Inpatient Rehabilitation Facilities
Quality Reporting Program Provider Training

Section M:
Skin Conditions

Ann Spenard, M.S.N., R.N.-BC

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Today's Presenter

Ann Spenard, M.S.N., R.N.-BC

Vice President and Principal

Qualidigm

INPATIENT REHABILITATION FACILITIES

POST-ACUTE CARE PROGRAM

Section M: Objectives

- Illustrate a working knowledge of Section M: Skin Conditions.
- Articulate the intent of Section M.
- Articulate the updates made to Section M in the IRF-PAI v1.4.

Section M: Objectives (cont.)

- Complete the new item: **M0800,** Worsening in Pressure Ulcer Status Since Admission.
- Interpret the coding options for each item and when they would be applied.
- Apply coding instructions in order to accurately code practice scenarios.

Section M: New Item

New Item:	Assessed On:
M0800, Worsening in Pressure Ulcer Status Since Admission	Discharge

Section M: Existing Items

Existing Items:	Assessed On:
M0210, Unhealed Pressure Ulcer(s)	Admission & Discharge
M0300, Current Number of Unhealed Pressure Ulcers at Each Stage	Admission & Discharge
M0900, Healed Pressure Ulcer(s)	Discharge

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Section M: Intent

Document the presence, appearance, and change of pressure ulcers.

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.

Section M: Overarching Principles

- Staging definitions are adapted from 2007 National Pressure Ulcer Advisory Panel (NPUAP) staging definitions.
- IRF-PAI does not preclude IRFs from providing complete and ongoing skin assessment using accepted clinical practice and guidelines.
- Identify and evaluate risk, and determine the etiology of all skin ulcers, wounds, and lesions to ensure appropriate treatment.

M0210

Unhealed Pressure Ulcer(s)

M0210 Item Rationale

- Pressure ulcer definitions are adapted from 2007 NPUAP staging definitions.
- Pressure ulcers occur when:
  - Tissue is compressed between a bony prominence and an external surface.
  - Shear force and friction are added to pressure.
- Soft tissue health can impact and increase vulnerability to pressure ulcers.
  - Aging.
  - Illness.
  - Small Blood Vessel Disease.
  - Malnutrition.

M0210 Item Rationale (cont.)

- Pressure ulcer risks:
  - External factors: excess moisture and tissue exposure to urine or feces.
  - Existing pressure ulcer.
- Quality-of-life impact:
  - Limits activity.
  - Pain.
  - Time-consuming treatments and dressing changes.
  - Risk of infection and sepsis.
- “Healed” refers to “closed” and “unhealed” refers to “open.”
  - Used throughout Section M.
  - Stage 1 exception, closed but not considered healed:
    - Suspected Deep Tissue Injury (sDTI).
    - Unstageable pressure ulcers.

M0210 Item Rationale (cont.)

- IRFs must code the IRF-PAI according to manual instructions.
  - Do not use the NPUAP definitions to code the IRF-PAI.
- Code the admission IRF-PAI assessment in terms of what is assessed as close to admission as possible.
  - Numerical staging of pressure ulcers.
  - Initial numerical staging of ulcers after debridement.
  - sDTI.
- Pressure ulcer staging.
  - Description/classification of anatomic depth of soft tissue damage.
  - Visible or palpable tissue damage in the ulcer bed.
  - Informs expectations for healing times.

M0210 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 or wound care specialist to:

