Number <input type="text"/> Enter Number <input type="text"/>	E. Unstageable - Non-removable dressing: Known but not stageable due to non-removable dressing/device 1. Number of unstageable pressure ulcers due to non-removable dressing/device - If 0 → Skip to M0300F, Unstageable: Slough and/or eschar 2. Number of these unstageable pressure ulcers that were present upon admission/entry or reentry - enter how many were noted at the time of admission/entry or reentry
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Item Rationale

Health-related Quality of Life

- Although the wound bed cannot be visualized, and hence the pressure ulcer cannot be staged, the pressure ulcer may affect quality of life for residents because it may limit activity and may be painful.

Planning for Care

- Although the pressure ulcer itself cannot be observed, the surrounding area is monitored for signs of redness, swelling, increased drainage, or tenderness to touch, and the resident is monitored for adequate pain control.

DEFINITION

NON-REMOVABLE DRESSING/ DEVICE

Includes, for example, a primary surgical dressing that cannot be removed, an orthopedic device, or cast.

Steps for Assessment

1. Review the medical record for documentation of a pressure ulcer covered by a non-removable dressing.
2. Determine the number of pressure ulcers unstageable related to a non-removable dressing/device. Examples of non-removable dressings/devices include a dressing that is not to be removed per physician's order, an orthopedic device, or a cast.
3. Identify the number of these pressure ulcers that were present on admission/entry or reentry (see page M-6 for assessment process).

M0300E: Unstageable Pressure Ulcers Related to Non-removable Dressing/Device (cont.)

Coding Instructions for M0300E

- **Enter the number** of pressure ulcers that are unstageable related to non-removable dressing/device.
- **Enter 0** if no unstageable pressure ulcers related to non-removable dressing/device are present and skip to **Current Number of Unhealed Pressure Ulcers at Each Stage** item (M0300F).
- **Enter the number** of unstageable pressure ulcers related to a non-removable dressing/device that were first noted at the time of admission/entry AND—for residents who are reentering the facility after a hospital stay, that were acquired during the hospitalization (i.e., the unstageable pressure ulcer related to a non-removable dressing/device was not acquired in the nursing facility prior to admission to the hospital).
- **Enter 0** if no unstageable pressure ulcers related to non-removable dressing/device were first noted at the time of admission/entry or reentry.

M0300F: Unstageable Pressure Ulcers Related to Slough and/or Eschar

Enter Number <input type="text"/> Enter Number <input type="text"/>	<p>F. Unstageable - Slough and/or eschar: Known but not stageable due to coverage of wound bed by slough and/or eschar</p> <p>1. Number of unstageable pressure ulcers due to coverage of wound bed by slough and/or eschar - If 0 → Skip to M0300G, Unstageable: Deep tissue</p> <p>2. Number of <u>these</u> unstageable pressure ulcers that were present upon admission/entry or reentry - enter how many were noted at the time of admission/entry or reentry</p>
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Item Rationale

Health-related Quality of Life

- Although the wound bed cannot be visualized, and hence the pressure ulcer cannot be staged, the pressure ulcer may affect quality of life for residents because it may limit activity, may be painful, and may require time-consuming treatments and dressing changes.

Planning for Care

- Visualization of the wound bed is necessary for accurate staging.
- The presence of pressure ulcers and other skin changes should be accounted for in the interdisciplinary care plan.

DEFINITIONS

SLOUGH TISSUE

Non-viable yellow, tan, gray, green or brown tissue; usually moist, can be soft, stringy and mucinous in texture. Slough may be adherent to the base of the wound or present in clumps throughout the wound bed.

ESCHAR TISSUE

Dead or devitalized tissue that is hard or soft in texture; usually black, brown, or tan in color, and may appear scab-like. Necrotic tissue and eschar are usually firmly adherent to the base of the wound and often the sides/ edges of the wound.

M0300F: Unstageable Pressure Ulcers Related to Slough and/or Eschar (cont.)

- Pressure ulcers that present as unstageable require care planning that includes, in the absence of ischemia, debridement of necrotic and dead tissue and restaging once this tissue is removed.

Steps for Assessment

1. Determine the number of pressure ulcers that are unstageable due to slough and/or eschar.
2. Identify the number of **these** pressure ulcers that were present on admission/entry or reentry (see page M-6 for assessment process).

Coding Instructions for M0300F

- **Enter the number** of pressure ulcers that are unstageable related to slough and/or eschar.
- **Enter 0** if no unstageable pressure ulcers related to slough and/or eschar are present and skip to **Current Number of Unhealed Pressure Ulcers at Each Stage** item (M0300G).
- **Enter the number** of unstageable pressure ulcers related to slough and/or eschar that were first noted at the time of admission/entry AND—for residents who are reentering the facility after a hospital stay that were acquired during the hospitalization (i.e., the unstageable pressure ulcer related to slough and/or eschar was not acquired in the nursing facility prior to admission to the hospital).
- **Enter 0** if no unstageable pressure ulcers related to slough and/or eschar were first noted at the time of admission/entry or reentry.

Coding Tips

- Pressure ulcers that are covered with slough and/or eschar should be coded as unstageable because the true anatomic depth of soft tissue damage (and therefore stage) cannot be determined. Only until enough slough and/or eschar is removed to expose the anatomic depth of soft tissue damage involved, can the stage of the wound be determined.
- Stable eschar (i.e., dry, adherent, intact without erythema or fluctuance) on the heels serves as “the body’s natural (biological) cover” and should only be removed after careful clinical consideration, including ruling out ischemia, and consultation with the resident’s physician, or nurse practitioner, physician assistant, or clinical nurse specialist if allowable under state licensure laws.
- Once the pressure ulcer is debrided of slough and/or eschar such that the anatomic depth of soft tissue damage involved can be determined, then code the ulcer for the reclassified stage. The pressure ulcer does not have to be completely debrided or free of all slough and/or eschar tissue in order for reclassification of stage to occur.

DEFINITION

FLUCTUANCE

Used to describe the texture of wound tissue indicative of underlying unexposed fluid.

M0300F: Unstageable Pressure Ulcers Related to Slough and/or Eschar (cont.)

Examples

1. A resident is admitted with a sacral pressure ulcer that is 100% covered with black eschar.

Coding: The pressure ulcer would be coded at **M0300F1 as 1, and at M0300F2 as 1, present on admission/entry or reentry.**

Rationale: The pressure ulcer depth is not observable because the pressure ulcer is covered with eschar. This pressure ulcer is unstageable and was present on admission.

2. A pressure ulcer on the sacrum was present on admission and was 100% covered with black eschar. On the admission assessment, it was coded as unstageable and present on admission. The pressure ulcer is later debrided using conservative methods and after 4 weeks the ulcer has 50% to 75% eschar present. The assessor can now see that the damage extends down to the bone.

Coding: The ulcer is reclassified as a Stage 4 pressure ulcer. On the subsequent MDS, it is coded at **M0300D1 as 1, and at M0300D2 as 1, present on admission/entry or reentry.**

Rationale: After debridement, the pressure ulcer is no longer unstageable because bone is visible in the wound bed. Therefore, this ulcer can be classified as a Stage 4 pressure ulcer and should be coded at M0300D. If this pressure ulcer has the largest surface area of all Stage 3 or 4 pressure ulcers for this resident, the pressure ulcer's dimensions would also be entered at M0610, Dimensions of Unhealed Stage 3 or 4 Pressure Ulcers or Unstageable Pressure Ulcer Due to Slough or Eschar.

3. Miss J. was admitted with one small Stage 2 pressure ulcer. Despite treatment, it is not improving. In fact, it now appears deeper than originally observed, and the wound bed is covered with slough.

Coding: Code at **M0300F1 as 1, and at M0300F2 as 0, not present on admission/entry or reentry.**

Rationale: The pressure ulcer depth is not observable because it is covered with slough. This pressure ulcer is unstageable and is not coded in M0300F2 as present on admission/entry or reentry because it can no longer be coded as a Stage 2.

M0300G: Unstageable Pressure Ulcers Related to Suspected Deep Tissue Injury

Enter Number <input type="text"/> Enter Number <input type="text"/>	<p>G. Unstageable - Deep tissue: Suspected deep tissue injury in evolution</p> <ol style="list-style-type: none"> 1. Number of unstageable pressure ulcers with suspected deep tissue injury in evolution - If 0 → Skip to M0610, Dimension of Unhealed Stage 3 or 4 Pressure Ulcers or Eschar 2. Number of <u>these</u> unstageable pressure ulcers that were present upon admission/entry or reentry - enter how many were noted at the time of admission/entry or reentry
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M0300G: Unstageable Pressure Ulcers Related to Suspected Deep Tissue Injury (cont.)

Item Rationale

Health-related Quality of Life

- Deep tissue injury may precede the development of a Stage 3 or 4 pressure ulcer even with optimal treatment.
- Quality health care begins with prevention and risk assessment, and care planning begins with prevention. Appropriate care planning is essential in optimizing a resident's ability to avoid, as well as recover from, pressure (as well as all) wounds. Deep tissue injuries may sometimes indicate severe damage. Identification and management of suspected deep tissue injury (sDTI) is imperative.

Planning for Care

- Suspected deep tissue injury requires vigilant monitoring because of the potential for rapid deterioration. Such monitoring should be reflected in the care plan.

DEFINITION

SUSPECTED DEEP TISSUE INJURY

Purple or maroon area of discolored intact skin due to damage of underlying soft tissue. The area may be preceded by tissue that is painful, firm, mushy, boggy, warmer or cooler as compared to adjacent tissue.

Steps for Assessment

1. Perform head-to-toe assessment. Conduct a full body skin assessment focusing on bony prominences and pressure-bearing areas (sacrum, buttocks, heels, ankles, etc.).
2. For the purposes of coding, determine that the lesion being assessed is primarily a result of pressure and that other conditions have been ruled out. If pressure is **not** the primary cause, do **not** code here.
3. Examine the area adjacent to, or surrounding, an intact blister for evidence of tissue damage. If the tissue adjacent to, or surrounding, the blister **does not show** signs of tissue damage (e.g., color change, tenderness, boggiess or firmness, warmth or coolness), do **not** code as a suspected deep tissue injury.
4. In dark-skinned individuals, the area of injury is probably not purple/maroon, but rather darker than the surrounding tissue.
5. Determine the number of pressure ulcers that are unstageable related to suspected deep tissue injury.
6. Identify the number of **these** pressure ulcers that were present on admission/entry or reentry (see page M-6 for instructions).
7. Clearly document assessment findings in the resident's medical record, and track and document appropriate wound care planning and management.

M0300G: Unstageable Pressure Ulcers Related to Suspected Deep Tissue Injury (cont.)

