Section M: Keys to Coding Accuracy
Objectives

Participants will be able to:

- Accurately code Section M
- Identify pressure ulcers that are present on admission and code appropriately on the MDS item set
- Accurately identify various stages of pressure ulcers
- Determine worsening in pressure ulcer status and accurately code on the MDS item set
Items M0100 & M0150
Determination of Pressure Ulcer Risk
M0100 Determination of PrU Risk

◆ Reflects multiple approaches for determining a resident’s risk for developing a pressure ulcer.
  - Presence or indicators of pressure ulcers
  - Assessment using a formal tool
  - Physical examination of skin and/or medical record
Item M0210
Unhealed
Pressure Ulcer(s)
A new MDS Coordinator is completing a quarterly assessment on Mr. J. In reviewing the clinical records she finds Mr. J had a pressure ulcer on the last quarterly asmt, but the pressure ulcer has since healed and is no longer present. How would you code M0210?
M0210 Unhealed Pressure Ulcers

Mrs. Smith’s quarterly assessment is also due and the ARD is set for 09/14/15. Records indicate on the last quarterly assessment Ms. S did not have any pressure ulcers. However, further review of clinical documentation reveals Ms. S developed a Stage 2 on her left heal on 08/27/15 but it has healed as of 09/12/15. How would you code M0210?

Code “0” No Unhealed pressure ulcers
M0210: 3rd Scenario

- On Mr. D’s quarterly assessment a Stage 4 pressure ulcer was present on his right hip. Documentation indicates that the pressure ulcer had to be surgically repaired with a graft due to complications in healing. Mr. D is now returning to your facility and it was determined a SCSA should be completed because the plan of care has changed. How would you code M0210 on the SCSA?
M0210 Unhealed Pressure Ulcers Coding Instructions

- A scab is evidence of wound healing.
- Coding or staging would not change due to the presence of a scab.
- Eschar characteristics, and the damage it causes to tissues, distinguishes it from a scab.
- A pressure ulcer with eschar or scab would be coded as “1” Yes, at M0210.
Item M0300
Current Number of Unhealed Pressure Ulcer(s) at Each Stage
3 Key Steps for Completing M0300A-G

◆ **Step 1:** Determine the deepest anatomical stage of each pressure ulcer
  ➢ **Do not back stage**

◆ **Step 2:** Identify any Unstageable pressure ulcers

◆ **Step 3:** Determine if any pressure ulcers were Present on Admission (POA)
Present on Admission (POA)

“On Admission” definition:
- As close to the actual time of admission as possible.

Determine if pressure ulcer (PrU) was present at time of admission/entry or re-entry and not acquired while in the care of the nursing home.

**KEY:** To be considered POA on subsequent assessments, the PrU must remain at the same anatomical location and at the same stage.
Present on Admission

- Special Considerations:
  - If PrU was POA and worsened to a higher stage during *nursing home stay*, code at higher stage and “*not* present on admission.”
  - If a current PrU worsens to a higher stage during a *hospitalized stay*, it *should* be coded as POA.
Review of “Present on Admission/Re-entry”

Example: The resident had a Stage 3 on admission. But on a later assessment, the wound is noted to be a Stage 4.

How would you code?

M0300C1(Number of Stage 3 PrU) =
M0300D1(Number of Stage 4 PrU) =
M0300D2(Number of these POA) =

Rationale:
Example: A resident develops a Stage 2 PrU while at the nursing home. The resident is hospitalized for pneumonia and returns with a Stage 3 PrU in the same location.

How would you code?

M0300C1 Number of Stage 3 PrU =
M0300C2 Number present on admission =

Rationale:
Present on Admission

Special Considerations Continued:

- If a resident who has a pressure ulcer is hospitalized and returns with that PrU at the same stage and same anatomical location, it is **not** coded as POA.