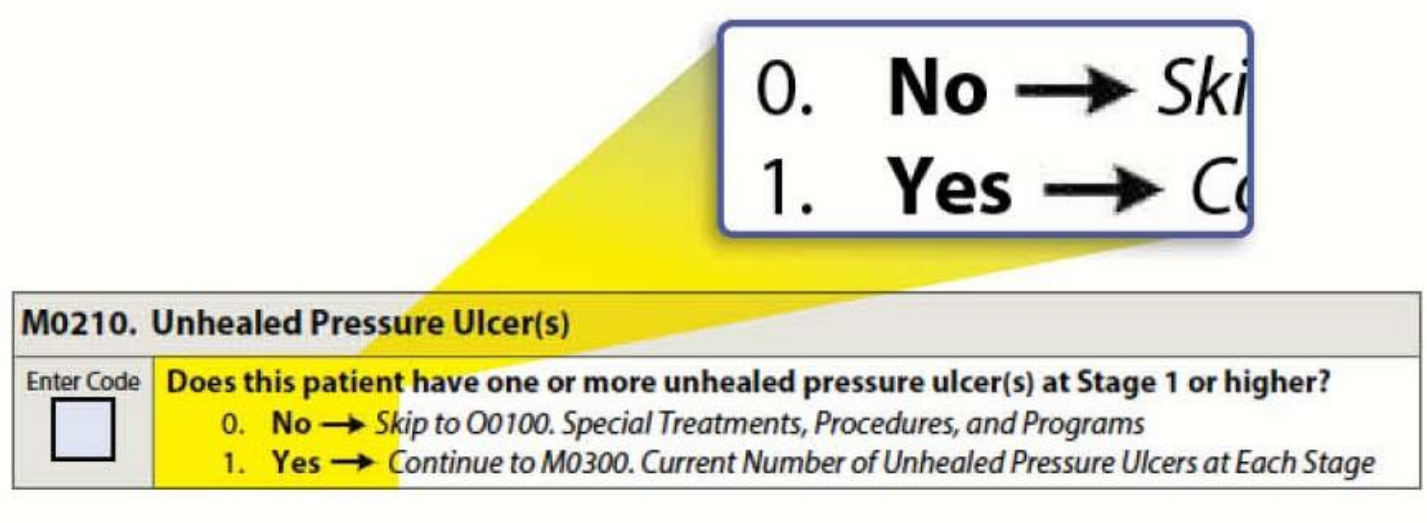
   - Confirm conclusions.
   - Clarify any questions from the medical record review.

M0210 Steps for Assessment (cont.)

3. Conduct a full-body assessment of the patient and determine whether any skin ulcers are present.
   - Assess high-risk areas for pressure ulcer development.
   - Examine the patient in a well-lit room.
   - For any pressure ulcers identified, measure and record the deepest anatomical stage.
4. Identify any known or likely unstageable pressure ulcers.

M0210 Coding Instructions

- **Code 0, No,** if the patient did not have a pressure ulcer in the 3-day assessment period.
- **Code 1, Yes,** if the patient had any pressure ulcer (Stage 1, 2, 3, 4, or unstageable) in the 3-day assessment period.



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M0210 Coding Tips

- If primary cause of an ulcer is pressure, then the ulcer should be included in this section as a pressure ulcer.
- Terminal illness or end-of-life skin ulcers (also known as Kennedy ulcers) should be assessed and staged, but not coded as a pressure ulcer.
- Mucosal ulcers should not be coded on the IRF-PAI.

M0210 Coding Tips (cont.)

- Do not code surgically closed pressure ulcers (flap or graph), healed or unhealed, as a pressure ulcer on the IRF-PAI.
  - Code as a surgical wound.
- For the Discharge Assessment, if a pressure ulcer healed and was not present on the Admission Assessment, **code as 0** on the Discharge Assessment.

M0210 Coding Tips (cont.)

- Consider primary etiology of ulcers with patients with diabetes mellitus (DM).
  - Was ulcer caused by pressure or other factors?
  - Example: If a patient with DM has a heel ulcer from pressure and the ulcer is present during the initial skin assessment that takes place following admission to the IRF, **code as 1.**
  - Example: If a patient with DM has an ulcer on the plantar (bottom) surface of the foot closer to the metatarsals and the ulcer is present in the 3-day assessment period, **code as 0.** It is not likely that pressure is the primary cause of the patient's ulcer when the ulcer is in this location.

M0300

Current Number of Unhealed Pressure Ulcers at Each Stage

Section M: Definitions

STAGE 1 PRESSURE ULCER:

An observable, pressure-related alteration of intact skin whose indicators, as compared with 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.

Section M: Definitions (cont.)

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.

Section M: Definitions (cont.)

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.

Section M: Definitions (cont.)

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.

Section M: Definitions (cont.)

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 than adjacent tissue.

Section M: Definitions (cont.)

SLOUGH TISSUE: Nonviable 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.

Section M: Definitions (cont.)

ON ADMISSION: As close to the actual time of admission as possible.

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

Section M: Definitions (cont.)

