

Section M

Skin Conditions

V1.01

Objectives

- Review key components of pressure ulcer risk assessment.
- Discuss the new pressure ulcer staging.
- Describe how to measure pressure ulcers.
- Discuss importance of interdisciplinary collaboration for wound differentiation.
- Code Section M correctly and accurately.

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Major Changes to Section M₁

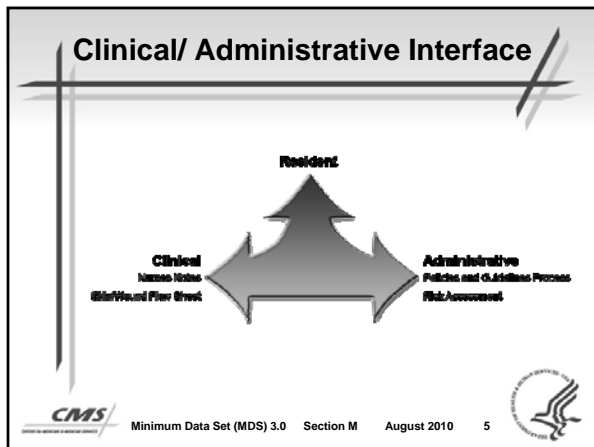
- Risk assessment
- Staging
 - No more “reverse” staging
 - Deepest pressure ulcer
 - Worsening pressure ulcer(s)
 - Separate items for unstageable and suspected Deep Tissue Injury (sDTI) pressure ulcers

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Major Changes to Section M₂

- Pressure ulcer present on admission/reentry
- Date of oldest Stage 2 pressure ulcer
- Dimensions in centimeters as actually measured
- Type of tissue in the wound bed

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Organizational Assessment

- Look at your systems
 - Clinical/ administrative intersection
 - Who does the data collection and how does it flow?
 - How is documentation done? Who is responsible?
- Review your current:
 - Pressure ulcer policies and guidelines
 - Process for pressure ulcer risk
 - Process for developing and implementing a care plan for at risk residents

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Clinician Skills Needed

- Risk assessment
- New pressure ulcer staging
- Ulcer measurement
 - Using instrument according to CMS guidelines.
- Wound identification
 - Etiology of the wound is paramount.
 - Requires interdisciplinary collaboration.
 - Consider the whole person and underlying etiology.

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NPUAP Pressure Ulcer Definition

- CMS has **adapted** the NPUAP 2007 definition of a pressure ulcer as well as categories/ staging.
- A pressure ulcer is a 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.

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Items M0100 & M0150

Determination of Pressure Ulcer Risk

Risk of Pressure Ulcers



Pressure Ulcer Risk Factors₁

- Immobility and decreased functional ability
- Co-morbid conditions (ESRD, thyroid, diabetes)
- Drugs such as steroids
- Impaired diffuse or localized blood flow
- Resident refusal of care and treatment

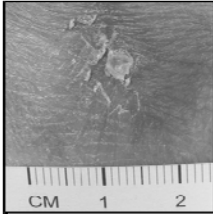

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Pressure Ulcer Risk Factors₂

- Cognitive impairment
- Exposure of skin to urinary and fecal incontinence
- Undernutrition, malnutrition, and hydration deficits
- Healed pressure ulcer that has closed
 - Higher risk of opening up due to damage, injury, or pressure
 - Due to loss of tensile strength of the overlying tissue
 - Tensile strength of skin overlaying a closed pressure ulcer only 80% of normal skin

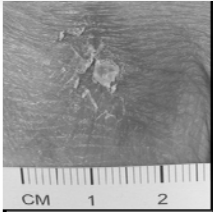
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Is This Evidence of a Risk Factor?





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Healed PU = Risk of PU



Ulcer healed
in 3 months



Presented with
Stage 4 ulcer

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M0100 Determination of Pressure Ulcer 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

M0100. Determination of Pressure Ulcer Risk

Check all that apply

A. Resident has a stage 1 or greater, a scar over bony prominence, or a non-removable dressing/device


B. Formal assessment instrument/tool (e.g., Braden, Norton, or other)

C. Clinical assessment

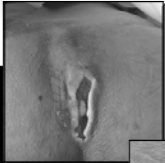
Z. None of the above

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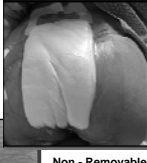
M0100A Risk Factors



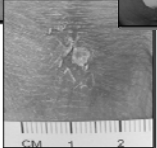
Non - Removable Device



Existing Pressure Ulcer



Non - Removable Dressing



Healed (Closed) Pressure Ulcer

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M0100B Formal Assessment/ Tools

- Braden Scale®
 - www.bradenscale.org
 - www.hartfordign.org
- Norton Scale
 - <http://www.ncbi.nlm.nih.gov/bookshelf/br.fcgi?book=hsahcpr&part=A4521>
- Other
 - Institution scales

M0100. Determination of Pressure Ulcer Risk

Check all that apply

A. Resident has a stage 1 or greater, a scar over bony prominence, or a non-removable dressing/device

B. Formal assessment instrument/tool (e.g., Braden, Norton, or other)

C. Clinical assessment

R. Formal assessment instrument/tool (e.g., Braden, Norton, or other)

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M0100C Clinical Assessment

- Observe the resident's skin.
- Review the medical record.
- Imperative to determine etiology of all wounds and lesions.
- Consider using mnemonics that capture key risk factors.
 - HALT® is one example.