Coding Instructions for M0300G

- **Enter the number** of unstageable pressure ulcers related to suspected deep tissue injury. Based on skin tone, the injured tissue area may present as a darker tone than the surrounding intact skin. These areas of discoloration are potentially areas of suspected deep tissue injury.
- **Enter 0** if no unstageable pressure ulcers related to suspected deep tissue injury are present and skip to **Dimensions of Unhealed Stage 3 or Stage 4 Pressure Ulcers or Eschar** item (M0610).
- **Enter the number** of unstageable pressure ulcers related to suspected deep tissue injury that were first noted at the time of admission/entry AND—for residents who are reentering the facility after a hospital stay, that were acquired during the hospitalization (i.e., the unstageable pressure ulcer related to suspected deep tissue injury was not acquired in the nursing facility prior to admission to the hospital).
- **Enter 0** if no unstageable pressure ulcers related to suspected deep tissue injury were first noted at the time of admission/entry or reentry.

Coding Tips

- Once suspected deep tissue injury has opened to an ulcer, reclassify the ulcer into the appropriate stage. Then code the ulcer for the reclassified stage.
- Deep tissue injury may be difficult to detect in individuals with dark skin tones.
- Evolution may be rapid, exposing additional layers of tissue even with optimal treatment.
- When a lesion due to pressure presents with an intact blister AND the surrounding or adjacent soft tissue does NOT have the characteristics of deep tissue injury, do **not** code here.

M0610: Dimensions of Unhealed Stage 3 or 4 Pressure Ulcers or Unstageable Pressure Ulcer Due to Slough and/or Eschar

M0610. Dimensions of Unhealed Stage 3 or 4 Pressure Ulcers or Eschar	
Complete only if M0300C1, M0300D1 or M0300F1 is greater than 0	
If the resident has one or more unhealed Stage 3 or 4 pressure ulcers or an unstageable pressure ulcer due to slough or eschar, identify the pressure ulcer with the largest surface area (length x width) and record in centimeters:	
<div> <input type="text"/> <input type="text"/> . <input type="text"/> cm </div>	A. Pressure ulcer length: Longest length from head to toe
<div> <input type="text"/> <input type="text"/> . <input type="text"/> cm </div>	B. Pressure ulcer width: Widest width of the same pressure ulcer, side-to-side perpendicular (90-degree angle) to length
<div> <input type="text"/> <input type="text"/> . <input type="text"/> cm </div>	C. Pressure ulcer depth: Depth of the same pressure ulcer from the visible surface to the deepest area (if depth is unknown, enter a dash in each box)

M0610: Dimensions of Unhealed Stage 3 or 4 Pressure Ulcers or Unstageable Pressure Ulcer Due to Slough and/or Eschar (cont.)

Item Rationale

Health-related Quality of Life


- Pressure ulcer dimensions are an important characteristic used to assess and monitor healing.

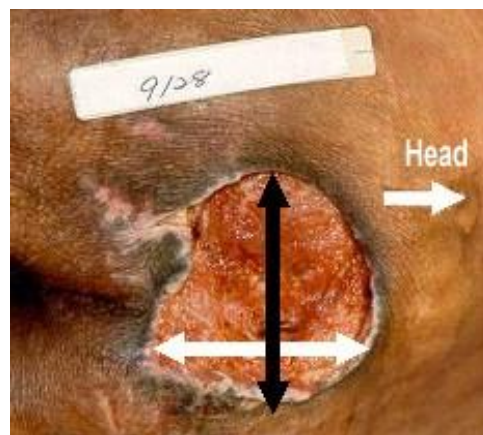
Planning for Care

- Evaluating the dimensions of the pressure ulcer is one aspect of the process of monitoring response to treatment.
- Pressure ulcer measurement findings are used to plan interventions that will best prepare the wound bed for healing.

Steps for Assessment

*If the resident has **one or more** unhealed Stage 3 or 4 pressure ulcers or an unstageable pressure ulcer due to slough and/or eschar, **identify the pressure ulcer with the largest surface area** (length \times width) and record in centimeters. **Complete only if a pressure ulcer is coded in M0300C1, M0300D1, or M0300F1.** The Figure (right) illustrates the measurement process.*

1. Measurement is based on observation of the Stage 3, Stage 4, or unstageable pressure ulcer due to slough and/or eschar after the dressing and any exudate are removed.
 2. Use a disposable measuring device or a cotton-tipped applicator.
 3. Determine longest length (white arrow line) head to toe and greatest width (black arrow line) of each Stage 3, Stage 4, or unstageable pressure ulcer due to slough and/or eschar.
 4. Measure the longest length of the pressure ulcer. If using a cotton-tipped applicator, mark on the applicator the distance between healthy skin tissue at each margin and lay the applicator next to a centimeter ruler to determine length.
 5. Using a similar approach, measure the longest width (perpendicular to the length forming a “+,” side to side).
 6. Measure every Stage 3, Stage 4, and unstageable pressure ulcer due to slough and/or eschar that is present. The clinician must be aware of all pressure ulcers present in order to determine which pressure ulcer is the largest. Use a skin tracking sheet or other worksheet to record the dimensions for each pressure ulcer. Select the largest one by comparing the surface areas (length x width) of each.
- 



M0610: Dimensions of Unhealed Stage 3 or 4 Pressure Ulcers or Unstageable Pressure Ulcer Due to Slough and/or Eschar (cont.)

7. Considering **only** the largest Stage 3 or 4 pressure ulcer or pressure ulcer that is unstageable due to slough or eschar, determine the deepest area and record the depth in centimeters. To measure wound depth, moisten a sterile, cotton-tipped applicator with 0.9% sodium chloride (NaCl) solution or sterile water. Place the applicator tip in the deepest aspect of the ulcer and measure the distance to the skin level. If the depth is uneven, measure several areas and document the depth of the ulcer that is the deepest. If depth cannot be assessed due to slough and/or eschar, enter dashes in M0610C.
8. If two pressure ulcers occur on the same bony prominence and are separated, at least superficially, by skin, then count them as two separate pressure ulcers. Stage and measure each pressure ulcer separately.

Coding Instructions for M0610 Dimensions of Unhealed Stage 3 or 4 Pressure Ulcers or Unstageable Due to Slough and/or Eschar

- **Enter the current longest length** of the largest Stage 3, Stage 4, or unstageable pressure ulcer due to slough and/or eschar in centimeters to one decimal point (e.g., 2.3 cm).
- **Enter the widest width** in centimeters of the largest Stage 3, Stage 4, or unstageable pressure ulcer due to slough and/or eschar. Record the width in centimeters to one decimal point.
- **Enter the depth** measured in centimeters of the largest Stage 3 or 4. Record the depth in centimeters to one decimal point. Note that depth cannot be assessed if wound bed is unstageable due to being covered with slough and/or eschar. If a pressure ulcer covered with slough and/or eschar is the largest unhealed pressure ulcer identified for measurement, enter dashes in item M0610C.

Coding Tips

- Place the resident in the most appropriate position which will allow for accurate wound measurement.
- Select a uniform, consistent method for measuring wound length, width, and depth to facilitate meaningful comparisons of wound measurements across time.
- Assessment of the pressure ulcer for tunneling and undermining is an important part of the complete pressure ulcer assessment. Measurement of tunneling and undermining is not recorded on the MDS but should be assessed, monitored, and treated as part of the comprehensive care plan.

M0700: Most Severe Tissue Type for Any Pressure Ulcer

M0700. Most Severe Tissue Type for Any Pressure Ulcer	
Enter Code <input type="checkbox"/>	Select the best description of the most severe type of tissue present in any pressure ulcer bed 1. Epithelial tissue - new skin growing in superficial ulcer. It can be light pink and shiny, even in persons with darkly pigmented skin 2. Granulation tissue - pink or red tissue with shiny, moist, granular appearance 3. Slough - yellow or white tissue that adheres to the ulcer bed in strings or thick clumps, or is mucinous 4. Eschar - black, brown, or tan tissue that adheres firmly to the wound bed or ulcer edges, may be softer or harder than surrounding skin 9. None of the Above

Item Rationale

Health-related Quality of Life

- The presence of a pressure ulcer may affect quality of life for residents because it may limit activity, may be painful, and may require time-consuming treatments and dressing changes.
- Identify tissue type.

Planning for Care

- Tissue characteristics of pressure ulcers should be considered when determining treatment options and choices.
- Changes in tissue characteristics over time are indicative of wound healing or degeneration.

Steps for Assessment

- Examine the wound bed or base of each pressure ulcer. Adequate lighting is important to detect skin changes.
- Determine the type(s) of tissue in the wound bed (e.g., epithelial, granulation, slough, eschar).

Coding Instructions for M0700

- Code 1, Epithelial tissue:** if the wound is superficial and is re-epithelializing.
- Code 2, Granulation tissue:** if the wound is clean (e.g., free of slough and eschar tissue) and contains granulation tissue.
- Code 3, Slough:** if there is any amount of slough tissue present and eschar tissue is absent.
- Code 4, Eschar:** if there is any eschar tissue present.
- Code 9, None of the above:** if none of the above apply.

DEFINITIONS

EPITHELIAL TISSUE

New skin that is light pink and shiny (even in person's with darkly pigmented skin). In Stage 2 pressure ulcers, epithelial tissue is seen in the center and edges of the ulcer. In full thickness Stage 3 and 4 pressure ulcers, epithelial tissue advances from the edges of the wound.

GRANULATION TISSUE

Red tissue with "cobblestone" or bumpy appearance, bleeds easily when injured.

SLOUGH TISSUE

Non-viable yellow, tan, gray, green or brown tissue; usually moist, can be soft, stringy and mucinous in texture. Slough may be adherent to the base of the wound or present in clumps throughout the wound bed.

ESCHAR

Dead or devitalized tissue that is hard or soft in texture; usually black, brown, or tan in color, and may appear scab-like. Eschar is usually firmly adherent to the base of the wound and often the sides/edges of the wound.

M0700: Most Severe Tissue Type for Any Pressure Ulcer (cont.)

Coding Tips and Special Populations

- Stage 2 pressure ulcers by definition have partial-thickness loss of the dermis. Granulation tissue, slough or eschar are not present in Stage 2 pressure ulcers. Therefore, Stage 2 pressure ulcers should **not** be coded as having granulation, slough or eschar tissue and should be **coded as 1** for this item.
- Code for the most severe type of tissue present in the pressure ulcer wound bed.
- If the wound bed is covered with a mix of different types of tissue, code for the most severe type. For example, if a mixture of necrotic tissue (eschar and slough) is present, code for eschar.
- Code this item with **Code 9, None of the above**, in the following situations:
 - Stage 1 pressure ulcer
 - Stage 2 pressure ulcer with intact blister
 - Unstageable pressure ulcer related to non-removable dressing/device
 - Unstageable pressure ulcer related to suspected deep tissue injury

Code 9 is being used in these instances because the wound bed cannot be visualized and therefore cannot be assessed.

Examples

1. A resident has a Stage 2 pressure ulcer on the right ischial tuberosity that is healing and a Stage 3 pressure ulcer on the sacrum that is also healing with red granulation tissue that has filled 75% of the ulcer and epithelial tissue that has resurfaced 25% of the ulcer.

Coding: Code **M0700 as 2, Granulation tissue**.

Rationale: Coding for M0700 is based on the sacral ulcer, because it is the pressure ulcer with the most severe tissue type. Code 2, (Granulation tissue), is selected because this is the most severe tissue present in the wound.