TUNNELING: A passageway 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.

Section M: Definitions (cont.)

ON-REMOVABLE DRESSING/DEVICE: Includes, for example, a primary surgical dressing that cannot be removed, an orthopedic device, or cast.

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

Steps for Completing M0300A–G

1. Determine Deepest Anatomical Stage.
2. Identify Unstageable Pressure Ulcers.
3. Determine “Present on Admission.”

For detailed instructions, refer to the IRF-PAI Program Manual, pages M-4 to M-6.

M0300A1–G1: Current Number of Unhealed Pressure Ulcers at Each Stage (Admission)

M0300. Current Number of Unhealed Pressure Ulcers at Each Stage	
Enter Number ☐	**A. 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. **Number of Stage 1 pressure ulcers**
Enter Number ☐	**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**
Enter Number ☐	**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. **1. Number of Stage 3 pressure ulcers**
Enter Number ☐	**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**
Enter Number ☐	**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**
Enter Number ☐	**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**
Enter Number ☐	**G. Unstageable - Deep tissue injury:** Suspected deep tissue injury in evolution **1. Number of unstageable pressure ulcers with suspected deep tissue injury in evolution**

M0300A1–G1 Coding Instructions

- Complete on Admission and Discharge Assessments.
- **Enter the number** of pressure ulcers that are currently present.
- **Enter 0** if no pressure ulcers are present.

M0300A2–G2: Current Number of Unhealed Pressure Ulcers at Each Stage (Discharge)

M0300. Current Number of Unhealed Pressure Ulcers at Each Stage	
Enter Number ☐	**A. 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. **Number of Stage 1 pressure ulcers**
Enter Number ☐ Enter Number ☐	**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 <u>these</u> Stage 2 pressure ulcers that were present upon admission** - enter how many were noted at the time of admission
Enter Number ☐ Enter Number ☐	**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. **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** - enter how many were noted at the time of admission

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M0300A2–G2: Current Number of Unhealed Pressure Ulcers at Each Stage (Discharge) (cont.)

M0300. Current Number of Unhealed Pressure Ulcers at Each Stage - Continued	
Enter Number ☐ Enter Number ☐	**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 <u>these</u> Stage 4 pressure ulcers that were present upon admission** - enter how many were noted at the time of admission
Enter Number ☐ Enter Number ☐	**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** - enter how many were noted at the time of admission
Enter Number ☐ Enter Number ☐	**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 injury* 2. **Number of <u>these</u> unstageable pressure ulcers that were present upon admission** - enter how many were noted at the time of admission
Enter Number ☐ Enter Number ☐	**G. Unstageable - Deep tissue injury:** Suspected deep tissue injury in evolution 1. **Number of unstageable pressure ulcers with suspected deep tissue injury in evolution** *If 0 → Skip to M0800. Worsening in Pressure Ulcer Status Since Admission* 2. **Number of <u>these</u> unstageable pressure ulcers that were present upon admission** - enter how many were noted at the time of admission

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M0300B2–G2 Coding Instructions

- Complete at the time of discharge.
- **Enter the number** of pressure ulcers that were present on admission (see instructions starting on M-5 under Steps for Completing M0300A–G, Step 3: Determine “Present on Admission”).
- **Enter 0** if no pressure ulcers were noted at the time of admission.

M0300 Coding Scenario (1)

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

How would you code M0300?

Item	Admission Assessment	Discharge Assessment
M0300B1, Number of Stage 2 pressure ulcers		
M0300B2, Number of these Stage 2 pressure ulcers present upon admission		
M0300C1, Number of Stage 3 pressure ulcers		
M0300C2, Number of these Stage 3 pressure ulcers present upon admission		

M0300 Coding Scenario (2)

- A patient enters the IRF with a Stage 2 pressure ulcer.
- On day two of the patient's stay, the wound is reassessed as a Stage 3 pressure ulcer.
- The wound does not heal by the time of discharge, two weeks later.

How would you code M0300?