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HALT®₁

- H** – History of pressure ulcer/ patient events
 - Immobility
 - Decreased functional ability
 - Undernutrition, malnutrition hydration deficits
- A** – Associated diagnoses/ co-morbidities
 - Advancing age
 - Medications (e.g. steroids)
 - Hemodynamic instability, blood flow impairment
 - ESRD, thyroid disease
 - Diastolic pressure below 60

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HALT[®]₂

- **L** – Look at the skin
- **T** – Touch the skin
 - Temperature changes of the skin
 - Exposure to incontinence

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M0150 Risk of Pressure Ulcers

- Determine if resident is at risk for pressure ulcers.
- Recognize/ evaluate each resident's risk factors.
- Identify/ evaluate all areas at risk of constant pressure.
- Determine if resident is at risk.

M0150. Risk of Pressure Ulcers

Enter Code: Is this resident at risk of developing pressure ulcers?


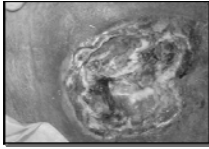
0. No
1. Yes

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Item M0210

Unhealed Pressure Ulcer(s)

M0210 Unhealed Pressure Ulcers Coding Instructions

M0210. Unhealed Pressure Ulcer(s)

Code: Does this resident have one or more unhealed pressure ulcer(s) at Stage 1 or higher?

0. No → Skip to M0900, Healed Pressure Ulcer
1. Yes → Continue to M0300, Current Number of Unhealed (non-epithelialized) Pressure Ulcers at Each Stage

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Item M0300

Current Number of Unhealed Pressure Ulcer(s) at Each Stage

Pressure Ulcer Staging is Within Scope of Nursing Practice

- Skin assessment part of health status.
- Skin assessment includes:
 - Differentiating from other wounds
 - Staging
- Determine nursing care needs and plan of care.


Lyder, DH, Krasner, DL, Ayello, EA. (2010). Clarification from the American Nurses Association on the Nurse's role in pressure ulcer staging. *Advances in Skin and Wound Care*. 23(1):8-10

Patton RM (2010). Is diagnosis of pressure ulcers within an RN's scope of practice? *American Nurse Today* 5(1):20


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New Staging Definitions

- Resources:
 - www.npuap.org
 - Free diagrams of ulcer stages can be downloaded for educational use.
- CMS has **adapted** these definitions.





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M0300 Guidelines₁

1. Determine deepest anatomical stage of each pressure ulcer.
2. Identify unstageable pressure ulcers.
3. Determine “present on admission.”





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M0300 Guidelines₂

- Do not reverse stage.
- Consider current and historical levels of tissue involvement.
- Do **not** code lesions not primarily related to pressure.
- Initial numerical staging and the initial numerical staging of ulcers after debridement or sDTI that declares itself should be coded in terms of what is assessed (seen and palpated, i.e. visible tissue, palpable bone) during the look-back period.



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Item M0300A

Number of Stage 1 Pressure Ulcers

M0300A Number of Stage 1 Pressure Ulcers

- Document number of Stage 1 pressure ulcers.
- Stage 1 pressure ulcers may deteriorate without adequate intervention.
- They are an important risk factor for further tissue damage.


M0300. Current Number of Unhealed (non-epithelialized) Pressure Ulcers at Each Stage

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 show a visible blanching; in dark skin tones only it may appear with increased heat or purple hue.

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 show a visible blanching; in dark skin tones only it may appear with persistent bluish or purple hue.




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M0300A Conduct the Assessment₁

- Perform a head-to-toe, full body skin assessment.
- Focus on bony prominences and pressure-bearing areas, such as:
 - Sacrum
 - Heels
 - Buttocks
 - Ankles



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M0300A Conduct the Assessment₂

- Check any reddened areas for ability to blanch.
 - Firmly press finger into tissue then remove
 - Non-blanchable: no loss of skin color or pressure-induced pallor at the compressed site
- Search for other areas of skin that differ from surrounding tissue.
 - Painful
 - Soft
 - Color change
 - Firm
 - Warmer or cooler



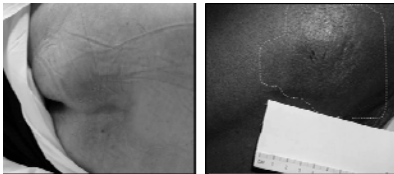
M0300A Assessment Guidelines

- Assessment to determine staging should be holistic.
- Stage 1 may be difficult to detect in individuals with dark skin tones.
- Determine whether an ulcer is a Stage 1 pressure ulcer or suspected deep tissue injury.
- Do not rely on only one descriptor as the descriptors for these two types of ulcers are similar.
- Code pressure ulcers with intact skin that are suspected deep tissue injury in M0300G Unstageable Pressure Ulcers Related to Suspected Deep Tissue Injury.

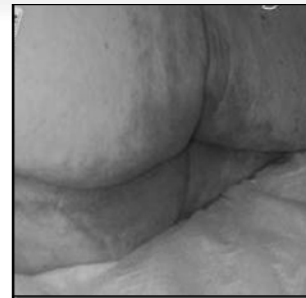


Category/ Stage 1 Pressure Ulcer

- Intact skin with **non-blanchable redness** of a localized area usually over a bony prominence.
- **Darkly pigmented skin** may not have visible blanching.
- Color may differ from the surrounding area.

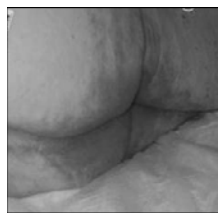


Is this a Stage 1 Pressure Ulcer?



Not a Stage 1 Pressure Ulcer

- This is moisture associated skin damage from incontinence.
- Do not document in M0300A.

