SECTION M: SKIN CONDITIONS

Intent: The items in this section of the LTCH CARE Data Set document the presence, appearance, and change of pressure ulcers. If warranted by additional quality measures finalized by CMS for the LTCH Quality Reporting Program through future rule-making cycles, CMS may add additional items to this section to address other skin ulcers, wounds, or lesions and to document treatment categories related to skin injury or avoiding skin injury.

CMS recognizes that, in addition to the items included in this section of the LTCH CARE data Set, a complete and ongoing assessment of patient's skin guided by clinical standards is essential to an effective pressure ulcer prevention and skin management program for all patients. Therefore, completion of this section does not replace a thorough assessment of each patient's risk factors for developing skin ulcers, wounds, or lesions. It is imperative to identify and evaluate all areas at-risk of constant pressure and to determine the etiology of all skin ulcers, wounds and lesions. This should determine and direct the proper treatment and appropriate skin management interventions for all patients in the LTCHs.

M0210: Unhealed Pressure Ulcer(s)

M0210. Unhealed Pressure Ulcer(s)	
Enter Code ☐	**Does this patient have one or more unhealed pressure ulcer(s) at Stage 1 or higher?** 0. **No** → *Skip to Z0400, Signature of Persons Completing the Assessment* 1. **Yes** → *Continue to M0300, Current Number of Unhealed Pressure Ulcers at Each Stage*

Item Rationale

- The pressure ulcer definitions used in the CMS LTCH Quality Reporting Program Manual have been adapted from those recommended by the National Pressure Ulcer Advisory Panel (NPUAP) 2007 Pressure Ulcer Stages.
- Pressure ulcers occur when tissue is compressed between a bony prominence and an external surface. In addition to pressure, shear force, and friction are important contributors to pressure ulcer development.
- The underlying health of a patient's soft tissue affects how much pressure, shear force, or friction is needed to damage tissue. Skin and soft tissue changes associated with aging, illness, small blood vessel disease, and malnutrition increase vulnerability to pressure ulcers.
- Additional external factors, such as excess moisture, and tissue exposure to urine or feces, can increase risk.
- An existing pressure ulcer identifies patients at risk for further complications or skin injury.

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.

- Pressure ulcers and other wounds or lesions affect quality of life for patients because they may limit activity, be painful, require time-consuming treatments and dressing changes and can pose a risk of infection and sepsis.
- Throughout this Chapter 3: LTCH CARE Data Set [Section M], terminology referring to "healed" vs. "unhealed" ulcers refers to whether or not the ulcer is "closed" vs. "open." When considering this, recognize that Stage 1, Suspected Deep Tissue Injury (sDTI), and unstageable pressure ulcers although "closed," (i.e. may be covered with tissue, eschar, slough, etc.) would not be considered "healed."
- LTCHs may adopt the NPUAP guidelines in their clinical practice and documentation. However, because CMS has adapted the NPUAP guidelines for LTCH CARE Data Set purposes, the definitions do not perfectly correlate with each stage as described by the NPUAP. Therefore, LTCHs cannot use the NPUAP definitions to code the LTCH CARE Data Set. You must code the LTCH CARE Data Set according to the instructions in this manual.
- For LTCH CARE Data Set assessment, initial numerical staging of pressure ulcers and the initial numerical staging of ulcers after debridement, or sDTI that declares itself, should be coded in terms of what is assessed (seen and palpated, i.e. visible tissue, palpable bone) during the 3-day assessment period.
- Pressure ulcer staging provides a description of the extent of visible tissue damage or palpable bone and informs expectations for healing times.

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 from the medical record review.
3. Examine the patient and determine whether any ulcers are present.
   - Key areas for pressure ulcer development include sacrum, coccyx, trochanters, ischial tuberosities, and heels. Other areas, such as bony deformities, skin under braces, and skin subjected to excess pressure, shear or friction, are also at risk for pressure ulcers.
   - Without a full body skin assessment, a pressure ulcer can be missed.
   - Examine the patient in a well-lit room. Adequate lighting is important for detecting skin changes.
   - For any pressure ulcers identified, measure and record the deepest anatomical stage.
4. Identify any known or likely unstageable pressure ulcers.

Coding Instructions

Code based on the presence of any pressure ulcer (regardless of stage) in the past 3 days.

- Code 0, no: if the patient did not have a pressure ulcer in the 3-day assessment period. Then, skip items M0300–M0800 and proceed to **Z0400**, **Signature of Persons Completing the Assessment**.

- Code 1, yes: if the patient had any pressure ulcer (Stage 1, 2, 3, 4, or unstageable) in the 3-day assessment period. Continue to **M0300, Current Number of Unhealed Pressure Ulcers at Each Stage**.

Coding Tips

- If an ulcer arises from a combination of factors that are primarily caused by pressure, then the ulcer should be included in this section as a pressure ulcer.
- If a pressure ulcer is surgically repaired with a flap or graft, it should be considered a surgical wound and not a pressure ulcer. If the flap or graft fails, it should be considered a surgical wound until healed. It should not be reported as a pressure ulcer on the LTCH CARE Data Set.
- For the admission assessment, if a pressure ulcer healed during the 3-day assessment period, then **code 0** on the admission assessment.
- For the discharge assessment, if a pressure ulcer healed during the 3-day assessment period and was *not* present on the admission assessment, **code 0** on the discharge assessment.
- Patients with diabetes mellitus (DM) can have a pressure, venous, arterial, or diabetic neuropathic ulcer. The primary etiology should be considered when coding whether the diabetic has an ulcer that is caused by pressure or other factors.
  - — Example: If a patient with DM has a heel ulcer from pressure and the ulcer is present in the 3-day assessment period, **code 1** and proceed to code **M0300, Current Number of Unhealed Pressure Ulcers at Each Stage.**
  - — 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 0**. The primary cause of the patient's ulcer is not likely pressure when the ulcer is in this location.

M0300: Current Number of Unhealed Pressure Ulcers at Each Stage

Steps for completing M0300A–G

Step 1: Determine Deepest Anatomical Stage

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

1. Observe the base of any pressure ulcers present to determine the depth of tissue layers involved.
2. Ulcer staging should be based on the ulcer's deepest visible anatomical level. Review the history of each pressure ulcer in the medical record. If the pressure ulcer has ever been classified at a deeper stage than what is observed now, it should continue to be classified at the deeper stage (i.e., do not reverse or back stage). LTCHs that carefully document and track ulcers will be able to code this item more accurately.