Item	Admission Assessment	Discharge Assessment
M0300B1, Number of Stage 2 pressure ulcers		
M0300B2, Number of these Stage 2 pressure ulcers present upon admission		
M0300C1, Number of Stage 3 pressure ulcers		
M0300C2, Number of these Stage 3 pressure ulcers present upon admission		

M0300 Coding Scenario (3)

- A patient develops a Stage 2 pressure ulcer while at the IRF.
- The patient is transferred to a short-stay acute-care hospital because of pneumonia.
- The patient returns to the IRF after four days and returns with a Stage 3 pressure ulcer in the same anatomical location.

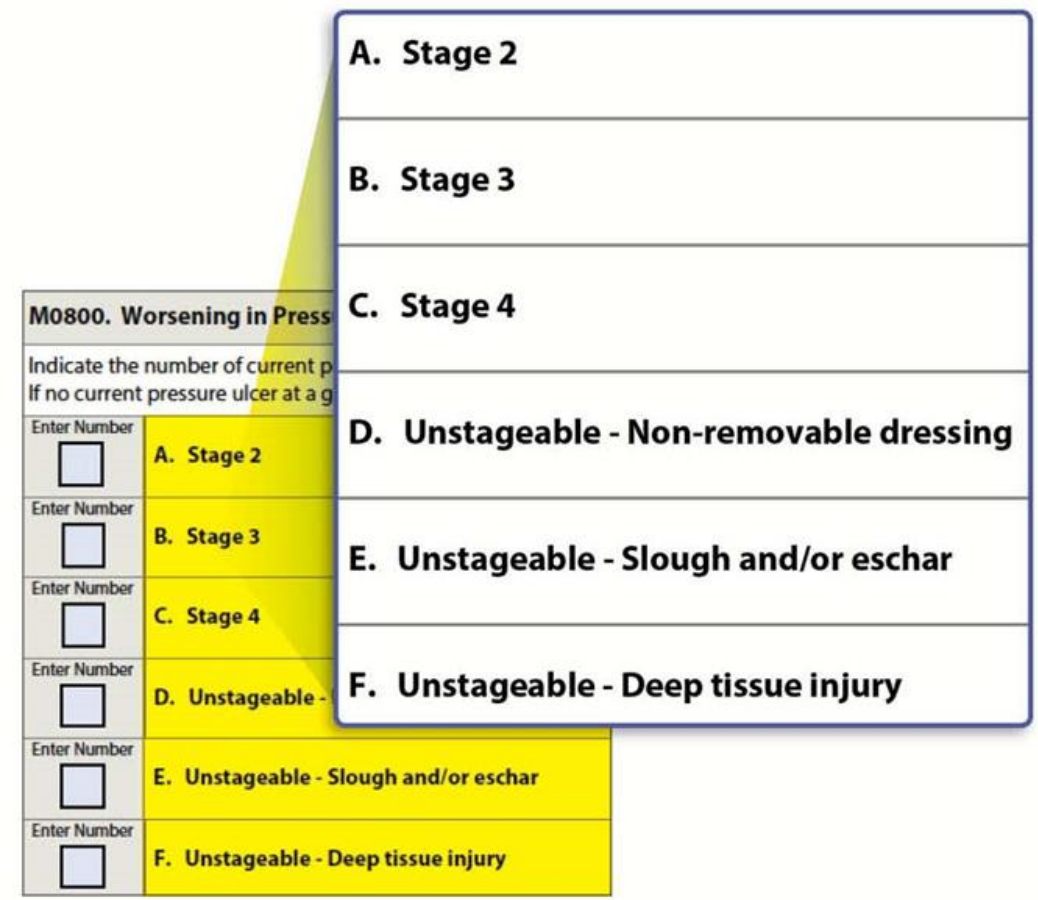
How would you code M0300?

Item	Admission Assessment #1	Discharge Assessment #1	Admission Assessment #2
M0300B1, Number of Stage 2 pressure ulcers			
M0300B2, Number of these Stage 2 pressure ulcers present upon admission			
M0300C1, Number of Stage 3 pressure ulcers			
M0300C2, Number of these Stage 3 pressure ulcers present upon admission			

M0800

Worsening in Pressure Ulcer Status Since Admission

M0800. Worsening in Pressure Ulcer Status Since Admission



Section M: Definitions

WORSENING IN PRESSURE ULCER STATUS:

- Pressure ulcer that has progressed to a deeper level of tissue damage.
- Staged at a higher number using the numerical scale of 1–4, increasing in severity to reflect progression.
- Discharge Assessment as compared to the Admission Assessment.
- Absence of a pressure ulcer, skin breakdown, or damage is scored with 0.