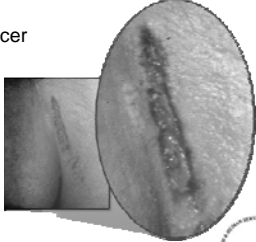


Item M0300B

Stage 2 Pressure Ulcers

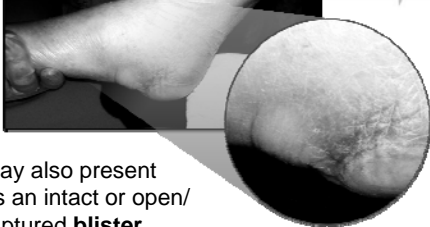
Category/ Stage 2 Pressure Ulcer₁

- **Partial thickness** loss of dermis presenting as:
 - **Shallow open** ulcer
 - Red or pink wound bed
 - **Without slough**



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Category/ Stage 2 Pressure Ulcer₂



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

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Category/ Stage 2 Pressure Ulcer₃

- Do **NOT** code as a Stage 2 when a deep tissue injury **is** determined.
- Code in M0300G Unstageable Pressure Ulcers Related to Suspected Deep Tissue Injury.
- Clearly document assessment findings in the resident's medical record.
- Facilities may adapt NPUAP guidelines in their clinical practice and nursing documentation.

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M0300B Conduct the Assessment

- Perform a head-to-toe, full body skin assessment.
- Focus on bony prominences and pressure-bearing areas.
- Examine the area adjacent to or surrounding any intact blister for evidence of tissue damage.
- Determine if lesion being assessed is primarily related to pressure.
- Rule out other conditions.
- Do not code here if pressure is not the primary cause.

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M0300B Assessment Guidelines₁

- Assessment to determine staging should be holistic.
- Determine if tissue adjacent to or surrounding the blister demonstrates signs of tissue damage:
 - Color change
 - Bogginess or firmness
 - Tenderness
 - Warmth or coolness

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M0300B Assessment Guidelines₂

- Stage 2 ulcers will **generally** lack the surrounding characteristics found with a deep tissue injury.
- Blood-filled blisters related primarily to pressure are more likely than serous filled blisters to be associated with a suspected deep tissue injury.
- Ensure, again, a complete, and comprehensive, assessment of the resident and the site of injury.
- Do **not** code skin tears, tape burns, perineal dermatitis, maceration, excoriation, or suspected deep tissue injury in M0300B.

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M0300B Stage 2 Pressure Ulcers Coding Instructions

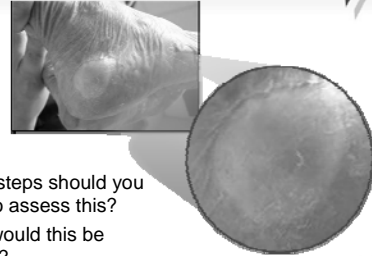
1. **Number** of Stage 2 pressure ulcers
2. Number of Stage 2 pressure ulcers **present upon admission/ reentry**
 - o Number of pressure ulcers first noted at time of admission
 - o Number of pressure ulcers acquired during a hospital stay if being readmitted
3. **Date of oldest** Stage 2 pressure ulcer
 - o Code suspected deep tissue injury at M0300G.



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Pressure Ulcer Blister



1. What steps should you take to assess this?
2. How would this be coded?



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Blood - Filled Blister



1. What steps should you take to assess this?
2. How would this be coded?



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Blisters from Burns



1. What steps should you take to assess this?
2. How would this be coded?



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Items M0300C & M0300D

Stage 3 Pressure Ulcers/ Stage 4 Pressure Ulcers

M0300C Conduct the Assessment

- Perform a head-to-toe, full body skin assessment.
- Focus on bony prominences and pressure-bearing areas.
- Determine if lesion being assessed is primarily related to pressure.
 - o Rule out other conditions.
 - o Do not code here if pressure is not the primary cause.



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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 obscure the depth of tissue loss.
- **May** include undermining and tunneling.



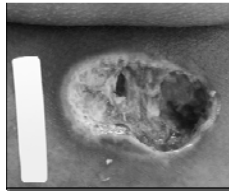
M0300C Stage 3 Pressure Ulcers Coding Instructions

1. **Number of Stage 3 pressure ulcers**
 - o Identify all Stage 3 pressure ulcers currently present.
2. **Number of Stage 3 pressure ulcers present upon admission/ reentry**
 - o Code the number of pressure ulcers first noted at time of admission.
 - o Code number of pressure ulcers acquired during a hospital stay if being readmitted.



Category/ 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.
- Depth varies by anatomical location (bridge of nose, ear, occiput, and malleous ulcers can be shallow).



M0300D Stage 4 Pressure Ulcers Coding Instructions

1. **Number of Stage 4 pressure ulcers**
2. **Number of Stage 4 pressure ulcers present upon admission/ reentry**

M0300. Current Number of Unhealed (non-epithelialized) Pressure Ulcers at Each Stage

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 - P.O. → Slip to M0300C, (Integriderm Non-removable dressing)

2. Number of these Stage 4 pressure ulcers that were present upon admission/reentry - onto how many were noted at the time of admission



M0300A - D Scenario #1

- A pressure ulcer described as a Stage 2 was noted and documented in the resident's medical record at the time of admission.
- On a later assessment, the wound is noted to be a full thickness ulcer.
- Thus it is now a Stage 3 pressure ulcer.