2. A resident has a Stage 2 pressure ulcer on the right heel and no other pressure ulcers.

Coding: Code **M0700 as 1, Epithelial tissue**.

Rationale: Coding for M0700 is Code 1, (Epithelial tissue) because epithelial tissue is consistent with identification of this pressure ulcer as a Stage 2 pressure ulcer.

3. A resident has a pressure ulcer on the left trochanter that has 25% black eschar tissue present, 75% granulation tissue present, and some epithelialization at the edges of the wound.

Coding: Code **M0700 as 4, Eschar**.

Rationale: Coding is for the most severe tissue type present, which is not always the majority of type of tissue. Therefore, Coding for M0700 is Code 4, Eschar).

M0800: Worsening in Pressure Ulcer Status Since Prior Assessment (OBRA or scheduled PPS) or Last Admission/Entry or Reentry

M0800. Worsening in Pressure Ulcer Status Since Prior Assessment (OBRA or Scheduled PPS) or Last Admission/Entry or Reentry	
Complete only if A0310E = 0	
Indicate the number of current pressure ulcers that were not present or were at a lesser stage on prior assessment (OBRA or scheduled PPS) or last entry. If no current pressure ulcer at a given stage, enter 0.	
Enter Number <input type="text"/>	A. Stage 2
Enter Number <input type="text"/>	B. Stage 3
Enter Number <input type="text"/>	C. Stage 4

Item Rationale

Health-related Quality of Life

- This item documents whether skin status, overall, has worsened since the last assessment. To track increasing skin damage, this item documents the number of new pressure ulcers and whether any pressure ulcers have “worsened” or increased in numerical stage since the last assessment. Such tracking of pressure ulcers is consistent with good clinical care.

Planning for Care

- The interdisciplinary care plan should be reevaluated to ensure that appropriate preventative measures and pressure ulcer management principles are being adhered to when new pressure ulcers develop or when pressure ulcers worsen.

Steps for Assessment

Look-back period for this item is back to the ARD of the prior assessment. If there was no prior assessment (i.e., if this is the first OBRA or scheduled PPS assessment), do not complete this item. Skip to M1030, Number of Venous and Arterial Ulcers.

- Review the history of each current pressure ulcer. Specifically, compare the current stage to past stages to determine whether any pressure ulcer on the current assessment is new or at an increased numerical stage when compared to the last MDS assessment. This allows a more accurate assessment than simply comparing total counts on the current and prior MDS assessment.

DEFINITION

PRESSURE ULCER “WORSENING”

Pressure ulcer “worsening” is defined as 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 (using the staging assessment system classifications assigned to each stage; starting at stage 1, and increasing in severity to stage 4) on an assessment as compared to the previous assessment. For the purposes of identifying the absence of a pressure ulcer, zero pressure ulcers is used when there is no skin breakdown or evidence of damage.

M0800: Worsening in Pressure Ulcer Status Since Prior Assessment (OBRA or scheduled PPS) or Last Admission/Entry or Reentry (cont.)

2. For each current stage, count the number of current pressure ulcers that are new or have increased in numerical stage since the last MDS assessment was completed.

Coding Instructions for M0800

- **Enter the number** of pressure ulcers that were not present OR were at a lesser numerical stage on prior assessment.
- **Code 0:** if no pressure ulcers have increased in numerical stage OR there are no new pressure ulcers.

Coding Tips

- Coding this item will be easier for nursing homes that document and follow pressure ulcer status on a routine basis.
- If a numerically staged pressure ulcer increases in numerical staging it is considered worsened.
- Coding worsening of unstageable pressure ulcers:
 - If a pressure ulcer was unstageable on admission/entry or reentry, do not consider it to be worsened on the first assessment that it is able to be numerically staged. However, if the pressure ulcer subsequently increases in numerical stage after that assessment, it should be considered worsened.
 - If a pressure ulcer was numerically staged and becomes unstageable due to slough or eschar, do not consider this pressure ulcer as worsened. The only way to determine if this pressure ulcer has worsened is to remove enough slough or eschar so that the wound bed becomes visible. Once enough of the wound bed can be visualized and/or palpated such that the tissues can be identified and the wound restaged, the determination of worsening can be made.
 - If a pressure ulcer was numerically staged and becomes unstageable, and is subsequently debrided sufficiently to be numerically staged, compare its numerical stage before and after it was unstageable. If the pressure ulcer's current numerical stage has increased, consider this pressure ulcer as worsened.
 - If two pressure ulcers merge, do not code as worsened. Although two merged pressure ulcers might increase the overall surface area of the ulcer, there would need to be an increase in numerical stage in order for it to be considered as worsened.
 - If a pressure ulcer is acquired during a hospital admission, its stage should be coded on admission and is considered as present on admission/entry or reentry. It is **not** included or coded in this item.

M0800: Worsening in Pressure Ulcer Status Since Prior Assessment (OBRA or scheduled PPS) or Last Admission/Entry or Reentry (cont.)

- If a pressure ulcer increases in numerical stage during a hospital admission, its stage should be coded on admission and is considered as present on admission/entry or reentry. It is **not** included or coded in this item. While not included in this item, it is important to recognize clinically on reentry that the resident's overall skin status deteriorated while in the hospital. In either case, if the pressure ulcer deteriorates further and increases in numerical stage on a subsequent MDS assessment, it would be considered as worsened and would be coded in this item.

Examples

1. A resident has a pressure ulcer on the right ischial tuberosity that was Stage 2 on the previous MDS assessment and has now increased in numerical stage to a Stage 3 pressure ulcer.

Coding: Code **M0800A as 0**, **M0800B as 1**, and **M0800C as 0**.

Rationale: The pressure ulcer was at a lesser numerical stage on the prior assessment.

2. A resident is admitted with an unstageable pressure ulcer on the sacrum, which is debrided and reclassified as a Stage 4 pressure ulcer 3 weeks later. The initial MDS assessment listed the pressure ulcer as unstageable.

Coding: Code **M0800A as 0**, **M0800B as 0**, and **M0800C as 0**.

Rationale: The unstageable pressure ulcer was present on the initial MDS assessment. After debridement it numerically staged as a Stage 4 pressure ulcer. This is the first numerical staging since debridement and therefore, should not be considered or coded as worsening on the MDS assessment.

3. A resident has previous medical record and MDS documentation of a Stage 2 pressure ulcer on the sacrum and a Stage 3 pressure ulcer on the right heel. Current skin care flow sheets indicate a Stage 3 pressure ulcer on the sacrum, a Stage 4 pressure ulcer on the right heel, as well as a new Stage 2 pressure ulcer on the left trochanter.

Coding: Code **M0800A as 1**, **M0800B as 1**, and **M0800C as 1**.

Rationale: M0800A would be coded 1 because the new Stage 2 pressure ulcer on the left trochanter was not present on the prior assessment. M0800B would be coded 1 and M0800C would be coded 1 for the increased numerical staging of both the sacrum and right heel pressure ulcers.

M0800: Worsening in Pressure Ulcer Status Since Prior Assessment (OBRA or scheduled PPS) or Last Admission/Entry or Reentry (cont.)

4. A resident develops a Stage 3 pressure ulcer while at the nursing home. The wound bed is subsequently covered with slough and is coded on the next assessment as unstageable due to slough. After debridement, the wound bed is clean and the pressure ulcer is reassessed and determined to still be a Stage 3 pressure ulcer.

Coding: Code **M0800A as 0**, **M0800B as 0**, and **M0800C as 0**.

Rationale: M0800B would be coded 0 because the numerical stage of the pressure ulcer is the same numerical stage as it was prior to the period it became unstageable.

M0900: Healed Pressure Ulcers

M0900. Healed Pressure Ulcers	
Complete only if A0310E = 0	
Enter Code <input type="checkbox"/>	A. Were pressure ulcers present on the prior assessment (OBRA or scheduled PPS)? 0. No → Skip to M1030, Number of Venous and Arterial Ulcers 1. Yes → Continue to M0900B, Stage 2
Indicate the number of pressure ulcers that were noted on the prior assessment (OBRA or scheduled PPS) that have completely closed (resurfaced with epithelium). If no healed pressure ulcer at a given stage since the prior assessment (OBRA or scheduled PPS), enter 0.	
Enter Number <input type="checkbox"/>	B. Stage 2
Enter Number <input type="checkbox"/>	C. Stage 3
Enter Number <input type="checkbox"/>	D. Stage 4

Item Rationale

Health-related Quality of Life

- Pressure ulcers do not heal in a reverse sequence, that is, the body does not replace the types and layers of tissue (e.g., muscle, fat, and dermis) that were lost during pressure ulcer development before they re-epithelialize. Stage 3 and 4 pressure ulcers fill with granulation tissue. This replacement tissue is never as strong as the tissue that was lost and hence is more prone to future breakdown.

DEFINITION

HEALED PRESSURE ULCER

Completely closed, fully epithelialized, covered completely with epithelial tissue, or resurfaced with new skin, *even if* the area continues to have some surface discoloration.

M0900: Healed Pressure Ulcers (cont.)

Planning for Care

- Pressure ulcers that heal require continued prevention interventions as the site is always at risk for future damage.
- **Most Stage 2** pressure ulcers should heal within a reasonable timeframe (e.g., 60 days). Full thickness Stage 3 and 4 pressure ulcers may require longer healing times.
- Clinical standards do not support reverse staging or backstaging 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. Previous standards using reverse or backstaging would have permitted identification of this pressure ulcer as a Stage 3, then a Stage 2, and so on, when it reached a depth consistent with these stages. Clinical standards now would require that this ulcer continue to be documented as a Stage 4 pressure ulcer until it has completely healed. Nursing homes can document the healing of pressure ulcers using descriptive characteristics of the wound (i.e. depth, width, presence or absence of granulation tissue, etc.) or by using a validated pressure ulcer healing tool. Once a pressure ulcer has healed, it is documented as a healed pressure ulcer at its highest numerical stage – in this example, a healed Stage 4 pressure ulcer. For care planning purposes, this healed Stage 4 pressure ulcer would remain at increased risk for future breakdown or injury and would require continued monitoring and preventative care.

Steps for Assessment

*Complete on all residents, including those without a current pressure ulcer. Look-back period for this item is the ARD of the prior assessment. **If no prior assessment (i.e., if this is the first OBRA or scheduled PPS assessment), do not complete this item. Skip to M1030.***

1. Review medical records to identify whether any pressure ulcers that were noted on the prior MDS assessment have healed by the ARD (A2300) of the current assessment.
2. Identify the deepest anatomical stage (see definition on page M-5) of each healed pressure ulcer.
3. Count the number of healed pressure ulcers for each stage.

M0900: Healed Pressure Ulcers (cont.)

Coding Instructions for M0900A

Complete on all residents (even if M0210 = 0)

- **Enter 0:** if there were no pressure ulcers on the prior assessment and skip to **Number of Venous and Arterial Ulcers** item (M1030).
- **Enter 1:** if there were pressure ulcers noted on the prior assessment.

Coding Instructions for M0900B, C, and D

- **Enter the number** of pressure ulcers that have healed since the last assessment for each Stage, 2 through 4.
- **Enter 0:** if there were no pressure ulcers at the given stage or no pressure ulcers that have healed.