- **Rationale:** The PrU was present at the facility prior to hospitalization and did not deteriorate during hospital stay.
The 5-day assessment indicates that Mr. Smith had a suspected deep tissue injury (sDTI) on his left hip. It is coded as unstageable on the 5-day. It’s now time to complete the 14-day. The clinician identifies from the wound care records that the wound is now staged as a Stage 3. Is this wound considered Present on Admission on the 14-day?
Present on Admission

- Special Considerations continued:
  - If the pressure ulcer was unstageable on admission or re-entry, but later becomes stageable, it should be considered present on admission (POA).
  - However, if it increases in numerical stage on the next assessment, that higher stage should not be considered present on admission.
Item M0300A
Number of Stage 1 Pressure Ulcers
Definition Stage 1 Pressure Ulcer

- An observable pressure related alteration of intact skin
- and/or a defined area of persistent redness (non-blanchable) in lightly pigmented skin, whereas in darker skin tones, the ulcer may appear with persistent red, blue or purplish hues.
M0300A Number of Stage 1 Pressure Ulcers

- Document number of Stage 1 pressure ulcers.
- Stage 1 pressure ulcers may deteriorate without adequate intervention.

M0300. Current Number of Unhealed Pressure Ulcers at Each Stage

<table>
<thead>
<tr>
<th>Enter Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stage 1: Intact skin with non-blancheable 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</td>
</tr>
</tbody>
</table>
Item M0300B
Stage 2 Pressure Ulcers
Category/ Stage 2 Pressure Ulcer

- **Partial thickness** loss of dermis presenting as:
  - Shallow **open** ulcer
  - Red or pink wound bed
  - **Without** slough
May also present as an intact or open/ruptured blister
Item M0300B—Stage 2

Suspected Deep Tissue Injury
M0300B Stage 2 Pressure Ulcers
Coding Instructions

- Enter Number of Stage 2 pressure ulcers
- Enter number of these Stage 2 PrU that were present on admission/entry or reentry from hospital stay
- Enter Date of oldest Stage 2 pressure ulcer

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

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:

   - Month
   - Day
   - Year
Items M0300C & M0300D
Stage 3 Pressure Ulcers/Stage 4 Pressure Ulcers
Category/Stage 3 Pressure Ulcer

- **Full thickness** tissue loss
- Subcutaneous fat may be visible but bone, tendon or muscle are *not* exposed
- Slough may be present but does not cover the depth of tissue loss. (Wound bed can be assessed)
- May include undermining and tunneling
- Depth varies depending on anatomical location
Category/ Stage 4 Pressure Ulcer

- **Full thickness** tissue loss with **exposed** bone, tendon or muscle

- Cartilage serves the same anatomical function as bone. Therefore, PrU that have exposed cartilage should be classified as a Stage 4. (New, May 2013)

- **Often** includes undermining and tunneling
Item M0300E/M0300F/M0300G
Unstageable Pressure Ulcers
Unstageable Pressure Ulcers

◆ Three types of Unstageable PrU to differentiate

◆ Number of these unstageable pressure ulcers present upon admission/ reentry

E. Unstageable - Non-removable dressing:

1. Number of unstageable pressure ulcers due to non-removable dressing/device - If 0 ➔ Skip to M0306F, Unstageable: Slough and/or eschar.

2. Number of these ulcers present upon admission/ reentry - enter how many were noted at the time of admission.

F. Unstageable - 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.

G. Unstageable - Deep tissue:

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 these unstageable pressure ulcers that were present upon admission/ reentry - enter how many were noted at the time of admission.
M0300E Unstageable Non-Removable Dressing/Device

- Ulcer covered with eschar under plaster cast
- **Known** but not stageable because of the non-removable device or dressing.
M0300F Unstageable Slough and/or Eschar

- Known but not stageable related to coverage of wound bed by slough and/or eschar
- Base of ulcer covered by slough (yellow, tan, gray, green or brown) and/or eschar (tan, brown or black) in the wound bed; may appear scab-like.
M0300G Unstageable
Suspected Deep Tissue Injury

- Localized purple or maroon area of discolored intact skin.