Step 2: Identify Unstageable Pressure Ulcers

1. Visualization of the wound bed is necessary for accurate staging. However, if the wound bed is partially covered by eschar (tan, black, or brown) or slough (yellow, tan, gray, green, or brown), but the depth of tissue loss can be measured, do not code as unstageable.
2. Pressure ulcers that have eschar or slough tissue present such that the tissue layers involved with the pressure ulcer cannot be determined should be classified as unstageable, as illustrated at http://www.npuap.org/wp-content/uploads/2012/03/NPUAP-Unstage2.jpg
3. A pressure ulcer with intact skin that is a sDTI should not be coded as a Stage 1 pressure ulcer. It should be coded as unstageable, as illustrated at http://www.npuap.org/wp-content/uploads/2012/03/NPUAP-SuspectDTI.jpg
4. Known pressure ulcers covered by a nonremovable dressing/device (e.g., primary surgical dressing, cast) should be coded as unstageable. "Known" refers to when documentation is available that says a pressure ulcer exists under the nonremovable dressing/device.

DEFINITIONS

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. Eschar tissue is usually firmly adherent to the base of the wound and often the sides/edges of the wound.

Step 3: Determine "Present on Admission"

*For **each** pressure ulcer, determine whether the pressure ulcer was present at the time of admission and **not** acquired while the patient was in the care of the LTCH. Consider current and historical levels of tissue involvement.*

1. Review the medical record for the history of the ulcer.
2. Review for location and stage at the time of admission. If the pressure ulcer was present on admission and subsequently increased in numerical stage during the patient's stay, the pressure ulcer is coded at that higher stage, and that higher stage **should not be coded as "present on admission."**
3. If the pressure ulcer was unstageable on admission, but becomes numerically stageable later, it **should be considered as "present on admission" at the stage at which it first becomes numerically stageable**. If it subsequently increases in numerical stage, that higher stage **should not be considered "present on admission."**
4. If a current pressure ulcer increases in numerical stage during a patient visit/stay longer than 3 calendar days at another hospital/facility, it **is coded at the higher stage and should be coded as "present on admission"** on the patient's new admission assessment.

DEFINITION

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

5. Clinical assessments performed on patients in the LTCH should be completed according to accepted clinical practice and comply with facility policy, state and Federal regulations. General standard of practice for newly admitted patients is that patient clinical admission assessments are completed beginning as close to the actual time of admission as possible, and usually within 24 hours. For example, if a facility requires that a full patient assessment be completed within the first 24 hours, then the information required in the LTCH CARE Data Set Admission Assessment would be coded based on that assessment and coincide with the findings that were completed within that same timeframe.

6. The 3-day assessment period used in the LTCH CARE Data Set is not intended to replace the timeframe required for clinical admission assessments as established by accepted standards of practice, facility policy, state and Federal regulations. Therefore, the LTCH CARE Data Set Admission Assessment's sections that include patient assessment should be consistent with the initial clinical assessment; e.g., the assessment of skin conditions that are present **on admission** are based on the skin assessment that is in conjunction with the admission. So, if a patient that is clinically assessed upon admission has a pressure ulcer identified and staged, that initial clinical assessment is what should be used to assist in coding the LTCH CARE Data Set Admission Assessment pressure ulcer items. If the pressure ulcer that is identified on admission increases in numerical staging (i.e. worsens) within the 3-day LTCH assessment period, the **initial** stage of the pressure ulcer and staging would be documented on the LTCH CARE Data Set Admission Assessment. This pressure ulcer would be captured on the LTCH CARE Data Set Discharge Assessment as worsened (unless it heals) and not present on admission.

M0300A: Number of Stage 1 Pressure Ulcers

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

Item Rationale

- Stage 1 pressure ulcers may deteriorate to more severe pressure ulcers without adequate intervention; as such, they are an important risk factor for further tissue damage.
- Development of a Stage 1 pressure ulcer should be one of multiple factors that initiate pressure ulcer prevention interventions.

Steps for Assessment

1. Perform head-to-toe assessment. Conduct a full-body skin assessment focusing on bony prominences and pressure-bearing areas (sacrum, buttocks, heels, ankles, etc.).

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

DEFINITIONS

STAGE 1 PRESSURE ULCER
An observable, pressure-related alteration of intact skin, whose indicators as compared to an adjacent or opposite area on the body may include changes in one or more of the following parameters: skin temperature (warmth or coolness); tissue consistency (firm or boggy); sensation (pain, itching); and/or a defined area of persistent redness in lightly pigmented skin, whereas in darker skin tones, the ulcer may appear with persistent red, blue or purple hues.

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

Coding Instructions for M0300A

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

Coding Tips

- If a pressure ulcer healed during the 3-day assessment period, and was not present on a prior assessment, **code 0**.

M0300B: Stage 2 Pressure Ulcers

M0300. Current Number of Unhealed Pressure Ulcers at Each Stage

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
3. **Date of oldest Stage 2 pressure ulcer** - Enter dashes if date is unknown:

☐☐ – ☐☐ – ☐☐☐☐
Month Day Year

Item Rationale

DEFINITION

STAGE 2 PRESSURE ULCER
Partial thickness loss of dermis presenting as a shallow open ulcer with a red-pink wound bed, **without slough.**

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

- Stage 2 pressure ulcers may worsen without proper interventions.
- These patients are at risk for further complications or skin injury.
- **Most Stage 2** pressure ulcers should heal in a reasonable time frame.
- Stage 2 pressure ulcers are often related to friction and/or shearing force, and the care plan should incorporate efforts to limit these forces on the skin and tissues.
- Stage 2 pressure ulcers may be more likely to heal with treatment than higher stage pressure ulcers.
- Note that pressure ulcers should generally show some evidence of healing within 14 days. Pressure ulcers that fail to show some evidence toward healing within 14 days could indicate that that are potential complications, and the patient's overall clinical condition ought to be reassessed.

Steps for Assessment

1. Perform head-to-toe assessment. Conduct a full-body skin assessment focusing on bony prominences and pressure-bearing areas (sacrum, buttocks, heels, ankles, etc.).
2. For the purposes of coding, determine that the lesion being assessed is primarily related to pressure and that other conditions have been ruled out. If pressure is *not* the primary cause, *do not code* here.
3. Examine the area adjacent to or surrounding an intact blister for evidence of tissue damage. If other conditions are ruled out and the tissue adjacent to, or surrounding the blister demonstrates signs of tissue damage (e.g., color change, tenderness, bogginess or firmness, warmth or coolness), these characteristics suggest a sDTI rather than a Stage 2 Pressure Ulcer.
4. Stage 2 pressure ulcers will *generally* lack the surrounding characteristics found with a deep tissue injury.
5. Identify the number of *these* pressure ulcers that were present on admission (see instructions starting on M-4 under **Steps for Completing M0300A-G, Step 3: Determine "Present on Admission"**).
6. Identify the oldest Stage 2 pressure ulcer and the date it was first noted at that stage.