M0300A - D Scenario #1 Coding

- Code M0300C1. Number of Stage 3 pressure ulcers as 1.
- Code M0300C2 as 0 (not present on admission).
- The designation of "present on admission" requires that the pressure ulcer be at the same location and not have worsened to a deeper anatomical stage.
- This pressure ulcer worsened after admission.



M0300A - D Scenario #2

- 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.
- The third has worsened to a Stage 3 pressure ulcer.



M0300A - D Scenario #2 Coding₁

- Code the two merged pressure ulcers:
 - M0300B1. Number of Stage 2 pressure ulcers as 1.
 - M0300B2 as 1 present upon admission.
- Two of the pressure ulcers on the coccyx have merged.
- They have remained at the same stage as they were at the time of admission.



M0300A - D Scenario #2 Coding₂

- Code the Stage 3 pressure ulcer:
 - M0300C1. Number of Stage 3 pressure ulcers as 1.
 - M0300C2 as 0 (not present on admission).
- The pressure ulcer has increased to a Stage 3 since admission.
- Therefore, it cannot be coded as present on admission.



M0300A - D Scenario #3

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



M0300A - D Scenario #3 Coding

- Code M0300C1 Number of Stage 3 pressure ulcers as 1.
- Code M0300C2 as 1 present on admission.
- Even though the resident had a pressure ulcer in the same anatomical location prior to transfer, because it worsened to a Stage 3 during hospitalization, it should be coded as a Stage 3, present on admission.



**Item M0300E/
M0300F/ M0300G**

**Unstageable
Pressure Ulcers**

Unstageable Pressure Ulcers

- Three types 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 dressings (E) → 0, 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20

2. Number of unstageable pressure ulcers due to non-removable dressings (E) → 0, 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20

3. Number of unstageable pressure ulcers due to non-removable dressings (E) → 0, 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20

4. Number of unstageable pressure ulcers due to non-removable dressings (E) → 0, 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20

5. Number of unstageable pressure ulcers due to non-removable dressings (E) → 0, 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20

6. Number of unstageable pressure ulcers due to non-removable dressings (E) → 0, 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20

7. Number of unstageable pressure ulcers due to non-removable dressings (E) → 0, 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20

8. Number of unstageable pressure ulcers due to non-removable dressings (E) → 0, 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20

9. Number of unstageable pressure ulcers due to non-removable dressings (E) → 0, 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20

10. Number of unstageable pressure ulcers due to non-removable dressings (E) → 0, 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20



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M0300E Unstageable Non-Removable Device

- Ulcer covered with eschar under plaster cast
- **Known** but not stageable because of the non-removable device

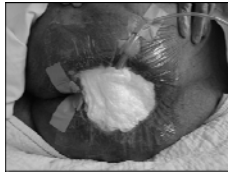


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M0300E Unstageable Non-Removable Dressing

- **Known** but not stageable because of the non-removable dressing

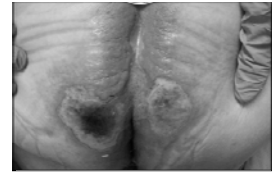


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M0300F Unstageable Slough and/ or Eschar

- **Known** but not stageable related to coverage of wound bed by slough and/ or eschar
- Full thickness tissue loss
- Base of ulcer covered by slough (yellow, tan, gray, green or brown) and/ or eschar (tan, brown or black) in the wound bed

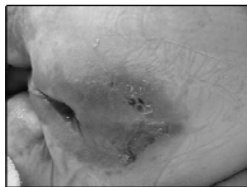


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M0300G Unstageable Suspected Deep Tissue Injury₁

- Localized area of discolored (darker than surrounding tissue) intact skin.
- Related to damage of underlying soft tissue from pressure and/ or shear.
- Area of discoloration may be preceded by tissue that is painful, firm, mushy, boggy, warmer or cooler as compared to adjacent tissue.
- Deep tissue injury may be difficult to detect in individuals with dark skin tones.



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M0300G Unstageable Suspected Deep Tissue Injury₂

- Quality health care begins with prevention and risk assessment.
- 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.



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M0300G Unstageable Suspected Deep Tissue Injury₃

- Clearly document assessment findings in the resident's medical record.
- Track and document appropriate wound care planning and management.
- Deep tissue injuries can indicate severe damage.
- Identification and management is imperative.



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M0300E, M0300F, M0300G Coding Instructions

- Code **number** of each type of pressure ulcer.
- Code number of each type of ulcer **present upon admission/ reentry**.
- Do not code M0300G when a lesion related to pressure presents with an intact blister **and** the surrounding or adjacent soft tissue does **not** have the characteristics of Deep Tissue Injury.
- Code under M0300B Unhealed Pressure Ulcers -- Stage 2.



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M0300E - G Scenario #1

- 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.



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M0300E–G Scenario #1 Coding

- Reclassify as a Stage 4 pressure ulcer.
- On the subsequent MDS:
 - Code M0300D1 Number of Stage 4 pressure ulcers as 1.
 - Code M0300D2 as 1 present on admission.
- After debridement, the pressure ulcer is no longer unstageable because it can be observed to be a Stage 4 pressure ulcer.
- Enter this pressure ulcer's dimensions at M0610 if it has the largest surface area of all Stage 3 or Stage 4 pressure ulcers for this resident.



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M0300E – G Scenario #2

- 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.
- The wound bed is covered with slough.



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M0300E – G Scenario #2 Coding

- Code M0300F1 Number of unstageable pressure ulcers related to coverage of wound bed by slough and/ or eschar as 1.
- Code M0300F2 as 0 not present on admission.
- The pressure ulcer is coded as unstageable due to coverage of the wound bed by slough.
- It is not coded as present on admission because it can no longer be coded as a Stage 2.