- Area of discoloration may be preceded by tissue that is painful, firm, mushy, boggy, warmer or cooler as compared to adjacent tissue.

- **Key**: If the surrounding tissue does not show signs of tissue damage, do **NOT** code as sDTI.
M0300G Unstageable Suspected Deep Tissue Injury

- Clearly document assessment findings in the resident’s medical record
- Deep tissue injuries can indicate severe damage
- Identification and close monitoring is critical due to rapid deterioration
M0300F Unstageable Scenario

- A pressure ulcer on the sacrum was present on admission and wound bed was 100% covered with black eschar.
- On the admission assessment, it was coded as unstageable and present on admission.
- The pressure ulcer is debrided, and the wound bed now has 50% eschar present.
- The clinician is able to assess the wound bed and can see that the damage extends to the bone.
- How would you code M0300?
M0300E–G Scenario #1 Coding

◆ Stage ___ pressure ulcer

◆ On the MDS:
  • Code M0300D1 Number of Stage 4 pressure ulcers as ___
  • Code M0300D2 as ___ present on admission

Rationale:
Item M0610

Dimensions of Unhealed Stage 3 or 4 Pressure Ulcers or Unstageable Pressure Ulcer Due to Slough or Eschar
Dimensions of a Pressure Ulcer: What to Measure

- Identify the pressure ulcer with the largest surface area from the following:
  - Unhealed Stage 3 or 4
  - Unstageable pressure ulcer related to slough or eschar
- Measure every Stage 3, Stage 4, and Unstageable PrU related to slough or eschar to determine the largest PrU.
Select a uniform and consistent method for measuring wounds

Compare measurements over time

Measurement of tunneling and undermining is not recorded on the MDS but should be measured, assessed and care planned.
M0610A Length

- Measure the longest length from head to toe using a disposable device

[Image showing measurement of longest length with a marker at 8 cm]
Measure widest width of the pressure ulcer side to side perpendicular (90° angle) to length

The depth of this pressure ulcer is 3.7 cm.
Moisten a cotton-tipped applicator with 0.9% sodium chloride (NaCl) solution or sterile water.

Place applicator tip in deepest aspect of the wound and measure distance to the skin level.
M0610 Coding Instructions

- Enter pressure ulcer dimensions in centimeters
- If depth is unknown, enter a dash in each space

<table>
<thead>
<tr>
<th>M0610. Dimensions of Unhealed Stage 3 or 4 Pressure Ulcers or Eschar</th>
</tr>
</thead>
<tbody>
<tr>
<td>Complete only if M0300C1, M0300D1 or M0300F1 is greater than 0</td>
</tr>
<tr>
<td>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:</td>
</tr>
<tr>
<td>A. Pressure ulcer length: Longest length from head to toe</td>
</tr>
<tr>
<td>[ ] [ ] . [ ] cm</td>
</tr>
<tr>
<td>B. Pressure ulcer width: Widest width of the same pressure ulcer, side-to-side perpendicular (90-degree angle) to length</td>
</tr>
<tr>
<td>[ ] [ ] . [ ] cm</td>
</tr>
<tr>
<td>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)</td>
</tr>
<tr>
<td>[ ] [ ] . [ ] cm</td>
</tr>
</tbody>
</table>
Item M0700
Most Severe Tissue Type for Any Pressure Ulcer
M0700 Most Severe Tissue Type for Any Pressure Ulcer

- Determine type(s) of tissue in the wound bed.
- Code for most severe type of tissue present in wound bed.
- Code for most severe type if wound bed is covered with a mix of different types of tissue.