Coding Instructions for M0300B1

- Enter the number of pressure ulcers that are currently present and whose deepest anatomical stage is Stage 2.
- Enter 0 if no Stage 2 pressure ulcers are present and skip to **M0300C, Current Number of Unhealed Pressure Ulcers at Each Stage**.

Coding Instructions for M0300B2

- Enter the number of Stage 2 pressure ulcers in M0300B1 that were first noted at the time of admission. For patients who return to the LTCH after a stay at another hospital/facility lasting longer than 3 calendar days, enter the number of Stage 2 pressure ulcers that are present at *this* admission on the new admission assessment.
- Enter 0 if no Stage 2 pressure ulcers were first noted at the time of admission.

Coding Instructions for M0300B3

- Enter the date of the oldest Stage 2 pressure ulcer**.** The LTCH should make every effort to determine the actual date that the Stage 2 pressure ulcer was first identified. If the month or day contains only a single digit, fill in the first box with a "0." For example, October 2, 2012 should be entered as 10-02-2012. If the facility is unable to determine the actual date that the Stage 2 pressure ulcer was first identified (i.e., the date is unknown), enter a dash in every block. *Do not leave any boxes blank***.**

Coding Tips

- A Stage 2 pressure ulcer presents as a shiny or dry shallow ulcer *without slough* or bruising.
- If the oldest Stage 2 pressure ulcer was present on admission and the date it was first noted is unknown, enter a dash in every block of **M0300B3**.
- Do *not* code skin tears, tape burns, perineal dermatitis, maceration, excoriation, or suspected deep tissue injury here.
- When a lesion that is related to pressure presents with an intact blister, examine the adjacent and surrounding area for signs of deep tissue injury. When a deep tissue injury *is* determined, do *not* code as a Stage 2.

M0300C: Stage 3 Pressure Ulcers

M0300. Current Number of Unhealed Pressure Ulcers at Each Stage

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

Item Rationale

- Pressure ulcers affect quality of life for patients because they may limit activity, be painful, and require time-consuming treatments and dressing changes.
- Pressure ulcers at more advanced stages typically require more aggressive interventions, including more frequent repositioning, attention to nutritional status, and care that may be more time or staff intensive.

- An existing pressure ulcer may put patients at risk for further complications or skin injury.
- If a pressure ulcer fails to show some evidence toward healing within 14 days, the pressure ulcer (including potential complications) and the patient's overall clinical condition should be reassessed.

DEFINITION

STAGE 3 PRESSURE ULCER

Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle is not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining or tunneling.

Steps for Assessment

1. Perform head-to-toe assessment. Conduct a full-body skin assessment focusing on bony prominences and pressure-bearing areas (sacrum, buttocks, heels, ankles, etc.).
2. For the purposes of coding, determine that the lesion being assessed is primarily related to pressure and that other conditions have been ruled out. If pressure is *not* the primary cause, *do not code here*.
3. Identify all Stage 3 pressure ulcers currently present.
4. Identify the number of *these* pressure ulcers that were present on admission (see instructions starting on M-4 under **Steps for Completing M0300A-G: Step 3: Determine "Present on Admission")**.

Coding Instructions for M0300C1

- Enter the number of pressure ulcers that are currently present and whose deepest anatomical stage is Stage 3.
- Enter 0 if no Stage 3 pressure ulcers are present and skip to **M0300D, Current Number of Unhealed Pressure Ulcers at Each Stage**.

Coding Instructions for M0300C2

- Enter the number of Stage 3 pressure ulcers in M0300C1 that were first noted at Stage 3 at the time of admission. For patients who return to the LTCH after a stay at another hospital/facility lasting longer than 3 calendar days, enter the number of Stage 3 pressure ulcers that are present at *this* admission on the new admission assessment.
- Enter 0 if no Stage 3 pressure ulcers were first noted at the time of admission.

Coding Tips

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

Coding Examples

1. A pressure ulcer described as a Stage 2 on the heel was noted and documented in the patient's medical record on admission. On discharge, this wound is noted to be a full thickness ulcer, thus it is now a Stage 3 pressure ulcer in the same location.

   Coding:

Item	Admission Assessment	Discharge Assessment
M0300B1, Number of Stage 2 pressure ulcers	**Code as 1**	**Code as 0**
M0300B2, Number of these Stage 2 pressure ulcers present on admission	**Code as 1**	**Leave blank**
M0300C1, Number of Stage 3 pressure ulcers	**Code as 0**	**Code as 1**
M0300C2, Number of these Stage 3 pressure ulcers present on admission	**Leave blank**	**Code as 0**

   Rationale: The designation of "present on admission" requires that the pressure ulcer be at the same location *and* not have increased in numerical stage. This (Stage 2) pressure ulcer increased in numerical staging (to Stage 3) after admission. So, **M0300C1 would be coded as 1 on discharge**. **M0300C1** would be **coded as 0 on admission** and **M0300C2** would be **coded as 0 on discharge** because it was not a *Stage 3* pressure ulcer on admission.

2. A patient develops a Stage 2 pressure ulcer on the sacrum *while* at the LTCH. The patient is transferred out of the LTCH to a short-stay acute care hospital for the treatment of an acute myocardial infarction for 8 days. The patient returns to the LTCH with a Stage 3 pressure ulcer in the same location. Subsequently, the patient is discharged with this wound noted to be a full thickness ulcer Stage 3 pressure ulcer in the same location.

   Coding:

Item	Admission Assessment #1	Discharge Assessment #1	Admission Assessment #2	Discharge Assessment #2
M0300B1, Number of Stage 2 pressure ulcers	**Code as 0**	**Code as 1**	**Code as 0**	**Code as 0**
M0300B2, Number of these Stage 2 pressure ulcers present on admission	**Leave blank**	**Code as 0**	**Leave blank**	**Leave blank**
M0300C1, Number of Stage 3 pressure ulcers	**Code as 0**	**Code as 0**	**Code as 1**	**Code as 1**
M0300C2, Number of these Stage 3 pressure ulcers present on admission	**Leave blank**	**Leave blank**	**Code as 1**	**Code as 1**

Rationale: Even though the patient had a pressure ulcer in the same anatomical location prior to his or her transfer to a short-stay acute care hospital, because the pressure ulcer increased in numerical stage to Stage 3 *during a stay at another hospital/facility that lasted more than 3 calendar days*, **M0300C2 is coded as 1** because the Stage 3 pressure ulcer was present on *second* admission to the LTCH.