M0800 Item Rationale

- Documents whether skin status, overall, has worsened since the Admission Assessment.
  - Number of new pressure ulcers.
  - Whether any pressure ulcers have increased in numerical stage.
- Pressure ulcer tracking is consistent with good clinical care.
- Reevaluation of the interdisciplinary care plan:
  - To ensure adherence to the appropriate preventative measures.
  - To apply pressure ulcer management principles when new pressure ulcers develop and/or worsen.

M0800 Steps for Assessment

1. Complete at the time of discharge based on pressure ulcer coding at the time of admission.
2. For each current Stage 2–4 and unstageable pressure ulcer, determine those that were not present or have worsened since admission.
   - Review the history of each.
   - Compare the number and status of pressure ulcers as documented on the Admission Assessment with the number and status of current pressure ulcers at discharge.

M0800 Coding Instructions

- **Enter the number** of Stage 2–4 or unstageable pressure ulcers:
  - Not present (i.e., are new) *or* were at a lesser stage as documented on the Admission Assessment.
  - Compared with the number that are present on discharge.
- **Enter 0** if there are no current Stage 2–4 or unstageable pressure ulcers on discharge.

M0800 Coding Tips

- Document and follow pressure ulcer status on a routine basis throughout the IRF stay.
- Code as worsened and count on the Discharge Assessment:
  - Pressure ulcer that increases in numerical stage from admission to discharge.
  - Stage 1 or 2 pressure ulcer that further deteriorates and becomes unstageable due to slough or eschar.
  - Previously numerically staged pressure ulcer that becomes unstageable and is debrided sufficiently to be numerically restaged *by discharge,* and the pressure ulcer stage has increased.

M0800 Coding Tips (cont.)

- Do not code as worsened:
  - If a previous Stage 3 or 4 pressure ulcer is unstageable due to slough or eschar on discharge.
  - If a pressure ulcer was unstageable on admission and is able to be numerically staged only at discharge:
    - Code the appropriate stage in M0300.
    - It is first time that the pressure ulcer was able to be numerically staged.
  - If two pressure ulcers merge with increased surface area but the numerical staging has not increased.

M0800 Coding Tips (cont.)

- The following guidance is provided regarding pressure ulcers present on admission (POA) that were numerically staged, become unstageable, are debrided, and subsequently become numerically restageable:
  - If a numerically staged pressure ulcer that was POA becomes unstageable during the stay (i.e., cannot be numerically staged), is debrided, and after debridement is able to be restaged numerically, and the reassessed stage is higher than the previous numerical stage, the pressure ulcer is considered to have worsened and is no longer considered POA.

M0800 Coding Tips (cont.)

- However, if a numerically staged pressure ulcer that was POA becomes unstageable (i.e., cannot be numerically staged), is debrided, and after debridement is able to be restaged numerically, and the reassessed stage is the same as the previous numerical stage, the pressure ulcer is considered ***not worsened*** and is still considered POA.

M0800 Coding Tips (cont.)

- If an unstageable pressure ulcer that was POA is debrided and is subsequently able to be numerically staged, the pressure ulcer is to be considered ***not worsened*** and POA because this would be the first time the pressure ulcer was able to be numerically staged. If, subsequent to this numerical staging, the pressure ulcer further deteriorates and is restaged at a higher numerical stage, the pressure ulcer would be considered worsened and not POA.

M0800 Coding Scenario (1)

- A patient develops a Stage 3 pressure ulcer while at the IRF.
- The wound bed is subsequently covered with slough; hence, the pressure ulcer becomes unstageable.
- At the time of discharge from the IRF, patient records note that wound debridement was performed on the Stage 3 pressure ulcer.
- After debridement, the wound bed was reassessed and numerically staged as a Stage 3.

How would you code M0800?