<table>
<thead>
<tr>
<th>Enter Code</th>
<th>Select the best description of the most severe type of tissue present in any pressure ulcer bed</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1. Epithelial tissue - new skin growing in superficial ulcer. It can be light pink and shiny, even in persons with darkly pigmented skin</td>
</tr>
<tr>
<td></td>
<td>2. Granulation tissue - pink or red tissue with shiny, moist, granular appearance</td>
</tr>
<tr>
<td></td>
<td>3. Slough - yellow or white tissue that adheres to the ulcer bed in strings or thick clumps, or is mucinous</td>
</tr>
<tr>
<td></td>
<td>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</td>
</tr>
<tr>
<td></td>
<td>9. None of the Above</td>
</tr>
</tbody>
</table>
Epithelial Tissue

Granulation Tissue

Slough

Eschar
Item M0800
Worsening in Pressure Ulcer Status Since Prior Assessment (OBRA, PPS, or Discharge)
M0800 Assessment Guidelines

- Look-back period is back to the ARD of the prior assessment
- If no prior assessment, do not complete this item.

<table>
<thead>
<tr>
<th>Enter Number</th>
<th>A. Stage 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Enter Number</td>
<td>B. Stage 3</td>
</tr>
<tr>
<td>Enter Number</td>
<td>C. Stage 4</td>
</tr>
</tbody>
</table>
M0800 Worsening in Pressure Ulcer Status

Definition Pressure Ulcer “Worsening”:

- 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 on an assessment as compared to the previous assessment.
M0800 Worsening in Pressure Ulcer Status

✦ If a numerical stage is not available on a previous assessment (e.g. sDTI), then determination of “worsening” cannot be made.

✦ However, If the resident has a Stage 2 and later develops slough, then the assessor can code as “worsening”.

CMS YouTube Video, May 2014
M0800 Coding Instructions

- Previously staged PrU becomes Unstageable due to slough or eschar—**not coded as worsened**.

- Previously staged PrU becomes Unstageable and then is debrided and can be staged, compare the stages **before and after** it was Unstageable—if worsened, code as such.
**Example of 1st bullet:** Stage 3 pressure ulcer becomes 100% covered with eschar, not coded as worsened.

**Example 2:** Now the doctor orders the wound to be debrided. Compare the stage prior to the eschar, (Stage 3), to the current stage after debridement, (Stage 4), increased in stage so means the pressure ulcer worsened.

Code M0800C “Number of Stage 4 pressure ulcers that were at a lesser stage on prior assessment” as “1”.
M0800 Coding Instructions

◆ If two pressure ulcers merge, do not code as worsened based on increased surface area.

◆ Determine if wound increased in numerical stage in order to determine if it worsened.
M0800 Coding Instructions

◆ If a pressure ulcer develops during hospital stay, it is coded as “present on admission” upon reentry and is not included or coded as worsened.

◆ If a pressure ulcer increases in numerical stage to a more severe stage during a hospital stay, it is coded as “present on admission” upon reentry and is not included or coded as worsened.
Item M0900
Healed Pressure Ulcers
M0900 Healed Pressure Ulcers

Definition:

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

Do not reverse stage. Clinical documentation should reflect “healed” or “closed” (at its highest numerical stage); “Closed Stage 3.”
M0900 Healed Pressure Ulcers

- If no prior assessment, do **not** complete this item.
- Look-back period, **ARD of the prior assessment**.
- Enter the number of healed PrU for each stage.

<table>
<thead>
<tr>
<th>Enter Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Were pressure ulcers present on the prior assessment (OBRA or scheduled PPS)?</td>
</tr>
<tr>
<td>0. No ➔ Skip to M1030, Number of Venous and Arterial Ulcers</td>
</tr>
<tr>
<td>1. Yes ➔ Continue to M0900B, Stage 2</td>
</tr>
<tr>
<td>Enter Number</td>
</tr>
<tr>
<td>B. Stage 2</td>
</tr>
<tr>
<td>Enter Number</td>
</tr>
<tr>
<td>C. Stage 3</td>
</tr>
<tr>
<td>Enter Number</td>
</tr>
<tr>
<td>D. Stage 4</td>
</tr>
</tbody>
</table>
Acknowledgements

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Questions? Contact Us:

QIES HELP DESK

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