3. 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.

   Coding:

Item	Admission Assessment	Discharge Assessment
M0300B1, Number of Stage 2 pressure ulcers	**Code as 3**	**Code as 1**
M0300B2, Number of these Stage 2 pressure ulcers present on admission	**Code as 3**	**Code as 1**
M0300C1, Number of Stage 3 pressure ulcers	**Code as 0**	**Code as 1**
M0300C2, Number of these Stage 3 pressure ulcers present on admission	**Leave blank**	**Code as 0**

   Rationale: Two of the pressure ulcers on the coccyx have merged, but have remained at the same stage as they were at the time of admission (therefore **M0300B1 is coded as 1** *at discharge*). The pressure ulcer that increased in numerical staging to a Stage 3 has developed a deeper level of tissue damage in the time since admission, and therefore on the discharge assessment, **M0300C2 is coded as 0**, not present on admission.

4. A patient developed two Stage 2 pressure ulcers during her stay at the LTCH: one on the coccyx and the other on the left lateral malleolus. She develops a gastrointestinal bleed and hypotension and requires transfer to a short-stay acute-care hospital for ten days. When she is returned to the LTCH, she has two pressure ulcers. One is the previous Stage 2 pressure ulcer on the coccyx, which has not changed; the other is a new Stage 3 pressure ulcer on the left trochanter. The Stage 2 pressure ulcer on the left lateral malleolus that was present at admission has healed.

   Coding:

Item	Admission Assessment #1	Discharge Assessment #1	Admission Assessment #2
M0300B1, Number of Stage 2 pressure ulcers	**Code as 0**	**Code as 2**	**Code as 1**
M0300B2, Number of these Stage 2 pressure ulcers present on admission	**Leave blank**	**Code as 0**	**Code as 1**
M0300C1, Number of Stage 3 pressure ulcers	**Code as 0**	**Code as 0**	**Code as 1**
M0300C2, Number of these Stage 3 pressure ulcers present on admission	**Leave blank**	**Leave blank**	**Code as 1**

Rationale: The Stage 2 pressure ulcer on the coccyx was present prior to the patient's transfer to a short-stay acute-care hospital. The Stage 3 pressure ulcer developed during a stay at another facility that was longer than 3 calendar days and therefore **M0300C2 is coded as 1** on the patient's second admission to the LTCH. The Stage 2 pressure ulcer on the left malleolus has healed and is not coded as an unhealed pressure ulcer when the patient is admitted to the LTCH for the second time.

5. A patient arrives at the LTCH with a Stage 2 pressure ulcer. The patient is transferred to a short-stay acute care hospital, but returns to the LTCH less than 3 calendar days after leaving the LTCH. When the patient returns, the LTCH notes that the Stage 2 pressure ulcer has worsened to a Stage 3 pressure ulcer. The patient is discharged 3 weeks later with a Stage 3 pressure ulcer.

   Coding:

Item	Admission Assessment	Discharge Assessment
M0300B1, Number of Stage 2 pressure ulcers	**Code as 1**	**Code as 0**
M0300B2, Number of these Stage 2 pressure ulcers present on admission	**Code as 1**	**Leave blank**
M0300C1, Number of Stage 3 pressure ulcers	**Code as 0**	**Code as 1**
M0300C2, Number of these Stage 3 pressure ulcers present on admission	**Leave blank**	**Code as 0**

   Rationale: Because the patient returned to the LTCH less than 3 calendar days after being transferred to a short-stay acute care hospital, the patient's return to the LTCH is not considered a new admission. Any new pressure ulcer formation or pressure ulcer increase in numerical staging that occurred at the short-stay acute care hospital should not be coded as "present on admission." The Stage 3 pressure ulcer was not present upon the patient's admission to the LTCH; therefore **M0300C2 should be coded as 0** *on the discharge assessment*.

6. A patient develops a Stage 2 pressure ulcer while at the LTCH. The patient is transferred to a short-stay acute care hospital because of pneumonia. The patient returns to the LTCH after 4 days and returns with a Stage 3 pressure ulcer in the same anatomical location.

Coding:

Item	Admission Assessment #1	Discharge Assessment #1	Admission Assessment #2
M0300B1, Number of Stage 2 pressure ulcers	**Code as 0**	**Code as 1**	**Code as 0**
M0300B2, Number of these Stage 2 pressure ulcers present on admission	**Leave blank**	**Code as 0**	**Leave blank**
M0300C1, Number of Stage 3 pressure ulcers	**Code as 0**	**Code as 0**	**Code as 1**
M0300C2, Number of these Stage 3 pressure ulcers present on admission	**Leave blank**	**Leave blank**	**Code as 1**

Rationale: Even though the patient had a pressure ulcer in the same anatomical location prior to transfer to the short-stay acute care hospital, because it increased in numerical staging to a Stage 3 during hospitalization at another facility that lasted longer than 3 calendar days, **both M0300C1 and M0300C2 should be coded as 1** on the second admission assessment to indicate that the Stage 3 pressure ulcer was present on the patient's *second admission* to the LTCH.

M0300D: Stage 4 Pressure Ulcers

M0300. Current Number of Unhealed Pressure Ulcers at Each Stage

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 these Stage 4 pressure ulcers that were present upon admission** - enter how many were noted at the time of admission

Item Rationale

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

Steps for Assessment

1. Perform head-to-toe assessment. Conduct a full-body skin assessment focusing on bony prominences and pressure-bearing areas (sacrum, buttocks, heels, ankles, etc.).
2. For the purposes of coding, determine that the lesion being assessed is primarily related to pressure and that other conditions have been ruled out. If pressure is *not* the primary cause, *do not code here*.
3. Identify all Stage 4 pressure ulcers currently present.
4. Identify the number of *these* pressure ulcers that were present on admission (see instructions starting on M-4 under **Steps for Completing M0300A-G, Step 3: Determine "Present on Admission")**.

DEFINITIONS

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.

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

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

Coding Instructions for M0300D1

- Enter the number of pressure ulcers that are currently present and whose deepest anatomical stage is Stage 4.
- Enter 0 if no Stage 4 pressure ulcers are present and skip to **M0300E, Current Number of Unhealed Pressure Ulcers at Each Stage**.