Item	Admission Assessment	Discharge Assessment
M0300C1, Number of Stage 3 pressure ulcers		
M0300C2, Number of these Stage 3 pressure ulcers that were present upon admission		
M0800A, Worsening in Pressure Ulcer Status Since Admission – Stage 2		
M0800B, Worsening in Pressure Ulcer Status Since Admission – Stage 3		
M0800C, Worsening in Pressure Ulcer Status Since Admission – Stage 4		
M0800D, Worsening in Pressure Ulcer Status Since Admission – Unstageable - Non-removable dressing		
M0800E, Worsening in Pressure Ulcer Status Since Admission – Unstageable - Slough and/or Eschar		
M0800F, Worsening in Pressure Ulcer Status Since Admission – Unstageable - Deep tissue injury		

M0800 Coding Scenario (2)

- A patient was admitted to the IRF from the acute-care hospital with two Stage 2 pressure ulcers, one on each heel.
- After two days, the left heel Stage 2 blister had ruptured and presented as a shallow ulcer with a pink wound bed. The right heel continued to evolve, having a blood-filled blister, and matured in color from red to a maroon/purple color with the area surrounding the blister being boggy, painful, and warm.
- After discussion with the family, and approval by the patient, they decided to care for the patient at home with home care services and asked to be discharged from the IRF against medical advice.

How would you code M0800?

Item	Admission Assessment	Discharge Assessment
M0300B1, Number of Stage 2 pressure ulcers		
M0300B2, Number of these Stage 2 pressure ulcers present upon admission		
M0800A, Worsening in Pressure Ulcer Status Since Admission – Stage 2		
M0800B, Worsening in Pressure Ulcer Status Since Admission – Stage 3		
M0800C, Worsening in Pressure Ulcer Status Since Admission – Stage 4		
M0800D, Worsening in Pressure Ulcer Status Since Admission – Unstageable - Non-removable dressing		
M0800E, Worsening in Pressure Ulcer Status Since Admission – Unstageable - Slough and/or Eschar		
M0800F, Worsening in Pressure Ulcer Status Since Admission – Unstageable - Deep tissue injury		

M0800 Coding Scenario (3)

- A patient is admitted to an IRF with two Stage 2 pressure ulcers.
- By the time of discharge, the two pressure ulcers had merged and increased in numerical stage to Stage 3.

How would you code M0800?

Item	Admission Assessment	Discharge Assessment
M0300B1, Number of Stage 2 pressure ulcers		
M0300B2, Number of these Stage 2 pressure ulcers present upon admission		
M0300C1, Number of Stage 3 pressure ulcers		
M0300C2, Number of these Stage 3 pressure ulcers present upon admission		
M0800A, Worsening in Pressure Ulcer Status Since Admission – Stage 2		
M0800B, Worsening in Pressure Ulcer Status Since Admission – Stage 3		
M0800C, Worsening in Pressure Ulcer Status Since Admission – Stage 4		
M0800D, Worsening in Pressure Ulcer Status Since Admission – Unstageable - Non-removable dressing		
M0800E, Worsening in Pressure Ulcer Status Since Admission – Unstageable - Slough and/or Eschar		
M0800F, Worsening in Pressure Ulcer Status Since Admission – Unstageable - Deep tissue injury		

M0900

Healed Pressure Ulcer(s)