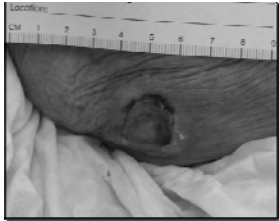
Minimum Data Set (MDS) 3.0 Section M August 2010 72




Pressure Ulcer Staging Quiz

Pressure Ulcer Quiz #1

- Stage 1
- Stage 2
- Stage 3
- Stage 4
- Unstageable - slough or eschar
- Unstageable - sDTI

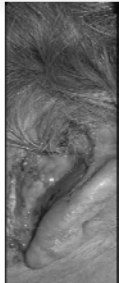


CMS
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Pressure Ulcer Quiz #2

- Stage 1
- Stage 2
- Stage 3
- Stage 4
- Unstageable - slough or eschar
- Unstageable - sDTI

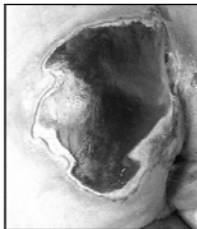


CMS
Minimum Data Set (MDS) 3.0 Section M August 2010 75




Pressure Ulcer Quiz #3

- Stage 1
- Stage 2
- Stage 3
- Stage 4
- Unstageable - slough or eschar
- Unstageable - sDTI

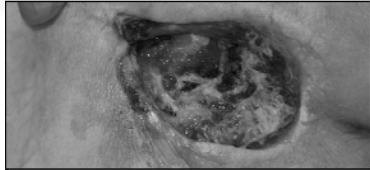


CMS
Minimum Data Set (MDS) 3.0 Section M August 2010 76




Pressure Ulcer Quiz #4

- Stage 1
- Stage 2
- Stage 3
- Stage 4
- Unstageable - slough or eschar
- Unstageable - sDTI




CMS
Minimum Data Set (MDS) 3.0 Section M August 2010 77




Pressure Ulcer Quiz #5

- Stage 1
- Stage 2
- Stage 3
- Stage 4
- Unstageable - slough or eschar
- Unstageable - sDTI






CMS
Minimum Data Set (MDS) 3.0 Section M August 2010 78



Pressure Ulcer Quiz #6


- Stage 1
- Stage 2
- Stage 3
- Stage 4
- Unstageable - slough or eschar
- Unstageable - sDTI





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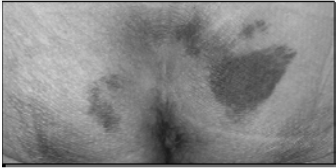
Pressure Ulcer Quiz #7

- Stage 1
- Stage 2
- Stage 3
- Stage 4
- Unstageable - slough or eschar
- Unstageable - sDTI





 Minimum Data Set (MDS) 3.0 Section M August 2010 80 

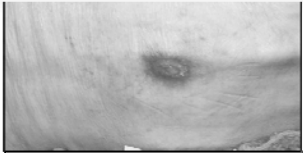
Pressure Ulcer Quiz #8





- Stage 1
- Stage 2
- Stage 3
- Stage 4
- Unstageable - slough or eschar
- Unstageable - sDTI

 Minimum Data Set (MDS) 3.0 Section M August 2010 81 

Pressure Ulcer Quiz #9



- Stage 1
- Stage 2
- Stage 3
- Stage 4
- Unstageable - slough or eschar
- Unstageable - sDTI



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Item M0610

Dimensions of Unhealed Stage 3 or 4 Pressure Ulcers or Unstageable Pressure Ulcer Due to Slough or Eschar

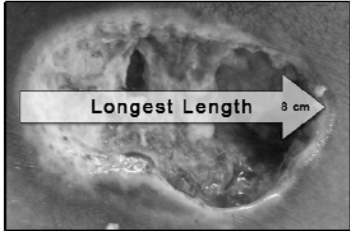
Dimensions of a Pressure Ulcer What to Measure

- Identify pressure ulcer with the largest surface area from the following:
 - o Unhealed (nonepithelialized) Stage 3 or 4
 - o Unstageable pressure ulcer related to slough or eschar
- Measure every Stage 3, Stage 4, and unstageable related to slough or eschar pressure ulcer to determine the largest.

 Minimum Data Set (MDS) 3.0 Section M August 2010 84 

M0610A Length

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



Head

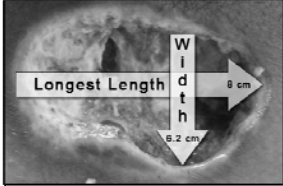
Longest Length 8 cm

Toe

CMS Minimum Data Set (MDS) 3.0 Section M August 2010 85

M0610B Width

- 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.



Head

Longest Length 8 cm

Width 8 cm

Depth 3.7 cm

Toe

CMS Minimum Data Set (MDS) 3.0 Section M August 2010 86

M0610 Coding Instructions

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

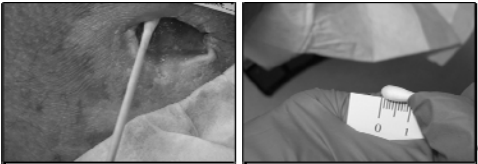
M0610. Dimensions of Unhealed Stage 3 or 4 Pressure Ulcers or Eschar
 Complete only if M0200C1, M0200C2 or M0200C3 is greater than 0.
 If the resident has one or more unhealed (non-epithelialized) Stage 3 or 4 pressure ulcers or an unstageable pressure ulcer due to slough or eschar, identify the pressure ulcer with the longest surface area (length x width) and record as follows:

8	0	cm	A. Pressure ulcer length: Longest length from head to toe
6	2	cm	B. Pressure ulcer width: Widest width of the same pressure ulcer, side-to-side perpendicular (90-degree angle) to length
3	7	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)

CMS Minimum Data Set (MDS) 3.0 Section M August 2010 87

M0610C Depth

- 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.