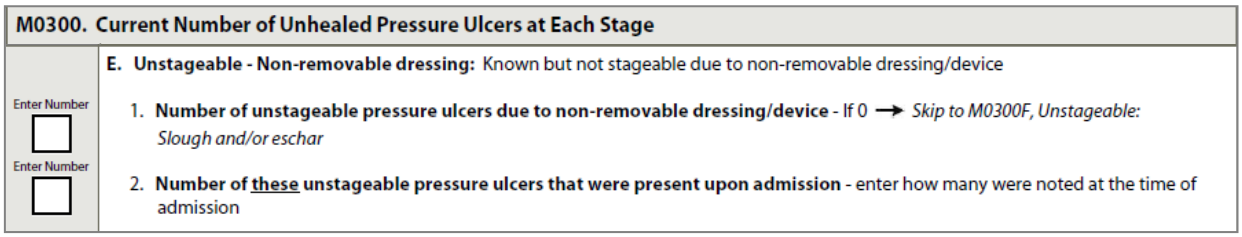
Coding Instructions for M0300D2

- Enter the number of Stage 4 pressure ulcers in M0300D1 that were first noted at Stage 4 at the time of admission. For patients who return to the LTCH after a stay at another hospital/facility lasting longer than 3 calendar days, enter the number of Stage 4 pressure ulcers that are present at *this* admission on the new admission assessment.
- Enter 0 if no Stage 4 pressure ulcers were first noted at the time of admission.

Coding Tips

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

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



M0300. Current Number of Unhealed Pressure Ulcers at Each Stage

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

Item Rationale

- Although the wound bed cannot be visualized due to the non-removable dressing/device, and hence the pressure ulcer cannot be numerically staged, the pressure ulcer may affect quality of life for patients because it may limit activity and be painful.
- Although the pressure ulcer itself cannot be observed, the surrounding area is monitored for signs of redness, swelling, increased drainage, or tenderness to the touch, and the patient is monitored for adequate pain control.

Steps for Assessment

1. Review the medical record for documentation of a pressure ulcer covered by a nonremovable dressing/device. <u>Documentation of an existing pressure ulcer is needed to complete this item</u>. Do not assume that there is a pressure ulcer that is covered by a nonremovable dressing.
2. Determine the number of pressure ulcers unstageable related to a nonremovable dressing/device. Examples of nonremovable dressings/devices include a dressing that is not to be removed per physician's order, an orthopedic device, or a cast.
3. Identify the number of *these* pressure ulcers that were present on admission (see instructions starting on M-4 under **Steps for Completing M0300A-G: Step 3: Determine "Present on Admission").**

DEFINITION

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

Coding Instructions for M0300E1

- Enter the number of pressure ulcers that are unstageable related to nonremovable dressing/device.
- Enter 0 if no unstageable pressure ulcers related to nonremovable dressing/device are present and skip to **M0300F, Current Number of Unhealed Pressure Ulcers at Each Stage**.

Coding Instructions for M0300E2

- Enter the number of unstageable pressure ulcers related to a nonremovable dressing/device in M0300E1 that were first noted at the time of admission. For patients who return to the LTCH after a stay at another hospital/facility lasting longer than 3 calendar days, enter the number of unstageable pressure ulcers related to nonremovable dressing/device that are present at *this* admission on the new admission assessment.
- Enter 0 if no unstageable pressure ulcers related to nonremovable dressing/device were first noted at the time of admission.

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

M0300. Current Number of Unhealed Pressure Ulcers at Each Stage

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

Item Rationale

- Although the wound bed cannot be visualized, and hence the pressure ulcer cannot be numerically staged, the pressure ulcer may affect quality of life for patients because it may limit activity, be painful, and require time-consuming treatments and dressing changes.
- Visualization of the wound bed is necessary for accurate numerical staging.
- The presence of pressure ulcers and other skin changes should be accounted for in the interdisciplinary care plan.
- Pressure ulcers that present as unstageable require care planning that includes, in the absence of ischemia, debridement of necrotic and dead tissue and restaging once the necrotic tissue is removed.

DEFINITIONS

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. Eschar tissue is usually firmly adherent to the base of the wound and often the sides/edges of the wound.

Steps for Assessment

1. Determine the number of pressure ulcers that are unstageable because of slough and/or eschar.
2. Identify the number of these pressure ulcers that were present on admission (see instructions starting on M-4 under **Steps for Completing M0300A-G: Step 3: Determine "Present on Admission").**

Coding Instructions for M0300F1

- Enter the number of pressure ulcers that are unstageable related to slough and/or eschar.
- Enter 0 if no unstageable pressure ulcers related to slough and/or eschar are present and skip to **M0300G, Current Number of Unhealed Pressure Ulcers at Each Stage**.

Coding Instructions for M0300F2

- Enter the number of unstageable pressure ulcers related to slough and/or eschar in M0300F1 that were first noted at the time of admission. For patients who return to the LTCH after a stay at another hospital/facility lasting longer than 3 calendar days, enter the number of pressure ulcers related to slough and/or eschar that are present at *this* admission on the new admission assessment.
- Enter 0 if no unstageable pressure ulcers related to slough and/or eschar were first noted at the time of admission.

Coding Tips

- Pressure ulcers that are covered with slough and/or eschar should be coded as unstageable because the true depth of injury (and therefore numerical stage) cannot be determined. Only until enough slough and/or eschar are removed to expose the depth of the tissue layers involved, can the numerical stage of the wound be determined.
- Stable eschar (i.e., dry, adherent, intact without erythema or fluctuance) on the heels serves as "the body's natural (biological) cover" and should only be removed after careful clinical consideration, including ruling out ischemia, and in consultation with the patient's physician, or nurse practitioner, physician assistant, or clinical nurse specialist if allowable under state licensure laws.

DEFINITION

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

- Once the pressure ulcer is debrided of enough slough and/or eschar such that the tissues within the wound bed can be identified, the ulcer can then be numerically staged. The pressure ulcer does not have to be completely debrided or free of all slough and/or eschar tissue for restaging of the ulcer to occur.

Coding Examples

1. A patient is admitted to an LTCH with two Stage 2 pressure ulcers, one on the left heel and one on the right heel. He also is admitted with a Stage 4 pressure ulcer to the sacral area. He develops a new Stage 4 pressure ulcer on the right greater trochanter area while at the LTCH. At the time of discharge he has resolved the Stage 2 pressure ulcers on both heels and continues to have the Stage 4 sacral ulcer.