Coding Tips

- Coding this item will be easier for nursing homes that systematically document and follow pressure ulcer status.
- If the prior assessment documents that a pressure ulcer healed between MDS assessments, but another pressure ulcer occurred at the same anatomical location, do **not** consider this pressure ulcer as healed. The re-opened pressure ulcer should be staged at its highest numerical stage until fully healed.

M1030: Number of Venous and Arterial Ulcers

M1030. Number of Venous and Arterial Ulcers	
Enter Number <input type="text"/>	Enter the total number of venous and arterial ulcers present

Item Rationale

Health-related Quality of Life

- Skin wounds and lesions affect quality of life for residents because they may limit activity, may be painful, and may require time-consuming treatments and dressing changes.

M1030: Number of Venous and Arterial Ulcers (cont.)

Planning for Care

- The presence of venous and arterial ulcers should be accounted for in the interdisciplinary care plan.
- This information identifies residents at risk for further complications or skin injury.

Steps for Assessment

1. Review the medical record, including skin care flow sheet or other skin tracking form.
2. Speak with direct care staff and the treatment nurse to confirm conclusions from the medical record review.
3. Examine the resident and determine whether any venous or arterial ulcers are present.
 - Key areas for venous ulcer development include the area proximal to the lateral and medial malleolus (e.g., above the inner and outer ankle area).
 - Key areas for arterial ulcer development include the distal part of the foot, dorsum or tops of the foot, or tips and tops of the toes.
 - Venous ulcers may or may not be painful and are typically shallow with irregular wound edges, a red granular (e.g., bumpy) wound bed, minimal to moderate amounts of yellow fibrinous material, and moderate to large amounts of exudate. The surrounding tissues may be erythematous or reddened, or appear brown-tinged due to hemosiderin staining. Leg edema may also be present.
 - Arterial ulcers are often painful and have a pale pink wound bed, necrotic tissue, minimal exudate, and minimal bleeding.

DEFINITIONS

VENOUS ULCERS

Ulcers caused by peripheral venous disease, which most commonly occur proximal to the medial or lateral malleolus, above the inner or outer ankle, or on the lower calf area of the leg.

ARTERIAL ULCERS

Ulcers caused by peripheral arterial disease, which commonly occur on the tips and tops of the toes, tops of the foot, or distal to the medial malleolus.

DEFINITION

HEMOSIDERIN

An intracellular storage form of iron; the granules consist of an ill-defined complex of ferric hydroxides, polysaccharides, and proteins having an iron content of approximately 33% by weight. It appears as a dark yellow-brown pigment.

Coding Instructions

Check all that apply in the last 7 days.

*Pressure ulcers coded in M0210 through M0900 should **not** be coded here.*

- **Enter the number** of venous and arterial ulcers present.
- **Enter 0:** if there were no venous or arterial ulcers present.

M1030: Number of Venous and Arterial Ulcers (cont.)

Coding Tips

Arterial Ulcers

- Trophic skin changes (e.g., dry skin, loss of hair growth, muscle atrophy, brittle nails) may also be present. The wound may start with some kind of minor trauma, such as hitting the leg on a wheelchair. The wound does not typically occur over a bony prominence, however, can occur on the tops of the toes. Pressure forces play virtually no role in the development of the ulcer, however, for some residents, pressure may play a part. Ischemia is the major etiology of these ulcers. Lower extremity and foot pulses may be diminished or absent.

Venous Ulcers

- The wound may start with some kind of minor trauma, such as hitting the leg on a wheelchair. The wound does not typically occur over a bony prominence, and pressure forces play virtually **no** role in the development of the ulcer.

Example

1. A resident has three toes on her right foot that have black tips. She does not have diabetes, but has been diagnosed with peripheral vascular disease.

Coding: Code **M1030 as 3.**

Rationale: Ischemic changes point to the ulcer being vascular.

M1040: Other Ulcers, Wounds and Skin Problems

M1040. Other Ulcers, Wounds and Skin Problems	
↓ Check all that apply	
Foot Problems	
<input type="checkbox"/>	A. Infection of the foot (e.g., cellulitis, purulent drainage)
<input type="checkbox"/>	B. Diabetic foot ulcer(s)
<input type="checkbox"/>	C. Other open lesion(s) on the foot
Other Problems	
<input type="checkbox"/>	D. Open lesion(s) other than ulcers, rashes, cuts (e.g., cancer lesion)
<input type="checkbox"/>	E. Surgical wound(s)
<input type="checkbox"/>	F. Burn(s) (second or third degree)
<input type="checkbox"/>	G. Skin tear(s)
<input type="checkbox"/>	H. Moisture Associated Skin Damage (MASD) (i.e. incontinence (IAD), perspiration, drainage)
None of the Above	
<input type="checkbox"/>	Z. None of the above were present

M1040: Other Ulcers, Wounds and Skin Problems (cont.)

Item Rationale

Health-related Quality of Life

- Skin wounds and lesions affect quality of life for residents because they may limit activity, may be painful, and may require time-consuming treatments and dressing changes.
- Many of these ulcers, wounds and skin problems can worsen or increase risk for local and systemic infections.

Planning for Care

- This list represents only a subset of skin conditions or changes that nursing homes will assess and evaluate in residents.
- The presence of wounds and skin changes should be accounted for in the interdisciplinary care plan.
- This information identifies residents at risk for further complications or skin injury.

Steps for Assessment

1. Review the medical record, including skin care flow sheets or other skin tracking forms.
2. Speak with direct care staff and the treatment nurse to confirm conclusions from the medical record review.
3. Examine the resident and determine whether any ulcers, wounds, or skin problems are present.
 - Key areas for diabetic foot ulcers include the plantar (bottom) surface of the foot, especially the metatarsal heads (the ball of the foot).

Coding Instructions

Check all that apply in the last 7 days. If there is no evidence of such problems in the last 7 days, check none of the above.

*Pressure ulcers coded in M0200 through M0900 should **not** be coded here.*

- **M1040A**, Infection of the foot (e.g., cellulitis, purulent drainage)
- **M1040B**, Diabetic foot ulcer(s)
- **M1040C**, Other open lesion(s) on the foot (e.g., cuts, fissures)

DEFINITIONS

DIABETIC FOOT ULCERS

Ulcers caused by the neuropathic and small blood vessel complications of diabetes. Diabetic foot ulcers typically occur over the plantar (bottom) surface of the foot on load bearing areas such as the ball of the foot. Ulcers are usually deep, with necrotic tissue, moderate amounts of exudate, and callused wound edges. The wounds are very regular in shape and the wound edges are even with a punched-out appearance. These wounds are typically not painful.

SURGICAL WOUNDS

Any healing and non-healing, open or closed surgical incisions, skin grafts or drainage sites.

OPEN LESION OTHER THAN ULCERS, RASHES, CUTS

Most typically skin ulcers that develop as a result of diseases and conditions such as syphilis and cancer.

BURNS (SECOND OR THIRD DEGREE)

Skin and tissue injury caused by heat or chemicals and may be in any stage of healing.

M1040: Other Ulcers, Wounds and Skin Problems (cont.)

- **M1040D**, Open lesion(s) other than ulcers, rashes, cuts (e.g., cancer lesion)
- **M1040E**, Surgical wound(s)
- **M1040F**, Burn(s)(second or third degree)
- **M1040G**, Skin tear(s)
- **M1040H**, Moisture Associated Skin Damage (MASD) (i.e., incontinence (IAD), perspiration, drainage)
- **M1040Z**, None of the above were present

Coding Tips

M1040B Diabetic Foot Ulcers

- Diabetic neuropathy affects the lower extremities of individuals with diabetes. Individuals with diabetic neuropathy can have decreased awareness of pain in their feet. This means they are at high risk for foot injury, such as burns from hot water or heating pads, cuts or scrapes from stepping on foreign objects, and blisters from inappropriate or tight-fitting shoes. Because of decreased circulation and sensation, the resident may not be aware of the wound.
- Neuropathy can also cause changes in the structure of the bones and tissue in the foot. This means the individual with diabetes experiences pressure on the foot in areas not meant to bear pressure. Neuropathy can also cause changes in normal sweating, which means the individual with diabetes can have dry, cracked skin on his other foot.
- Do **not** include pressure ulcers that occur on residents with diabetes mellitus here. For example, an ulcer caused by pressure on the heel of a diabetic resident is a pressure ulcer and not a diabetic foot ulcer.

M1040D Open Lesion Other than Ulcers, Rashes, Cuts

- Do **not** code rashes, skin tears, cuts/lacerations here. Although not recorded on the MDS assessment, these skin conditions should be considered in the plan of care.

M1040E Surgical Wounds

- This category does not include healed surgical sites and healed stomas or lacerations that require suturing or butterfly closure as surgical wounds. PICC sites, central line sites, and peripheral IV sites are not coded as surgical wounds.
- Surgical debridement of a pressure ulcer does not create a surgical wound. Surgical debridement is used to remove necrotic or infected tissue from the pressure ulcer in order to facilitate healing. A pressure ulcer that has been surgically debrided should continue to be coded as a pressure ulcer.

M1040: Other Ulcers, Wounds and Skin Problems (cont.)

- Code pressure ulcers that require surgical intervention for closure with graft and/or flap procedures in this item (e.g., excision of pressure ulcer with myocutaneous flap). Once a pressure ulcer is excised and a graft and/or flap is applied, it is no longer considered a pressure ulcer, but a surgical wound

M1040F Burns (Second or Third Degree)

- Do **not** include first degree burns (changes in skin color only).

M1040G Skin Tear(s)

- Skin tears are a result of shearing, friction or trauma to the skin that causes a separation of the skin layers. They can be partial or full thickness. Code all skin tears in this item, even if already coded in Item J1900B.

M1040H Moisture Associated Skin Damage (MASD)

- Moisture associated skin damage (MASD) is a result of skin damage caused by moisture rather than pressure. It is caused by sustained exposure to moisture which can be caused, for example, by incontinence, wound exudate and perspiration. It is characterized by inflammation of the skin, and occurs with or without skin erosion and/or infection. MASD is also referred to as incontinence-associated dermatitis and can cause other conditions such as intertriginous dermatitis, periwound moisture-associated dermatitis, and peristomal moisture-associated dermatitis. Provision of optimal skin care and early identification and treatment of minor cases of MASD can help avoid progression and skin breakdown.

Examples

1. A resident with diabetes mellitus presents with an ulcer on the heel that is due to pressure.

Coding: This ulcer is **not checked at M1040B**. This ulcer should be coded where appropriate under the Pressure Ulcers items (M0210-M0900).

Rationale: Persons with diabetes can still develop pressure ulcers.

2. A resident is readmitted from the hospital after myocutaneous flap surgery to excise and close his sacral pressure ulcer.

Coding: Check **M1040E**, Surgical Wound.

Rationale: A surgical flap procedure was used to close the resident's pressure ulcer. The pressure ulcer is now considered a surgical wound.

3. Mrs. J. was reaching over to get a magazine off of her bedside table and sustained a skin tear on her wrist from the edge of the table when she pulled the magazine back towards her.