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Item M0700

Most Severe Tissue Type for Any Pressure Ulcer

M0700 Most Severe Tissue Type for Any Pressure Ulcer

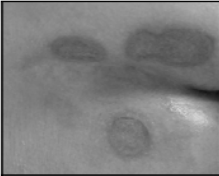
- Determine type(s) of tissue in the wound bed.
- Code for most severe type of tissue present in pressure ulcer wound bed.
- Code for most severe type if wound bed is covered with a mix of different types of tissue.

M0700. Most Severe Tissue Type for Any Pressure Ulcer
 Select the best description of the most severe type of tissue present in any pressure ulcer bed.

<input type="checkbox"/>	<ol style="list-style-type: none"> Epithelial tissue - new skin growing in superficial ulcer. It can be light pink and shiny, seen in persons with darkly pigmented skin. Granulation tissue - pink or red tissue with shiny, moist, granular appearance. Slough - yellow or white tissue that adheres to the ulcer bed in strings or thick clumps, or is mucous. 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.
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CMS Minimum Data Set (MDS) 3.0 Section M August 2010 90

MO700 Epithelial Tissue



Epithelial tissue - new skin growing in superficial ulcer. It can be light pink and shiny, even in persons with darkly pigmented skin.

M0700 - Most Severe Tissue Type for Any Pressure Ulcer

Select the best description of the most severe type of tissue present in any pressure ulcer bed.

Epithelial tissue - new skin growing in superficial ulcer. It can be light pink and shiny, even in persons with darkly pigmented skin.


Granulation tissue - pink or red tissue with shiny, moist, granular appearance.

Slough - yellow or white tissue that adheres to the ulcer bed in strings or thick clumps, or is mucinous.

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.

CMS Minimum Data Set (MDS) 3.0 Section M August 2010 91

MO700 Granulation Tissue



Granulation tissue - pink or red tissue with shiny, moist, granular appearance.

M0700 - Most Severe Tissue Type for Any Pressure Ulcer

Select the best description of the most severe type of tissue present in any pressure ulcer bed.

Epithelial tissue - new skin growing in superficial ulcer. It can be light pink and shiny, even in persons with darkly pigmented skin.

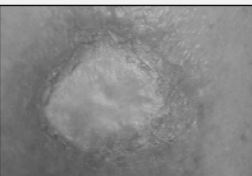
Granulation tissue - pink or red tissue with shiny, moist, granular appearance.

Slough - yellow or white tissue that adheres to the ulcer bed in strings or thick clumps, or is mucinous.

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.

CMS Minimum Data Set (MDS) 3.0 Section M August 2010 92

MO700 Slough



Slough - yellow or white tissue that adheres to the ulcer bed in strings or thick clumps, or is mucinous.

M0700 - Most Severe Tissue Type for Any Pressure Ulcer

Select the best description of the most severe type of tissue present in any pressure ulcer bed.

Epithelial tissue - new skin growing in superficial ulcer. It can be light pink and shiny, even in persons with darkly pigmented skin.

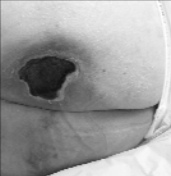
Granulation tissue - pink or red tissue with shiny, moist, granular appearance.

Slough - yellow or white tissue that adheres to the ulcer bed in strings or thick clumps, or is mucinous.

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.

CMS Minimum Data Set (MDS) 3.0 Section M August 2010 93

MO700 Necrotic Tissue (Eschar)



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.

M0700 - Most Severe Tissue Type for Any Pressure Ulcer

Select the best description of the most severe type of tissue present in any pressure ulcer bed.

Epithelial tissue - new skin growing in superficial ulcer. It can be light pink and shiny, even in persons with darkly pigmented skin.

Granulation tissue - pink or red tissue with shiny, moist, granular appearance.

Slough - yellow or white tissue that adheres to the ulcer bed in strings or thick clumps, or is mucinous.

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.

CMS Minimum Data Set (MDS) 3.0 Section M August 2010 94

M0700 Scenario #1

- A resident has a Stage 2 pressure ulcer on the right ischial tuberosity that is healing.
- The resident has 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.

CMS Minimum Data Set (MDS) 3.0 Section M August 2010 95

M0700 Scenario #1 Coding

- Code M0700 Most Severe Tissue Type for Any Pressure Ulcer as **2. Granulation tissue**.
- 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.

CMS Minimum Data Set (MDS) 3.0 Section M August 2010 96

M0700 Scenario #2

- A resident has a pressure ulcer on the left trochanter that has:
 - 25% black necrotic tissue present
 - 75% granulation tissue present
 - Some epithelialization at the edges of the wound



M0700 Scenario #2 Coding

- Code M0700 as **4. Necrotic tissue (Eschar)**.
- Coding is for the most severe tissue type present.
- This is not always the majority of type of tissue.
- Therefore, code M0700 as **4. Necrotic tissue**.



Item M0800

Worsening in Pressure Ulcer Status Since Prior Assessment (OBRA, PPS, or Discharge)

M0800 Assessment Guidelines

- Complete only if this is **not** the first assessment since the most recent admission (A0310E = 0).
- Look-back period is back to the ARD of the prior assessment.