Coding:

Item	Admission Assessment	Discharge Assessment
M0300B1, Number of Stage 2 pressure ulcers	**Code as 2**	**Code as 0**
M0300B2, Number of these Stage 2 pressure ulcers present on admission	**Code as 2**	**Leave blank**
M0300C1, Number of Stage 3 pressure ulcers	**Code as 0**	**Code as 0**
M0300C2, Number of these Stage 3 pressure ulcers present on admission	**Leave blank**	**Leave blank**
M0300D1, Number of Stage 4 pressure ulcers	**Code as 1**	**Code as 2**
M0300D2, Number of these Stage 4 pressure ulcers present on admission	**Code as 1**	**Code as 1**

Rationale: The two Stage 2 pressure ulcers on the heels that were present on admission have resolved, so **M0300B1 is coded 0** at discharge. **M0300D1 is coded 2** on discharge because the patient has a new Stage 4 pressure ulcer in addition to the previous one. **M0300D2 is coded 1** on discharge because only one of the two Stage 4 pressure ulcers was present on admission to the LTCH.

2. A patient is admitted to an LTCH with one Stage 2 pressure ulcer on the left heel, and a Stage 3 pressure ulcer on the coccyx. He transfers to a short-stay acute-care hospital three times for repeat CT studies of his abdomen, and each time returns the same day. There is no documentation of wound changes immediately after the patient returns from the acute-care hospital. The patient is reassessed before discharge to a nursing home and the Stage 2 pressure ulcer on the left heel is now a Stage 4, his coccyx wound has increased in numerical staging to a Stage 4, and he has a new Stage 3 on his left buttock area.

Coding:

Item	Admission Assessment	Discharge Assessment
M0300B1, Number of Stage 2 pressure ulcers	**Code as 1**	**Code as 0**
M0300B2, Number of these Stage 2 pressure ulcers present on admission	**Code as 1**	**Leave blank**
M0300C1, Number of Stage 3 pressure ulcers	**Code as 1**	**Code as 1**
M0300C2, Number of these Stage 3 pressure ulcers present on admission	**Code as 1**	**Code as 0**
M0300D1, Number of Stage 4 pressure ulcers	**Code as 0**	**Code as 2**
M0300D2, Number of these Stage 4 pressure ulcers present on admission	**Leave blank**	**Code as 0**

Rationale: The Stage 2 pressure ulcer on the heel and the Stage 3 pressure ulcer on the coccyx that were identified on admission and **coded as 1 in M0300B1, M0300B2 and M0300C1, M0300C2**, respectively, on the admission assessment have both increased in numerical staging to Stage 4; therefore on discharge, **M0300D1 is coded as 2** and **M0300D2 is coded 0**. The new Stage 3 pressure ulcer identified on the left buttock area is coded in

M0300C1 as 1 and M0300C2 as 0 because it is a new Stage 3 pressure ulcer that was not present on admission.

3. Patient is admitted to an LTCH with a short leg cast to the right lower extremity. He has no visible wounds on admission but arrives with documentation that a pressure ulcer exists under the cast. Two weeks after admission to the LTCH the cast is removed by the physician. He has a right heel Stage 3 pressure ulcer from the cast, which remains until discharge.

   Coding:

Item	Admission Assessment	Discharge Assessment
M0300B1, Number of Stage 2 pressure ulcers	**Code as 0**	**Code as 0**
M0300B2, Number of these Stage 2 pressure ulcers present on admission	**Leave blank**	**Leave blank**
M0300C1, Number of Stage 3 pressure ulcers	**Code as 0**	**Code as 1**
M0300C2, Number of these Stage 3 pressure ulcers present on admission	**Leave blank**	**Code as 1**
M0300D1, Number of Stage 4 pressure ulcers	**Code as 0**	**Code as 0**
M0300D2, Number of these Stage 4 pressure ulcers present on admission	**Leave blank**	**Leave blank**
M0300E1, Number of Unstageable pressure ulcers due to nonremovable dressing/device	**Code as 1**	**Code as 0**
M0300E2, Number of these Unstageable pressure ulcers due to nonremovable dressing/device present on admission	**Code as 1**	**Leave blank**

   Rationale: Because the patient came to the LTCH with documentation that a pressure ulcer was present under the cast and since the cast could not be removed for the first 2 weeks, the admission assessment is coded for the pressure ulcer hidden by the cast and would be **coded 1 for M0300E1** and **coded 1 for M0300E2** on admission assessment. Once it is staged, **M0300C1 is coded 1** and **M0300C2 is coded 1**, indicating that the Stage 3 pressure ulcer was present on admission.

4. Patient is admitted to the LTCH with eschar tissue identified on both the right and left heels as well as a Stage 2 pressure ulcer to the coccyx. She is reassessed before discharge and the Stage 2 coccyx pressure ulcer has healed. Her left heel eschar became fluctuant, showed signs of infection and had to be debrided at the bedside. The left heel wound was subsequently numerically staged as a Stage 4 pressure ulcer. The right heel eschar remained stable and dry, i.e. remained unstageable.

Coding:

Item	Admission Assessment	Discharge Assessment
M0300B1, Number of Stage 2 pressure ulcers	**Code as 1**	**Code as 0**
M0300B2, Number of these Stage 2 pressure ulcers present on admission	**Code as 1**	**Leave blank**
M0300C1, Number of Stage 3 pressure ulcers	**Code as 0**	**Code as 0**
M0300C2, Number of these Stage 3 pressure ulcers present on admission	**Leave blank**	**Leave blank**
M0300D1, Number of Stage 4 pressure ulcers	**Code as 0**	**Code as 1**
M0300D2, Number of these Stage 4 pressure ulcers present on admission	**Leave blank**	**Code as 1**
M0300E1, Number of Unstageable pressure ulcers due to nonremovable dressing/device	**Code as 0**	**Code as 0**
M0300E2, Number of these Unstageable pressure ulcers due to nonremovable dressing/device present on admission	**Leave blank**	**Leave blank**
M0300F1, Number of Unstageable pressure ulcers due to slough/eschar	**Code as 2**	**Code as 1**
M0300F2, Number of these Unstageable pressure ulcers due to slough/eschar present on admission	**Code as 2**	**Code as 1**

Rationale: Both heels are not able to be numerically staged because the level of tissue damage cannot be determined due to eschar present, so they are coded on the admission assessment as Unstageable due to slough/eschar and present on admission (**M0300F1 and M0300F2 are coded as 1**). The Stage 2 pressure ulcer on the coccyx healed so **M0300B1 is coded 0** at discharge. The left heel eschar that was debrided is coded as a Stage 4 at discharge, so **M0300D1 is coded 1.** Since the right heel eschar was present on admission, **M0300D2 is coded 1**.