Coding: Check **M1040G**, Skin Tear(s).

Rationale: The resident sustained a skin tear while reaching for a magazine.

M1040: Other Ulcers, Wounds and Skin Problems (cont.)

4. Mr. S. who is incontinent, is noted to have a large, red and excoriated area on his buttocks and interior thighs with serous exudate which is starting to cause skin glistening.

Coding: Check **M1040H**, Moisture Associated Skin Damage (MASD).

Rationale: Mr. S. skin assessment reveals characteristics of incontinence-associated dermatitis.

5. Mrs. F. complained of discomfort of her right great toe and when her stocking and shoe was removed, it was noted that her toe was red, inflamed and had pus draining from the edge of her nail bed. The podiatrist determined that Mrs. F. has an infected ingrown toenail.

Coding: Check **M1040A**, Infection of the foot.

Rationale: Mrs. F. has an infected right great toe due to an ingrown toenail.

6. Mr. G. has bullous pemphigoid and requires the application of sterile dressings to the open and weeping blistered areas.

Coding: Check **M1040D**, Open lesion other than ulcers, rashes, cuts.

Rationale: Mr. G. has open bullous pemphigoid blisters.

7. Mrs. A. was just admitted to the nursing home from the hospital burn unit after sustaining second and third degree burns in a house fire. She is here for continued treatment of her burns and for rehabilitative therapy.

Coding: Check **M1040F**, Burns (second or third degree).

Rationale: Mrs. A. has second and third degree burns, therefore, burns (second or third degree) should be checked.

M1200: Skin and Ulcer Treatments

M1200. Skin and Ulcer Treatments	
↓ Check all that apply	
<input type="checkbox"/>	A. Pressure reducing device for chair
<input type="checkbox"/>	B. Pressure reducing device for bed
<input type="checkbox"/>	C. Turning/repositioning program
<input type="checkbox"/>	D. Nutrition or hydration intervention to manage skin problems
<input type="checkbox"/>	E. Pressure ulcer care
<input type="checkbox"/>	F. Surgical wound care
<input type="checkbox"/>	G. Application of nonsurgical dressings (with or without topical medications) other than to feet
<input type="checkbox"/>	H. Applications of ointments/medications other than to feet
<input type="checkbox"/>	I. Application of dressings to feet (with or without topical medications)
<input type="checkbox"/>	Z. None of the above were provided

M1200: Skin and Ulcer Treatments (cont.)

Item Rationale

Health-related Quality of Life

- Appropriate prevention and treatment of skin changes and ulcers reduce complications and promote healing.

Planning for Care

- These general skin treatments include basic pressure ulcer prevention and skin health interventions that are a part of providing quality care and consistent with good clinical practice for those with skin health problems.
- These general treatments should guide more individualized and specific interventions in the care plan.
- If skin changes are not improving or are worsening, this information may be helpful in determining more appropriate care.

DEFINITION

PRESSURE REDUCING DEVICE(S)

Equipment that aims to relieve pressure away from areas of high risk. May include foam, air, water gel, or other cushioning placed on a chair, wheelchair, or bed. Include pressure relieving, pressure reducing, and pressure redistributing devices. Devices are available for use with beds and seating.

Steps for Assessment

1. Review the medical record, including treatment records and health care provider orders for documented skin treatments during the past 7 days. Some skin treatments may be part of routine standard care for residents, so check the nursing facility's policies and procedures and indicate here if administered during the look-back period.
2. Speak with direct care staff and the treatment nurse to confirm conclusions from the medical record review.
3. Some skin treatments can be determined by observation. For example, observation of the resident's wheelchair and bed will reveal if the resident is using pressure-reducing devices for the bed or wheelchair.

Coding Instructions

Check all that apply in the last 7 days. Check Z, None of the above were provided, if none applied in the past 7 days.

- **M1200A**, Pressure reducing device for chair
- **M1200B**, Pressure reducing device for bed
- **M1200C**, Turning/repositioning program
- **M1200D**, Nutrition or hydration intervention to manage skin problems
- **M1200E**, Pressure ulcer care
- **M1200F**, Surgical wound care

M1200: Skin and Ulcer Treatments (cont.)

- **M1200G**, Application of non-surgical dressings (with or without topical medications) other than to feet. Non-surgical dressings do not include Band-Aids.
- **M1200H**, Application of ointments/medications other than to feet
- **M1200I**, Application of dressings to feet (with or without topical medications)
- **M1200Z**, None of the above were provided

Coding Tips

M1200A/M1200B Pressure Reducing Devices

- Pressure reducing devices redistribute pressure so that there is some relief on or near the area of the ulcer. The appropriate reducing (redistribution) device should be selected based on the individualized needs of the resident.
- Do **not** include egg crate cushions of any type in this category.
- Do **not** include doughnut or ring devices in chairs.

M1200C Turning/Repositioning Program

- The turning/repositioning program is specific as to the approaches for changing the resident's position and realigning the body. The program should specify the intervention (e.g., reposition on side, pillows between knees) and frequency (e.g., every 2 hours).
- Progress notes, assessments, and other documentation (as dictated by facility policy) should support that the turning/repositioning program is monitored and reassessed to determine the effectiveness of the intervention.

M1200D Nutrition or Hydration Intervention to Manage Skin Problems

- The determination as to whether or not one should receive nutritional or hydration interventions for skin problems should be based on an individualized nutritional assessment. The interdisciplinary team should review the resident's diet and determine if the resident is taking in sufficient amounts of nutrients and fluids or are already taking supplements that are fortified with the US Recommended Daily Intake (US RDI) of nutrients.

DEFINITIONS

TURNING/ REPOSITIONING PROGRAM

Includes a consistent program for changing the resident's position and realigning the body. "Program" is defined as a specific approach that is organized, planned, documented, monitored, and evaluated based on an assessment of the resident's needs.

NUTRITION OR HYDRATION INTERVENTION TO MANAGE SKIN PROBLEMS

Dietary measures received by the resident for the purpose of preventing or treating specific skin conditions, e.g., wheat-free diet to prevent allergic dermatitis, high calorie diet with added supplementation to prevent skin breakdown, high-protein supplementation for wound healing.

M1200: Skin and Ulcer Treatments (cont.)

- Additional supplementation above the US RDI has not been proven to provide any further benefits for management of skin problems including pressure ulcers. Vitamin and mineral supplementation should only be employed as an intervention for managing skin problems, including pressure ulcers, when nutritional deficiencies are confirmed or suspected through a thorough nutritional assessment (AMDA PU Guideline, page 6). If it is determined that nutritional supplementation, i.e. adding additional protein, calories, or nutrients is warranted, the facility should document the nutrition or hydration factors that are influencing skin problems and/or wound healing and “tailor nutritional supplementation to the individual’s intake, degree of under-nutrition, and relative impact of nutrition as a factor overall; and obtain dietary consultation as needed,” (AMDA PU Therapy Companion, page 4).
- It is important to remember that additional supplementation is not automatically required for pressure ulcer management. Any interventions should be specifically tailored to the resident’s needs, condition, and prognosis (AMDA PU Therapy Companion, page 11).

M1200E Pressure Ulcer Care

- Pressure ulcer care includes **any** intervention for treating pressure ulcers coded in **Current Number of Unhealed Pressure Ulcers at Each Stage (M0300A-G)**. Examples may include the use of topical dressings, enzymatic, mechanical or surgical debridement, wound irrigations, negative pressure wound therapy (NPWT), and/or hydrotherapy.

M1200F Surgical Wound Care

- Does not include post-operative care following eye or oral surgery.
- Surgical debridement of a pressure ulcer does not create a surgical wound. Surgical debridement is used to remove necrotic or infected tissue from the pressure ulcer in order to facilitate healing, and thus, any wound care associated with pressure ulcer debridement would be coded in **M1200E, Pressure Ulcer Care**. The only time a surgical wound would be created is if the pressure ulcer itself was excised and a flap and/or graft used to close the pressure ulcer.
- Surgical wound care may include any intervention for treating or protecting any type of surgical wound. Examples may include topical cleansing, wound irrigation, application of antimicrobial ointments, application of dressings of any type, suture/staple removal, and warm soaks or heat application.
- Surgical wound care for pressure ulcers that require surgical intervention for closure (e.g., excision of pressure ulcer with flap and/or graft coverage) can be coded in this item, as once a pressure ulcer is excised and flap and/or graft applied, it is no longer considered a pressure ulcer, but a surgical wound.

M1200: Skin and Ulcer Treatments (cont.)

M1200G Application of Non-surgical Dressings (with or without Topical Medications) Other than to Feet

- Do **not** code application of non-surgical dressings for pressure ulcer(s) other than to feet in this item; use **M1200E, Pressure Ulcer Care**.
- Dressings do not have to be applied daily in order to be coded on the MDS assessment. If any dressing meeting the MDS definitions was applied even once during the 7-day look-back period, the assessor should check that MDS item.
- This category may include but is not limited to: dry gauze dressings, dressings moistened with saline or other solutions, transparent dressings, hydrogel dressings, and dressings with hydrocolloid or hydroactive particles used to treat a skin condition, compression bandages, etc. Non-surgical dressings do not include adhesive bandages (e.g., BAND-AID® bandages).

M1200H Application of Ointments/Medications Other than to Feet

- Do **not** code application of ointments/medications (e.g., chemical or enzymatic debridement) for pressure ulcers here; use **M1200E, Pressure Ulcer Care**.
- This category may include ointments or medications used to treat a skin condition (e.g., cortisone, antifungal preparations, chemotherapeutic agents).
- Ointments/medications may include topical creams, powders, and liquid sealants used to treat or prevent skin conditions.
- This category does not include ointments used to treat non-skin conditions (e.g., nitropaste for chest pain, testosterone cream).

M1200I Application of Dressings to the Feet (with or without Topical Medications)

- Includes interventions to treat any foot wound or ulcer **other than a pressure ulcer**.
- Do **not** code application of dressings to pressure ulcers on the foot, use **M1200E, Pressure Ulcer Care**.
- Do not code application of dressings to the ankle. The ankle is not considered part of the foot.

Examples

1. A resident is admitted with a Stage 3 pressure ulcer on the sacrum. Care during the last 7 days has included one debridement by the wound care consultant, application of daily dressings with enzymatic ointment for continued debridement, nutritional supplementation, and use of a pressure reducing (redistribution) pad on the wheelchair. The medical record documents delivery of care and notes that the resident is on a 2-hour turning/repositioning

M1200: Skin and Ulcer Treatments (cont.)

program that is organized, planned, documented, monitored and evaluated based on an individualized assessment of her needs. The physician documents that after reviewing the resident's nutritional intake, healing progress of the resident's pressure ulcer, dietician's nutritional assessment and laboratory results, that the resident has protein-calorie undernutrition. In order to support proper wound healing, the physician orders an oral supplement that provides all recommended daily allowances for protein, calories, nutrients and micronutrients. All mattresses in the nursing home are pressure reducing (redistribution) mattresses.