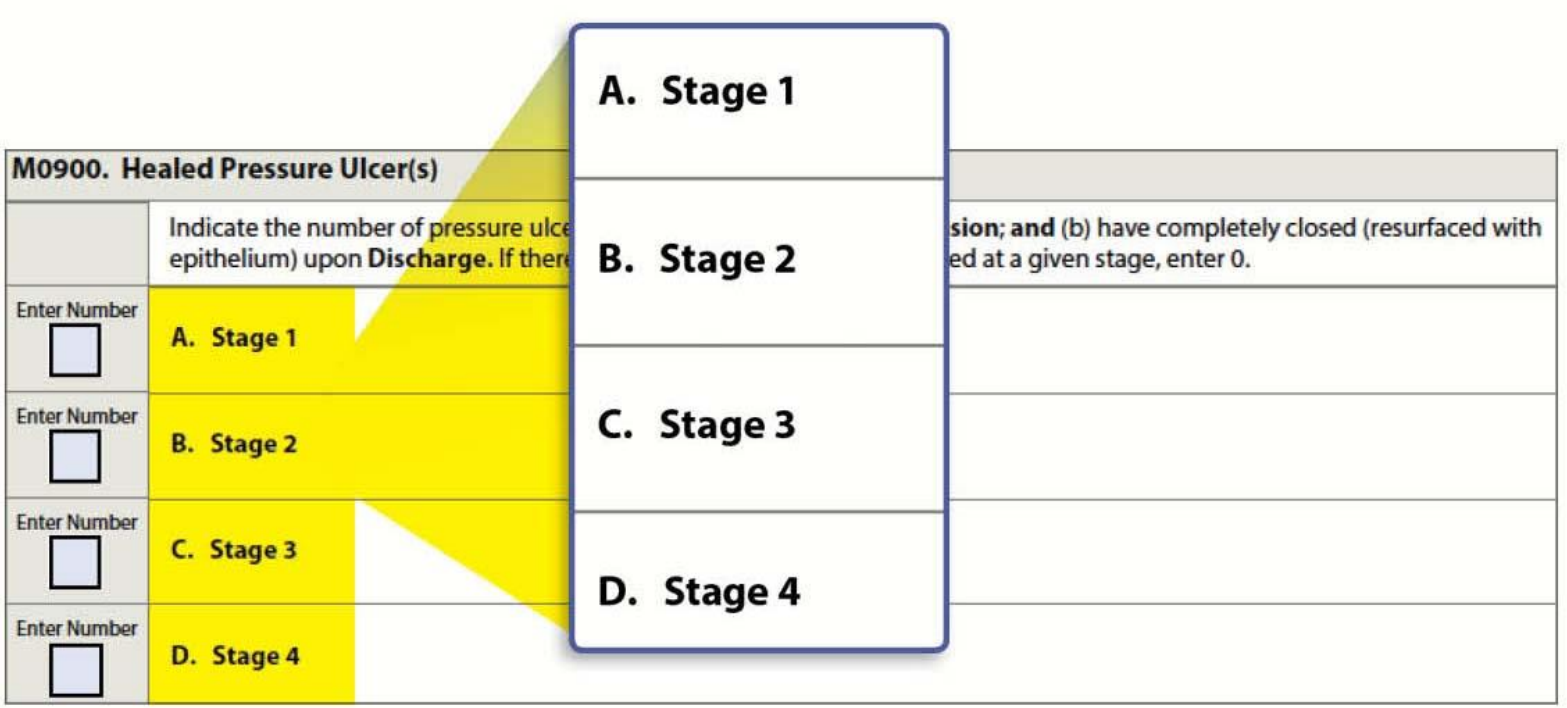
M0900 Item Rationale

- Documents the number of pressure ulcers that were present on admission and have healed by discharge.

M0900A–D Coding Instructions

- Complete on Discharge Assessment.
- For each stage, **enter the number** of pressure ulcers that:
  - Were present on admission.
  - Have completely healed/closed upon discharge.
- **Enter 0** if no admission pressure ulcers have healed by discharge.

M0900A–D Coding Instructions (cont.)



M0900. Healed Pressure Ulcer(s)		
	Indicate the number of pressure ulce epithelium) upon **Discharge.** If there	**sion; and** (b) have completely closed (resurfaced with ed at a given stage, enter 0.
Enter Number ☐	A. Stage 1	
Enter Number ☐	B. Stage 2	
Enter Number ☐	C. Stage 3	
Enter Number ☐	D. Stage 4	

A. Stage 1

B. Stage 2

C. Stage 3

D. Stage 4

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M0900 Coding Tips

- If an sDTI is identified as present on admission, opens to an ulcer during the IRF stay, and heals prior to discharge, it is documented in Item **M0900,** Healed Pressure Ulcers – Discharge, as the highest stage it was prior to its healing.

Section M: Summary

- Section M documents the presence, appearance, and change of pressure ulcers.
- Keep the overarching principles in mind when completing Section M.
- M0800 is a new item coded on the Discharge Assessment.

Section M: Action Plan

- Revise processes to ensure tracking of all pressure ulcers and changes in pressure ulcer status in the patient record.
- Review current way you are capturing “Present on Admission” pressure ulcers and compare it to how these ulcers are captured on the new IRF-PAI v1.4.
- Be sure to add unstageable pressure ulcers to your tracking of new and/or worsened pressure ulcers.
- Practice coding a variety of scenarios with staff.

Questions?