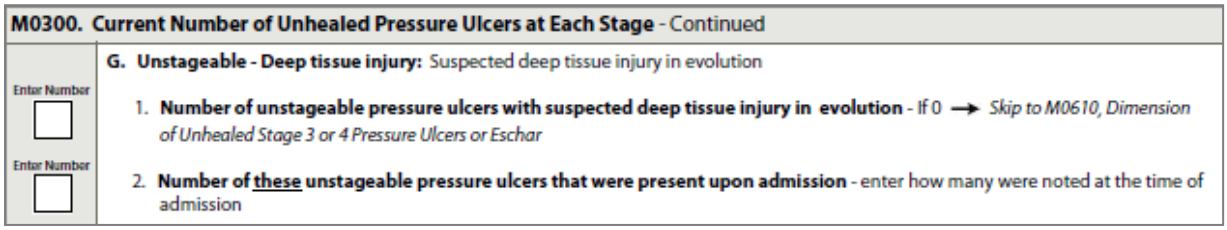
5. Patient is admitted to the LTCH with a necrotic sacral pressure ulcer. After 20 days, his nutritional status improves and surgery is consulted for debridement of the necrotic pressure ulcer. He is transferred to the short-stay acute-care hospital and undergoes surgical debridement of the sacral wound and transfers back to the LTCH the same day. Upon return to the LTCH, the wound care nurse assesses the wound and numerically stages it as a Stage 4 pressure ulcer. The patient eventually gets discharged to a nursing home for extended wound care.

Coding:

Item	Admission Assessment	Discharge Assessment
M0300B1, Number of Stage 2 pressure ulcers	**Code as 0**	**Code as 0**
M0300B2, Number of these Stage 2 pressure ulcers present on admission	**Leave blank**	**Leave blank**
M0300C1, Number of Stage 3 pressure ulcers	**Code as 0**	**Code as 0**
M0300C2, Number of these Stage 3 pressure ulcers present on admission	**Leave blank**	**Leave blank**
M0300D1, Number of Stage 4 pressure ulcers	**Code as 0**	**Code as 1**
M0300D2, Number of these Stage 4 pressure ulcers present on admission	**Leave blank**	**Code as 1**
M0300E1, Number of Unstageable pressure ulcers due to nonremovable dressing/device	**Code as 0**	**Code as 0**
M0300E2, Number of these Unstageable pressure ulcers due to nonremovable dressing/device present on admission	**Leave blank**	**Leave blank**
M0300F1, Number of Unstageable pressure ulcers due to slough/eschar	**Code as 1**	**Code as 0**
M0300F2, Number of these Unstageable pressure ulcers due to slough/eschar present on admission	**Code as 1**	**Leave blank**

Rationale: The patient presented with an unstageable pressure ulcer on admission. After surgical debridement, the wound is numerically staged as a Stage 4. On discharge, **M0300D1 and M0300D2 are coded as 1** due to the fact that this pressure ulcer is unsteageable on admission but was debrided and able to be numerically staged at a later assessment.

M0300G: Unstageable Pressure Ulcers Related to Suspected Deep Tissue Injury



Item Rationale

- Deep tissue injury may precede the development of a Stage 3 or 4 pressure ulcer even with optimal treatment.
- Quality health care begins with prevention and risk assessment, and care planning begins with prevention. Appropriate care planning is essential in optimizing a patient's ability to

avoid, as well as recover from, pressure (as well as all) wounds. Deep tissue injuries may sometimes indicate severe tissue damage. Identification and management sDTI is imperative.

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

Steps for Assessment

DEFINITION

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

1. Perform head-to-toe assessment. Conduct a full-body skin assessment focusing on bony prominences and pressure-bearing areas (sacrum, buttocks, heels, ankles, etc.).
2. For the purposes of coding, determine that the lesion being assessed is primarily a result of pressure and that other conditions have been ruled out. If pressure is *not* the primary cause, *do not code here*.
3. Examine the area adjacent to, or surrounding, an intact, blister for evidence of tissue damage. If the tissue adjacent to, or surrounding, the blister *does not show* signs of tissue damage (e.g., color change, tenderness, bogginess or firmness, warmth or coolness), *do not code* as a sDTI.
4. In dark-skinned individuals, the area of injury is probably not purple/maroon, but rather darker than the surrounding tissue.
5. Determine the number of pressure ulcers that are unstageable related to sDTI.
6. Identify the number of *these* pressure ulcers that were present on admission (see instructions starting on M-4 under **Steps for Completing M0300A-G, Step 3: Determine "Present on Admission**.").
7. Clearly document assessment findings in the patient's medical record, and track and document appropriate wound care planning and management.

Coding Instructions for M0300G1

- Enter the number of unstageable pressure ulcers related to suspected deep tissue injury. Based on skin tone, the injured tissue area may present as a darker tone than the surrounding intact skin. These areas of discoloration are potentially areas of suspected deep tissue injury.
- Enter 0 if no unstageable pressure ulcers related to suspected deep tissue injury are present and skip to **M0610, Dimensions of Unhealed Stage 3 or Stage 4 Pressure Ulcers or Eschar**.

Coding Instructions for M0300G2

- Enter the number of unstageable pressure ulcers related to suspected deep tissue injury in M0300G1 that were first noted at the time of admission. For patients who return to the LTCH after a stay at another hospital/facility lasting longer than 3 calendar days, enter the number of unstageable pressure ulcers related to suspected deep tissue injury that are present at *this* admission on the new admission assessment.

- Enter 0 if no unstageable pressure ulcers related to suspected deep tissue injury were first noted at the time of admission.

Coding Tips

- Once a sDTI has opened to an ulcer, the ulcer should be reassessed, staged numerically, and coded on the LTCH Care Data set at the appropriate stage.
- Deep tissue injury may be difficult to detect in individuals with dark skin tones.
- Evolution of deep tissue injuries may be rapid, exposing additional layers of tissue even with optimal treatment.
- When a lesion due to pressure presents with an intact blister *and* the surrounding or adjacent soft tissue does *not* have the characteristics of deep tissue injury, *do not code here*.