Coding: Check items **M1200A, M1200B, M1200C, M1200D, and M1200E.**

Rationale: Interventions include pressure reducing (redistribution) pad in the wheelchair (M1200A) and pressure reducing (redistribution) mattress on the bed (M1200B), turning and repositioning program (M1200C), nutritional supplementation (M1200D), enzymatic debridement and application of dressings (M1200E).

2. A resident has a venous ulcer on the right leg. During the past 7 days the resident has had a three layer compression bandaging system applied once (orders are to reapply the compression bandages every 5 days). The resident also has a pressure redistributing mattress and pad for the wheelchair.

Coding: Check items **M1200A, M1200B, and M1200G.**

Rationale: Treatments include pressure reducing (redistribution) mattress (M1200B) and pad (M1200A) in the wheelchair and application of the compression bandaging system (M1200G).

3. Mrs. S. has a diagnosis of right-sided hemiplegia from a previous stroke. As part of her assessment, it was noted that while in bed Mrs. S. is able to tolerate pressure on each side for approximately 3 hours before showing signs of the effects of pressure on her skin. Staff assist her to turn every 3 hours while in bed. When she is in her wheelchair, it is difficult for her to offload the pressure to her buttocks. Her assessment indicates that her skin cannot tolerate pressure for more than 1 hour without showing signs of the effect of the pressure when she is sitting, and therefore, Mrs. S. is assisted hourly by staff to stand for at least 1 full minute to relieve pressure. Staff document all of these interventions in the medical record and note the resident's response to the interventions.

Coding: Check **M1200C.**

Rationale: Treatments meet the criteria for a turning/repositioning program (i.e., it is organized, planned, documented, monitored, and evaluated), that is based on an assessment of the resident's unique needs.

M1200: Skin and Ulcer Treatments (cont.)

4. Mr. J. has a diagnosis of Advanced Alzheimer's and is totally dependent on staff for all of his care. His care plan states that he is to be turned and repositioned, per facility policy, every 2 hours.

Coding: Do **not** check item **M1200C**.

Rationale: Treatments provided do not meet the criteria for a turning/repositioning program. There is no notation in the medical record about an assessed need for turning/repositioning, nor is there a specific approach or plan related to positioning and realigning of the body. There is no reassessment of the resident's response to turning and repositioning. There are not any skin or ulcer treatments being provided.

Scenarios for Pressure Ulcer Coding

Examples M0300, M0610, M0700 and M0800

1. Mr. S was admitted to the nursing home on January 22, 2011 with a Stage 2 pressure ulcer. The pressure ulcer history was not available due to resident being admitted to the hospital from home prior to coming to the nursing home. On Mr. S' quarterly assessment, it was noted that the Stage 2 pressure ulcer had neither worsened nor improved. On the second quarterly assessment the Stage 2 pressure ulcer was noted to have worsened to a Stage 3. The current dimensions of the Stage 3 pressure ulcer are L 3.0cm, W 2.4cm, and D 0.2cm with 100% granulation tissue noted in the wound bed.

Admission Assessment:

Coding:

- **M0300A** (Number of Stage 1 pressure ulcers), Code 0.
- **M0300B1** (Number of Stage 2 pressure ulcers), Code 1.
- **M0300B2** (Number of these Stage 2 pressure ulcers present on admission/entry or reentry), Code 1.
- **M0300B3** (Date of the oldest Stage 2 pressure ulcer), code with dashes.

Rationale: The resident had one Stage 2 pressure ulcer on admission and the date of the oldest pressure ulcer was unknown.

M0300. Current Number of Unhealed (non-epithelialized) Pressure Ulcers at Each Stage	
Enter Number <div>0</div>	A. Number of Stage 1 pressure ulcers Stage 1: Intact skin with non-blanchable redness of a localized area usually over a bony prominence. Darkly pigmented skin may not have a visible blanching; in dark skin tones only it may appear with persistent blue or purple hues
Enter Number <div>1</div>	B. Stage 2: Partial thickness loss of dermis presenting as a shallow open ulcer with a red or pink wound bed, without slough. May also present as an intact or open/ruptured blister
Enter Number <div>1</div>	1. Number of Stage 2 pressure ulcers - If 0 → Skip to M0300C, Stage 3 2. Number of these Stage 2 pressure ulcers that were present upon admission/entry or reentry - enter how many were noted at the time of admission/entry or reentry 3. Date of oldest Stage 2 pressure ulcer - Enter dashes if date is unknown: <div> <div>-</div> <div>-</div> <div>-</div> <div>-</div> <div>-</div> <div>-</div> <div>-</div> <div>-</div> <div>-</div> <div>-</div> <div>-</div> <div>-</div> </div> <div>Month Day Year</div>

Scenarios for Pressure Ulcer Coding (cont.)

Quarterly Assessment #1:

Coding:

- **M0300A** (Number of Stage 1 pressure ulcers), Code 0.
- **M0300B1** (Number of Stage 2 pressure ulcers), Code 1.
- **M0300B2** (Number of these Stage 2 pressure ulcers present upon admission/entry or reentry), Code 1.
- **M0300B3** (Date of the oldest Stage 2 pressure ulcer), code with dashes.

Rationale: On the quarterly assessment the Stage 2 pressure ulcer is still present and date was unknown. Therefore, **M0300B3** is still coded with dashes.

M0300. Current Number of Unhealed (non-epithelialized) Pressure Ulcers at Each Stage	
Enter Number <div>0</div>	A. Number of Stage 1 pressure ulcers Stage 1: Intact skin with non-blanchable redness of a localized area usually over a bony prominence. Darkly pigmented skin may not have a visible blanching; in dark skin tones only it may appear with persistent blue or purple hues
Enter Number <div>1</div>	B. Stage 2: Partial thickness loss of dermis presenting as a shallow open ulcer with a red or pink wound bed, without slough. May also present as an intact or open/ruptured blister
Enter Number <div>1</div>	1. Number of Stage 2 pressure ulcers - If 0 → Skip to M0300C, Stage 3 2. Number of these Stage 2 pressure ulcers that were present upon admission/entry or reentry - enter how many were noted at the time of admission/entry or reentry 3. Date of oldest Stage 2 pressure ulcer - Enter dashes if date is unknown: <div> <div>-</div><div>-</div> - <div>-</div><div>-</div> - <div>-</div><div>-</div><div>-</div><div>-</div> Month Day Year </div>

Quarterly Assessment #2:

Coding:

- **M0300A** (Number of Stage 1 pressure ulcers), Code 0.
- **M0300B1** (Number of Stage 2 pressure ulcers), Code 0 and skip to **M0300C**, Stage 3 pressure ulcers.
- **M0300C1** (Number of Stage 3 pressure ulcers). Code 1.
- **M0300C2** (Number of these Stage 3 pressure ulcers that were present upon admission//entry or reentry). Code 0.
- **M0300D1**, **M0300E1**, **M0300F1**, and **M0300G1** Code 0's and proceed to code **M0610** (Dimensions of unhealed Stage 3 or 4 pressure ulcers or unstageable pressure ulcer related to slough or eschar) with the dimensions of the Stage 3 ulcer.
- **M0610A** (Pressure ulcer length), Code 03.0, **M0610B** (Pressure ulcer width), Code 02.4, **M0610C** (Pressure ulcer depth) Code 00.2.
- **M0700** (Most severe tissue type for any pressure ulcer), Code 2, Granulation tissue.
- **M0800** (Worsening in pressure ulcer status since prior assessment – (OBRA or scheduled PPS or Last Admission/Entry or Reentry) – **M0800A** (Stage 2) Code 0, **M0800B** (Stage 3) Code 1, **M0800C** (Stage 4) Code 0.

Scenarios for Pressure Ulcer Coding (cont.)

Rationale:

- **M0300B1** is coded 0 due to the fact that the resident now has a Stage 3 pressure ulcer and no longer has a Stage 2 pressure ulcer. Therefore, you are required to skip to **M0300C** (Stage 3 pressure ulcer).
- **M0300C1** is coded as 1 due to the fact the resident has one Stage 3 pressure ulcer.
- **M0300C2** is coded as 0 due to the fact that the Stage 3 pressure ulcer was not present on admission, but worsened from a Stage 2 to a Stage 3 in the facility.
- **M0300D1, M0300E1, M0300F1, and M0300G1** are coded as zeros (due to the fact the resident does not have any Stage 4 or unstageable ulcers). Proceed to code **M0610** with the dimensions of the Stage 3 ulcer.
- **M0610A** is coded, 03.0 for length, **M0610B** is coded 02.4 for width, and **M0610C** is coded 00.2 for depth. Since this resident only had one Stage 3 pressure ulcer at the time of second quarterly assessment, these are the dimensions that would be coded here as the largest ulcer.
- **M0700** is coded as 2 (Granulation tissue) because this is the most severe type of tissue present.
- **M0800A** is coded as 0, **M0800B** is coded as 1, and **M0800C** is coded as 0 because the Stage 2 pressure ulcer that was present on admission has now worsened to a Stage 3 pressure ulcer since the last assessment.

M0300. Current Number of Unhealed (non-epithelialized) Pressure Ulcers at Each Stage	
Enter Number <input type="text" value="0"/>	A. Number of Stage 1 pressure ulcers Stage 1: Intact skin with non-blanchable redness of a localized area usually over a bony prominence. Darkly pigmented skin may not have a visible blanching; in dark skin tones only it may appear with persistent blue or purple hues
Enter Number <input type="text" value="0"/>	B. Stage 2: Partial thickness loss of dermis presenting as a shallow open ulcer with a red or pink wound bed, without slough. May also present as an intact or open/ruptured blister
Enter Number <input type="text"/>	1. Number of Stage 2 pressure ulcers - If 0 → Skip to M0300C, Stage 3 2. Number of these Stage 2 pressure ulcers that were present upon admission/entry or reentry - enter how many were noted at the time of admission/entry or reentry 3. Date of oldest Stage 2 pressure ulcer - Enter dashes if date is unknown: <div style="display: flex; align-items: center; gap: 10px;"> <div><input type="text"/><input type="text"/> - <input type="text"/><input type="text"/></div> <div><input type="text"/><input type="text"/> - <input type="text"/><input type="text"/><input type="text"/><input type="text"/></div> </div> <div style="display: flex; justify-content: space-around; font-size: small;"> Month Day Year </div>
Enter Number <input type="text" value="1"/>	C. 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
Enter Number <input type="text" value="0"/>	1. Number of Stage 3 pressure ulcers - If 0 → Skip to M0300D, Stage 4 2. Number of these Stage 3 pressure ulcers that were present upon admission/entry or reentry - enter how many were noted at the time of admission/entry or reentry
Enter Number <input type="text" value="0"/>	D. 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
Enter Number <input type="text"/>	1. Number of Stage 4 pressure ulcers - If 0 → Skip to M0300E, Unstageable: Non-removable dressing 2. Number of these Stage 4 pressure ulcers that were present upon admission/entry or reentry - enter how many were noted at the time of admission/entry or reentry
M0300 continued on next page	

Scenarios for Pressure Ulcer Coding (cont.)