M0800: Worsening in Pressure Ulcer Status Since Prior Assessment (OBRA, PPS, or Discharge)
Complete only if A0310E = 0.
Indicates the number of current pressure ulcers that were not present or were at a lesser stage on prior assessment (OBRA, PPS, or Discharge).
If no current pressure ulcers at a given stage, enter 0.

<input type="checkbox"/>	A. Stage 2
<input type="checkbox"/>	B. Stage 3
<input type="checkbox"/>	C. Stage 4



M0800 Coding Instructions

- Enter the number of pressure ulcers that:
 - Were not present.**OR**
 - Were at a lesser stage on prior assessment.
- Code **0** if:
 - No pressure ulcers have worsened.**OR**
 - There are no new pressure ulcers.



M0800 Scenario #1

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



M0800 Scenario #1 Coding

- Code M800A Stage 2 as **0**.
- Code M800B Stage 3 as **0**.
- Code M800C Stage 4 as **0**.
- The unstageable pressure ulcer was present on the initial MDS assessment.
- After debridement, it was a Stage 4.
- This is the first staging since debridement and should not be counted as worsening on the MDS assessment.



M0800 Scenario #2

- 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:
 - Stage 3 pressure ulcer on the sacrum
 - Stage 4 pressure ulcer on the right heel
 - Stage 2 pressure ulcer on the left trochanter



M0800 Scenario #2 Coding

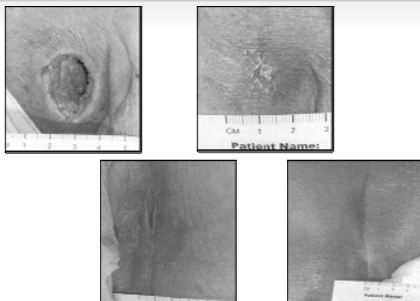
- Code M0800A Stage 2 as **1**.
- Code M0800B Stage 3 as **1**.
- Code M0800C Stage 4 as **1**.
- M0800A is coded **1** because the new Stage 2 pressure ulcer on the left trochanter was not present on the prior assessment.
- M0800B and M0800C are coded **1** for the worsening in pressure ulcer status (i.e. increased severity) of the sacrum and right heel pressure ulcers.



Item M0900

Healed Pressure Ulcers

Healed Pressure Ulcers



M0900 Healed Pressure Ulcers

- Complete only if this is **not** the first assessment since the most recent admission (A0310E=0).

M0900: Healed Pressure Ulcers
 Complete only if A0310E=0

None

A. Were pressure ulcers present on the prior assessment (O88A, PPS, or Discharge)?

No → Skip to M1000: Number of Venous and Arterial Ulcers

Yes → Continue to M0900: Stage 2

Indicate the number of pressure ulcers that were noted on the prior assessment (O88A, PPS, or Discharge) that have completely closed (excisional with epithelialized). If no healed pressure ulcer at a pressure stage since the prior assessment (O88A, PPS, or Discharge), enter 0.

B. Stage 2

None

C. Stage 3

None

D. Stage 4

None




Item M1030

Number of Venous and Arterial Ulcers

M1030 Conduct the Assessment


- Review the medical record.
 - Skin care flow sheet or other skin tracking form
- Speak with direct care staff and treatment nurse.
 - Confirm conclusions from the medical record review.
- Examine the resident.

CMS Minimum Data Set (MDS) 3.0 Section M August 2010 110




Venous Ulcers

- Wound may start due to minor trauma.
- Usual location is lower leg area or medial or lateral malleolus.
- Characterized by:
 - Irregular wound edges
 - Hemosiderin staining
 - Leg edema




CMS Minimum Data Set (MDS) 3.0 Section M August 2010 111




Arterial Ulcers₁

- Wound may start due to minor trauma.
- Usual location:
 - Toes
 - Top of foot
 - Distal to medial malleolus




CMS Minimum Data Set (MDS) 3.0 Section M August 2010 112



Arterial Ulcers₂

- Characterized by:
 - Necrotic tissue or pale pink wound bed
 - Diminished or absent pulses
- Trophic skin changes:
 - Dry skin
 - Loss of hair
 - Brittle nails
 - Muscle atrophy

CMS Minimum Data Set (MDS) 3.0 Section M August 2010 113



M1030 Coding Instructions


- Enter the total number of venous and arterial ulcers present.

M1030. Number of Venous and Arterial Ulcers

Enter Number:

Enter the total number of venous and arterial ulcers present

CMS Minimum Data Set (MDS) 3.0 Section M August 2010 114



Item M1040 & M1200

Other Ulcers, Wounds and Skin Problems

Skin and Ulcer Treatments


M1040/ M1200

Conduct the Assessment

- Review the medical record.
 - Skin care flow sheet or other skin tracking form
 - Treatment records and orders for documented treatments in the look-back period
- Speak with direct care staff and treatment nurse.
 - Confirm conclusions from the medical record review.
- Examine the resident.
 - Determine if ulcers, wounds, or skin problems are present.
 - Observe skin treatments.