M0300. Current Number of Unhealed (non-epithelialized) Pressure Ulcers at Each Stage - Continued	
Enter Number <input type="text" value="0"/>	E. Unstageable - Non-removable dressing: Known but not stageable due to non-removable dressing/device 1. Number of unstageable pressure ulcers due to non-removable dressing/device - If 0 → Skip to M0300F, Unstageable: Slough and/or eschar 2. Number of <u>these</u> unstageable pressure ulcers that were present upon admission/entry or reentry - enter how many were noted at the time of admission/entry or reentry
Enter Number <input type="text" value="0"/>	F. Unstageable - Slough and/or eschar: Known but not stageable due to coverage of wound bed by slough and/or eschar 1. Number of unstageable pressure ulcers due to coverage of wound bed by slough and/or eschar - If 0 → Skip to M0300G, Unstageable: Deep tissue 2. Number of <u>these</u> unstageable pressure ulcers that were present upon admission/entry or reentry - enter how many were noted at the time of admission/entry or reentry
Enter Number <input type="text" value="0"/>	G. Unstageable - Deep tissue: Suspected deep tissue injury in evolution 1. Number of unstageable pressure ulcers with suspected deep tissue injury in evolution - If 0 → Skip to M0610, Dimension of Unhealed Stage 3 or 4 Pressure Ulcers or Eschar 2. Number of <u>these</u> unstageable pressure ulcers that were present upon admission/entry or reentry - enter how many were noted at the time of admission/entry or reentry
M0610. Dimensions of Unhealed Stage 3 or 4 Pressure Ulcers or Eschar	
Complete only if M0300C1, M0300D1 or M0300F1 is greater than 0	
If the resident has one or more unhealed (non-epithelialized) Stage 3 or 4 pressure ulcers or an unstageable pressure ulcer due to slough or eschar, identify the pressure ulcer with the largest surface area (length x width) and record in centimeters:	
<input type="text" value="0"/> <input type="text" value="3"/> . <input type="text" value="0"/> cm	A. Pressure ulcer length: Longest length from head to toe
<input type="text" value="0"/> <input type="text" value="2"/> . <input type="text" value="4"/> cm	B. Pressure ulcer width: Widest width of the same pressure ulcer, side-to-side perpendicular (90-degree angle) to length
<input type="text" value="0"/> <input type="text" value="0"/> . <input type="text" value="2"/> cm	C. Pressure ulcer depth: Depth of the same pressure ulcer from the visible surface to the deepest area (if depth is unknown, enter a dash in each box)
M0700. Most Severe Tissue Type for Any Pressure Ulcer	
Enter Code <input type="text" value="2"/>	Select the best description of the most severe type of tissue present in any pressure ulcer bed 1. Epithelial tissue - new skin growing in superficial ulcer. It can be light pink and shiny, even in persons with darkly pigmented skin 2. Granulation tissue - pink or red tissue with shiny, moist, granular appearance 3. Slough - yellow or white tissue that adheres to the ulcer bed in strings or thick clumps, or is mucinous 4. Necrotic tissue (Eschar) - black, brown, or tan tissue that adheres firmly to the wound bed or ulcer edges, may be softer or harder than surrounding skin 9. None of the Above
M0800. Worsening in Pressure Ulcer Status Since Prior Assessment (OBRA or Scheduled PPS) or Last Admission/Entry or Reentry	
Complete only if A0310E = 0	
Indicate the number of current pressure ulcers that were not present or were at a lesser stage on prior assessment (OBRA or scheduled PPS) or last entry. If no current pressure ulcer at a given stage, enter 0.	
Enter Number <input type="text" value="0"/>	A. Stage 2
Enter Number <input type="text" value="1"/>	B. Stage 3
Enter Number <input type="text" value="0"/>	C. Stage 4

Scenarios for Pressure Ulcer Coding (cont.)

Example M0100-M1200

1. Mrs. P is admitted to the nursing home on 10/23/2010 for a Medicare stay. In completing the PPS 5-day assessment, it was noted that the resident had a head-to-toe skin assessment and her skin was intact, but upon assessment using the Braden scale, was found to be at risk for skin break down. On the 14-day PPS (ARD of 11/5/2010), the resident was noted to have a Stage 2 pressure ulcer that was identified on her coccyx on 11/1/2010. This Stage 2 pressure ulcer was noted to have pink tissue with some epithelialization present in the wound bed. Dimensions of the ulcer were length 01.1 cm, width 00.5 cm, and no measurable depth. Mrs. P does not have any arterial or venous ulcers, wounds, or skin problems. She is receiving ulcer care with application of a dressing applied to the coccygeal ulcer. Mrs. P. also has pressure redistribution devices on both her bed and chair, and has been placed on a 1½ hour turning and repositioning schedule per tissue tolerance. On 11/13/2010 the resident was discharged return anticipated and reentered the facility on 11/15/2010. Upon reentry the 5-day PPS ARD was set at 11/19/2010. In reviewing the record for this 5-day PPS assessment, it was noted that the resident had the same Stage 2 pressure ulcer on her coccyx, however, the measurements were now length 01.2 cm, width 00.6 cm, and still no measurable depth. It was also noted upon reentry that the resident had a suspected deep tissue injury of the right heel that was measured at length 01.9cm, width 02.5cm, and no visible depth.

5-Day PPS #1:

Coding:

- **M0100B** (Formal assessment instrument), Check box.
- **M0100C** (Clinical assessment), Check box.
- **M0150** (Risk of Pressure Ulcers), Code 1.
- **M0210** (One or more unhealed pressure ulcer(s) at Stage 1 or higher), Code 0 and skip to **M0900** (Healed pressure ulcers).
- **M0900** (Healed pressure ulcers). Skip to **M1030** since this item is only completed if **A0310E=0**. The 5-Day PPS Assessment is the first assessment since the most recent admission/entry or reentry, therefore, **A0310E=1**.
- **M1030** (Number of Venous and Arterial ulcers), Code 0.
- **M1040** (Other ulcers, wounds and skin problems), Check Z (None of the above).
- **M1200** (Skin and Ulcer Treatments), Check Z (None of the above were provided).

Rationale: The resident had a formal assessment using the Braden scale and also had a head-to-toe skin assessment completed. Pressure ulcer risk was identified via formal assessment. Upon assessment the resident's skin was noted to be intact, therefore, **M0210** was coded 0, **M0900** was skipped because the 5-Day PPS is the first assessment. **M1030** was coded 0 due to the resident not having any of these conditions. **M1040Z** was checked since none of these problems were noted. **M1200Z** was checked because none of these treatments were provided.

Scenarios for Pressure Ulcer Coding (cont.)

M1030. Number of Venous and Arterial Ulcers	
Enter Number <input type="text" value="0"/>	Enter the total number of venous and arterial ulcers present
M1040. Other Ulcers, Wounds and Skin Problems	
↓ Check all that apply	
Foot Problems	
<input type="checkbox"/>	A. Infection of the foot (e.g., cellulitis, purulent drainage)
<input type="checkbox"/>	B. Diabetic foot ulcer(s)
<input type="checkbox"/>	C. Other open lesion(s) on the foot
Other Problems	
<input type="checkbox"/>	D. Open lesion(s) other than ulcers, rashes, cuts (e.g., cancer lesion)
<input type="checkbox"/>	E. Surgical wound(s)
<input type="checkbox"/>	F. Burn(s) (second or third degree)
<input type="checkbox"/>	G. Skin tear(s)
<input type="checkbox"/>	H. Moisture Associated Skin Damage (MASD) (i.e. incontinence (IAD), perspiration, drainage)
None of the Above	
<input checked="" type="checkbox"/>	Z. None of the above were present
M1200. Skin and Ulcer Treatments	
↓ Check all that apply	
<input type="checkbox"/>	A. Pressure reducing device for chair
<input type="checkbox"/>	B. Pressure reducing device for bed
<input type="checkbox"/>	C. Turning/repositioning program
<input type="checkbox"/>	D. Nutrition or hydration intervention to manage skin problems
<input type="checkbox"/>	E. Pressure ulcer care
<input type="checkbox"/>	F. Surgical wound care
<input type="checkbox"/>	G. Application of nonsurgical dressings (with or without topical medications) other than to feet
<input type="checkbox"/>	H. Applications of ointments/medications other than to feet
<input type="checkbox"/>	I. Application of dressings to feet (with or without topical medications)
<input checked="" type="checkbox"/>	Z. None of the above were provided

Scenarios for Pressure Ulcer Coding (cont.)

14-Day PPS:

Coding:

- **M0100A** (Resident has a Stage 1 or greater, a scar over bony prominence, or a non-removable dressing/device), Check box.
- **M0100B** (Formal assessment instrument), Check box.
- **M0100C** (Clinical assessment), Check box.
- **M0150** (Risk of Pressure Ulcers), Code 1.
- **M0210** (One or more unhealed pressure ulcer(s) at Stage 1 or higher), Code 1.
- **M0300A** (Number of Stage 1 pressure ulcers), Code 0.
- **M0300B1** (Number of Stage 2 pressure ulcers), Code 1.
- **M0300B2** (Number of these Stage 2 pressure ulcers present on admission/entry or reentry), Code 0.
- **M0300B3** (Date of the oldest Stage 2 pressure ulcer), Enter 11-01-2010.
- **M0300C1** (Number of Stage 3 pressure ulcers), Code 0 and skip to **M0300D** (Stage 4).
- **M0300D1** (Number of Stage 4 pressure ulcers), Code 0 and skip to M0300E (Unstageable: Non-removable dressing).
- **M0300E1** (Unstageable: Non-removable dressing), Code 0 and skip to M0300F (Unstageable: Slough and/or Eschar).
- **M0300F1** (Unstageable: Slough and/or Eschar), Code 0 and skip to M0300G (Unstageable: Deep tissue).
- **M0300G1** (Unstageable: Deep tissue), Code 0 and skip to M0610 (Dimension of Unhealed Stage 3 or 4 Pressure Ulcers or Eschar).
- **M0610** (Dimension of Unhealed Stage 3 or 4 Pressure Ulcers or Eschar), is **not** completed, as the resident has a Stage 2 pressure ulcer.
- **M0700** (Most severe tissue type for any pressure ulcer), Code 1 (Epithelial tissue).
- **M0800** (Worsening in pressure ulcer status since prior assessment (OBRA or scheduled PPS or Last Admission/Entry or Reentry)), **M0800A**, Code 1; **M0800B**, Code 0; **M0800C**, Code 0. This item is completed because the 14-Day PPS is **not** the first assessment since the most recent admission/entry or reentry. Therefore, A0310E=0. **M0800A** is coded 1 because the resident has a new Stage 2 pressure ulcer that was not present on the prior assessment.
- **M0900A** (Healed pressure ulcers), Code 0. This is completed because the 14-Day PPS is **not** the first assessment since the most recent admission/entry or reentry. Therefore A0310E=0. Since there were no pressure ulcers noted on the 5-Day PPS assessment, this is coded 0, and skip to **M1030**.
- **M1030** (Number of Venous and Arterial ulcers), Code 0.
- **M1040** (Other ulcers, wounds and skin problems), Check Z (None of the above).

Scenarios for Pressure Ulcer Coding (cont.)

- **M1200A** (Pressure reducing device for chair), **M1200B** (Pressure reducing device for bed), **M1200C** (Turning/repositioning program), and **M1200E** (Pressure ulcer care) are all checked.

Rationale: The resident had a formal assessment using the Braden scale and also had a head-to-toe skin assessment completed. Pressure ulcer risk was identified via formal assessment. On the 5-Day PPS assessment the resident's skin was noted to be intact, however, on the 14-Day PPS assessment, it was noted that the resident had a new Stage 2 pressure ulcer. Since the resident has had both a 5-day and 14-Day PPS completed, the 14-Day PPS would be coded 0 at **A0310E**. This is because the 14-Day PPS is **not** the first assessment since the most recent admission/entry or reentry. Since **A0310E=0**, items **M0800** (Worsening in pressure ulcer status) and **M0900** (Healed pressure ulcers) would be completed. Since the resident did not have a pressure ulcer on the 5-Day PPS and did have one on the 14-Day PPS, the new Stage 2 pressure ulcer is documented under **M0800** (Worsening in pressure ulcer status). **M0900** (Healed pressure ulcers) is coded as 0 because there were no pressure ulcers noted on the prior assessment (5-Day PPS). There were no other skin problems noted. However the resident, since she is at an even higher risk of breakdown since the development of a new ulcer, has preventative measures put in place with pressure redistribution devices for her chair and bed. She was also placed on a turning and repositioning program based on tissue tolerance. Therefore **M1200A**, **M1200B**, and **M1200C** were all checked. She also now requires ulcer care and application of a dressing to the coccygeal ulcer, so **M1200E** is also checked. **M1200G** (Application of nonsurgical dressings – with or without topical medications) would **not** be coded here because **any** intervention for treating pressure ulcers is coded in **M1200E** (Pressure ulcer care).

Scenarios for Pressure Ulcer Coding (cont.)

M0100. Determination of Pressure Ulcer Risk	
↓ Check all that apply	
<input checked="" type="checkbox"/>	A. Resident has a stage 1 or greater, a scar over bony prominence, or a non-removable dressing/device
<input checked="" type="checkbox"/>	B. Formal assessment instrument/tool (e.g., Braden, Norton, or other)
<input checked="" type="checkbox"/>	C. Clinical assessment
<input type="checkbox"/>	Z. None of the above
M0150. Risk of Pressure Ulcers	
Enter Code <input type="text" value="1"/>	Is this resident at risk of developing pressure ulcers? 0. No 1. Yes
M0210. Unhealed Pressure Ulcer(s)	
Enter Code <input type="text" value="1"/>	Does this resident have one or more unhealed pressure ulcer(s) at Stage 1 or higher? 0. No → Skip to M0900, Healed Pressure Ulcers 1. Yes → Continue to M0300, Current Number of Unhealed (non-epithelialized) Pressure Ulcers at Each Stage
M0300. Current Number of Unhealed (non-epithelialized) Pressure Ulcers at Each Stage	
Enter Number <input type="text" value="0"/>	A. Number of Stage 1 pressure ulcers Stage 1: Intact skin with non-blanchable redness of a localized area usually over a bony prominence. Darkly pigmented skin may not have a visible blanching; in dark skin tones only it may appear with persistent blue or purple hues
Enter Number <input type="text" value="1"/>	B. Stage 2: Partial thickness loss of dermis presenting as a shallow open ulcer with a red or pink wound bed, without slough. May also present as an intact or open/ruptured blister
Enter Number <input type="text" value="0"/>	1. Number of Stage 2 pressure ulcers - If 0 → Skip to M0300C, Stage 3
	2. Number of <u>these</u> Stage 2 pressure ulcers that were present upon admission/entry or reentry - enter how many were noted at the time of admission/entry or reentry
	3. Date of oldest Stage 2 pressure ulcer - Enter dashes if date is unknown: <div style="display: flex; align-items: center; gap: 10px;"> <div style="border: 1px solid black; width: 20px; height: 20px; display: flex; align-items: center; justify-content: center;"> </div> <div style="border: 1px solid black; width: 20px; height: 20px; display: flex; align-items: center; justify-content: center;"> </div> <div>–</div> <div style="border: 1px solid black; width: 20px; height: 20px; display: flex; align-items: center; justify-content: center;"> </div> <div style="border: 1px solid black; width: 20px; height: 20px; display: flex; align-items: center; justify-content: center;"> </div> <div>–</div> <div style="border: 1px solid black; width: 20px; height: 20px; display: flex; align-items: center; justify-content: center;"> </div> <div style="border: 1px solid black; width: 20px; height: 20px; display: flex; align-items: center; justify-content: center;"> </div> <div style="border: 1px solid black; width: 20px; height: 20px; display: flex; align-items: center; justify-content: center;"> </div> <div style="border: 1px solid black; width: 20px; height: 20px; display: flex; align-items: center; justify-content: center;"> </div> </div> <div style="display: flex; justify-content: space-around; font-size: small;"> Month Day Year </div>
Enter Number <input type="text" value="0"/>	C. 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
Enter Number <input type="text" value=" "/>	1. Number of Stage 3 pressure ulcers - If 0 → Skip to M0300D, Stage 4
	2. Number of <u>these</u> Stage 3 pressure ulcers that were present upon admission/entry or reentry - enter how many were noted at the time of admission/entry or reentry
Enter Number <input type="text" value="0"/>	D. 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
Enter Number <input type="text" value=" "/>	1. Number of Stage 4 pressure ulcers - If 0 → Skip to M0300E, Unstageable: Non-removable dressing
	2. Number of <u>these</u> Stage 4 pressure ulcers that were present upon admission/entry or reentry - enter how many were noted at the time of admission/entry or reentry
M0300 continued on next page	

Scenarios for Pressure Ulcer Coding (cont.)

M0300. Current Number of Unhealed (non-epithelialized) Pressure Ulcers at Each Stage - Continued	
Enter Number <input type="text" value="0"/>	E. Unstageable - Non-removable dressing: Known but not stageable due to non-removable dressing/device 1. Number of unstageable pressure ulcers due to non-removable dressing/device - If 0 → Skip to M0300F, Unstageable: Slough and/or eschar 2. Number of <u>these</u> unstageable pressure ulcers that were present upon admission/entry or reentry - enter how many were noted at the time of admission/entry or reentry
Enter Number <input type="text" value="0"/>	F. Unstageable - Slough and/or eschar: Known but not stageable due to coverage of wound bed by slough and/or eschar 1. Number of unstageable pressure ulcers due to coverage of wound bed by slough and/or eschar - If 0 → Skip to M0300G, Unstageable: Deep tissue 2. Number of <u>these</u> unstageable pressure ulcers that were present upon admission/entry or reentry - enter how many were noted at the time of admission/entry or reentry
Enter Number <input type="text" value="0"/>	G. Unstageable - Deep tissue: Suspected deep tissue injury in evolution 1. Number of unstageable pressure ulcers with suspected deep tissue injury in evolution - If 0 → Skip to M0610, Dimension of Unhealed Stage 3 or 4 Pressure Ulcers or Eschar 2. Number of <u>these</u> unstageable pressure ulcers that were present upon admission/entry or reentry - enter how many were noted at the time of admission/entry or reentry
M0700. Most Severe Tissue Type for Any Pressure Ulcer	
Enter Code <input type="text" value="1"/>	Select the best description of the most severe type of tissue present in any pressure ulcer bed 1. Epithelial tissue - new skin growing in superficial ulcer. It can be light pink and shiny, even in persons with darkly pigmented skin 2. Granulation tissue - pink or red tissue with shiny, moist, granular appearance 3. Slough - yellow or white tissue that adheres to the ulcer bed in strings or thick clumps, or is mucinous 4. Necrotic tissue (Eschar) - black, brown, or tan tissue that adheres firmly to the wound bed or ulcer edges, may be softer or harder than surrounding skin 9. None of the Above
M0800. Worsening in Pressure Ulcer Status Since Prior Assessment (OBRA or Scheduled PPS) or Last Admission/Entry or Reentry	
Complete only if A0310E = 0	
Indicate the number of current pressure ulcers that were not present or were at a lesser stage on prior assessment (OBRA or scheduled PPS) or last entry. If no current pressure ulcer at a given stage, enter 0.	
Enter Number <input type="text" value="1"/>	A. Stage 2
Enter Number <input type="text" value="0"/>	B. Stage 3
Enter Number <input type="text" value="0"/>	C. Stage 4

Scenarios for Pressure Ulcer Coding (cont.)

M0900. Healed Pressure Ulcers	
Complete only if A0310E = 0	
Enter Code <input type="text" value="0"/>	A. Were pressure ulcers present on the prior assessment (OBRA or scheduled PPS)? 0. No → Skip to M1030, Number of Venous and Arterial Ulcers 1. Yes → Continue to M0900B, Stage 2
Enter Number <input type="text"/>	Indicate the number of pressure ulcers that were noted on the prior assessment (OBRA or scheduled PPS) that have completely closed (resurfaced with epithelium). If no healed pressure ulcer at a given stage since the prior assessment (OBRA or scheduled PPS), enter 0.
Enter Number <input type="text"/>	B. Stage 2
Enter Number <input type="text"/>	C. Stage 3
Enter Number <input type="text"/>	D. Stage 4
M1030. Number of Venous and Arterial Ulcers	
Enter Number <input type="text" value="0"/>	Enter the total number of venous and arterial ulcers present
M1040. Other Ulcers, Wounds and Skin Problems	
↓ Check all that apply	
<input type="checkbox"/>	Foot Problems
<input type="checkbox"/>	A. Infection of the foot (e.g., cellulitis, purulent drainage)
<input type="checkbox"/>	B. Diabetic foot ulcer(s)
<input type="checkbox"/>	C. Other open lesion(s) on the foot
<input type="checkbox"/>	Other Problems
<input type="checkbox"/>	D. Open lesion(s) other than ulcers, rashes, cuts (e.g., cancer lesion)
<input type="checkbox"/>	E. Surgical wound(s)
<input type="checkbox"/>	F. Burn(s) (second or third degree)
<input type="checkbox"/>	G. Skin tear(s)
<input type="checkbox"/>	H. Moisture Associated Skin Damage (MASD) (i.e. incontinence (IAD), perspiration, drainage)
<input type="checkbox"/>	None of the Above
<input checked="" type="checkbox"/>	Z. None of the above were present
M1200. Skin and Ulcer Treatments	
↓ Check all that apply	
<input checked="" type="checkbox"/>	A. Pressure reducing device for chair
<input checked="" type="checkbox"/>	B. Pressure reducing device for bed
<input checked="" type="checkbox"/>	C. Turning/repositioning program
<input type="checkbox"/>	D. Nutrition or hydration intervention to manage skin problems
<input checked="" type="checkbox"/>	E. Pressure ulcer care
<input type="checkbox"/>	F. Surgical wound care
<input type="checkbox"/>	G. Application of nonsurgical dressings (with or without topical medications) other than to feet
<input type="checkbox"/>	H. Applications of ointments/medications other than to feet
<input type="checkbox"/>	I. Application of dressings to feet (with or without topical medications)
<input type="checkbox"/>	Z. None of the above were provided