CMS Minimum Data Set (MDS) 3.0 Section M August 2010 116

M1040B Diabetic Foot Ulcers



B. Diabetic foot ulcer(s)

M1040. Other Ulcers, Wounds and Skin Problems

Check all that apply

Foot Problems


- A. Infection of the foot (e.g., cellulitis, purulent drainage)
- B. Diabetic foot ulcer(s)
- C. Other open lesion(s) on the foot

Other Problems

- D. Open lesion(s) other than ulcers, rashes, cuts (e.g., cancer lesion)

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M1040D Open Lesions Other than Ulcers, Rashes, Cuts



D. Open lesion(s) other than ulcers, rashes, cuts (e.g., cancer lesion)

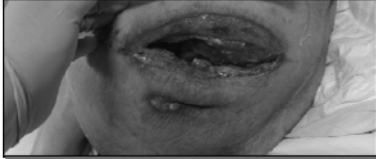
C. Other open lesion(s) on the foot

Other Problems

- D. Open lesion(s) other than ulcers, rashes, cuts (e.g., cancer lesion)
- E. Surgical wound(s)
- F. Burn(s) (second or third degree)

CMS Minimum Data Set (MDS) 3.0 Section M August 2010 118

M1040E Surgical Wounds



Failed Flap

E. Surgical wound(s)


C. Other open lesion(s) on the foot

Other Problems

- D. Open lesion(s) other than ulcers, rashes, cuts (e.g., cancer lesion)
- E. Surgical wound(s)
- F. Burn(s) (second or third degree)

CMS Minimum Data Set (MDS) 3.0 Section M August 2010 119

M1040F Burns



F. Burn(s) (second or third degree)

C. Other open lesion(s) on the foot

Other Problems

- D. Open lesion(s) other than ulcers, rashes, cuts (e.g., cancer lesion)
- E. Surgical wound(s)
- F. Burn(s) (second or third degree)
- None of the Above
- Z. None of the above ever present

CMS Minimum Data Set (MDS) 3.0 Section M August 2010 120

M1200 Skin and Ulcer Treatments₁

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. 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



Minimum Data Set (MDS) 3.0 Section M August 2010 121



M1200 Skin and Ulcer Treatments₂

- Pressure-relieving devices do not include:
 - o Egg crate cushions of any type
 - o Doughnut or ring devices in chairs
- Turning/ repositioning program
 - o Specific approaches for changing resident's position and realigning the body
 - o Program should specify intervention and frequency
- Nutrition and hydration
 - o High calorie diets with added supplements to prevent skin breakdown
 - o High protein supplements for wound healing



Minimum Data Set (MDS) 3.0 Section M August 2010 122



M1200E Ulcer Care

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. 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



Minimum Data Set (MDS) 3.0 Section M August 2010 123



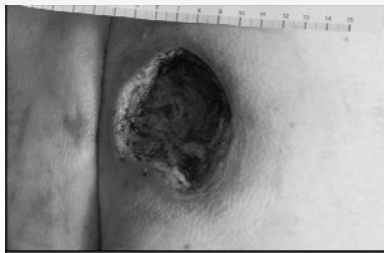
Initial Presentation Then Went for Surgical Debridement



Minimum Data Set (MDS) 3.0 Section M August 2010 124



Debrided Surgically

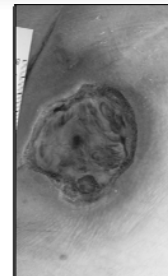


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Slough Returned After Surgical Debridement

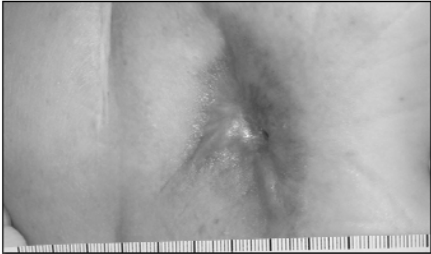
- Used enzyme for maintenance debridement.
- Used Negative Pressure Wound Therapy (NPWT).





Minimum Data Set (MDS) 3.0 Section M August 2010 126





Closed after 6 Months



 Minimum Data Set (MDS) 3.0 Section M August 2010 127 



M1040 Scenario #1

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

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M1040 Scenario #1 Coding

- This ulcer is not checked at M1040B.
- **This ulcer should be coded where appropriate under the Pressure Ulcer items (M0210-M0900).**
- Persons with diabetes can still develop pressure ulcers.

 Minimum Data Set (MDS) 3.0 Section M August 2010 129 



M1040 Scenario #2

- A resident is readmitted from the hospital after flap surgery to repair a sacral pressure ulcer.

 Minimum Data Set (MDS) 3.0 Section M August 2010 130 



M1040 Scenario #2 Coding

- Check M1040E. Surgical Wound(s).
- A surgical flap procedure to repair pressure ulcers changes the coding to a surgical wound.

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M1200 Scenario #1

- 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.

 Minimum Data Set (MDS) 3.0 Section M August 2010 132 

M1200 Scenario #1 Coding

- Check items:
 - M1200A Pressure reducing device for chair
 - M1200B Pressure reducing device for bed
 - M1200G Application of nonsurgical dressings
- Treatments include pressure reducing (redistribution) mattress and pad in the wheelchair and application of the compression bandaging system.



M1200 Scenario #2

- 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.



M1200 Scenario #2 Coding

- Do **not** check item M1200C. Turning/ Repositioning Program.
- 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.



Acknowledgements

- Photos provided by:
 - Jane Fore MD, FAPWCA, FACCWS
 - Stanley K. McCallon, PT, DPT
 - Dot Weir RN, CWON, CWS
 - Cindy Labish, RN, MS, CWOCN



Section M Scenario

Section M Scenario Instructions

- Turn to Section M in the MDS 3.0 item set.
- Review the Section M scenario.
- Code the MDS for the three assessments in the scenario:
 - Admission assessment
 - Quarterly #1 assessment
 - Quarterly #2 assessment