Coding Example

1. Patient is admitted to LTCH with a bruised butterfly-shaped area on the sacrum and a blood-filled blister to the right heel. The sacral area develops a hard eschar and based on assessment of the surrounding tissues is determined to be a sDTI. The heel blister is also assessed, and based on the assessment of the surrounding tissues, it is determined that the heel blister is also a sDTI. Four days after admission, the right heel blister is drained and conservatively debrided at the bedside. After debridement, the right heel is numerically staged as a Stage 3 pressure ulcer. On discharge, the right heel remains a Stage 3 and the sacral area eschar remains dry and stable.

   Coding:

Item	Admission Assessment	Discharge Assessment
M0300B1, Number of Stage 2 pressure ulcers	**Code as 0**	**Code as 0**
M0300B2, Number of these Stage 2 pressure ulcers present on admission	**Leave blank**	**Leave blank**
M0300C1, Number of Stage 3 pressure ulcers	**Code as 0**	**Code as 1**
M0300C2, Number of these Stage 3 pressure ulcers present on admission	**Leave blank**	**Code as 1**
M0300D1, Number of Stage 4 pressure ulcers	**Code as 0**	**Code as 0**
M0300D2, Number of these Stage 4 pressure ulcers present on admission	**Leave blank**	**Leave blank**
M0300E1, Number of Unstageable pressure ulcers due to nonremovable dressing/device	**Code as 0**	**Code as 0**
M0300E2, Number of these Unstageable pressure ulcers due to nonremovable dressing/device present on admission	**Leave blank**	**Leave blank**
M0300F1, Number of Unstageable pressure ulcers due to slough/eschar	**Code as 0**	**Code as 0**
M0300F2, Number of these Unstageable pressure ulcers due to slough/eschar present on admission	**Leave blank**	**Leave blank**
M0300G1, Number of Unstageable pressure ulcers with suspected deep tissue injury	**Code as 2**	**Code as 1**
M0300G2, Number of these Unstageable pressure ulcers with suspected deep tissue injury present on admission	**Code as 2**	**Code as 1**

Rationale: After a thorough clinical and skin examination as well as an assessment of the lesions and surrounding tissues, the sacral and the heel areas are determined to be consistent with what constitutes sDTI. For the admission assessment, **M0300G1 and M0300G2 are both coded with a 2** since there were two sDTIs, both present on admission. Once the heel sDTI is drained, debrided, and numerically staged, both **M0300C1 and M0300C2 are coded as 1** on the discharge assessment. **M0300G1 and M0300G2 are coded as 1 on the discharge assessment**, because the sacral sDTI is dry and stable and cannot be numerically staged.

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

M0610. Dimensions of Unhealed Stage 3 or 4 Pressure Ulcers or Eschar Complete only if M0300C1, M0300D1 or M0300F1 is greater than 0	
If the patient 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:	
☐☐.☐ cm	**A. Pressure ulcer length:** Longest length in any direction
☐☐.☐ cm	**B. Pressure ulcer width:** Widest width of the same pressure ulcer, side-to-side perpendicular (90-degree angle) to length
☐☐.☐ 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)

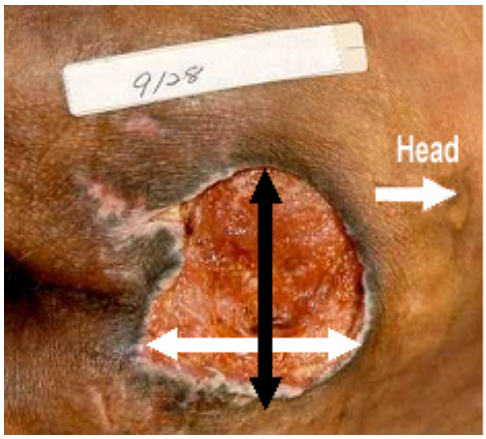
Item Rationale

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

Steps for Assessment

If the patient 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. Complete only if a pressure ulcer is coded in M0300C1, M0300D1, or M0300F1. The figure (right) illustrates the measurement process.

1. Measurement is based on observation of the Stage 3, Stage 4, or unstageable pressure ulcer due to slough or eschar **after** the dressing and any exudate are removed.
2. Use a disposable measuring device or a cotton-tipped applicator.
3. Determine longest length (white arrow line) head to toe and greatest width (black arrow line) of each Stage 3, Stage 4, or unstageable pressure ulcer due to slough or eschar.



4. Measure the longest length of the pressure ulcer. If using a cotton-tipped applicator, mark on the applicator the distance between healthy skin tissue at each margin and lay the applicator next to a centimeter ruler to determine length.
5. Using a similar approach, measure the longest width (perpendicular to the length forming a "+," side to side).
6. Measure every Stage 3, Stage 4, and unstageable pressure ulcer due to slough or eschar that is present. **The clinician must be aware of all pressure ulcers present in order to determine which pressure ulcer is the largest.** Use a skin tracking sheet or other worksheet to record the dimensions for each pressure ulcer. Select the largest one by comparing the surface areas (length x width) of each.
7. Considering **only** the largest Stage 3 or 4 pressure ulcer due to slough or eschar, determine the deepest area and record the depth in centimeters. To measure wound depth, moisten a sterile, cotton-tipped applicator with 0.9% sodium chloride (NaCl) solution or sterile water. Place the applicator tip in the deepest aspect of the ulcer and measure the distance to the skin level. If the depth is uneven, measure several areas and document the depth of the ulcer that is the deepest. If depth cannot be assessed because of slough or eschar, enter dashes in M0610C.
8. If two pressure ulcers occur on the same bony prominence and are separated, at least superficially, by skin, then count them as two separate pressure ulcers. Classify the stage and measure each pressure ulcer separately.

Coding Instructions for M0610

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

Coding Tips

- Place the patient in the most appropriate position that will allow for accurate wound measurement.
- The methods for wound measurement described above should be used consistently to facilitate meaningful comparisons of wound measurements across time.

- Assessment of the pressure ulcer for tunneling and undermining is an important part of the complete pressure ulcer assessment. Measurement of tunneling and undermining is not recorded on the LTCH CARE Data Set assessment record but should be assessed, monitored, and treated as part of the comprehensive care plan.

M0700: Most Severe Tissue Type for Any Pressure Ulcer

M0700. Most Severe Tissue Type for Any Pressure Ulcer	
Enter Code ☐	Select the best description of the most severe type of tissue present in any pressure ulcer bed, consider all pressure ulcers 1. **Epithelial tissue** - new skin growing in superficial ulcer. It can be light pink and shiny, even in persons with darkly pigmented skin 2. **Granulation tissue** - pink or red tissue with shiny, moist, granular appearance 3. **Slough** - yellow or white tissue that adheres to the ulcer bed in strings or thick clumps, or is mucinous 4. **Necrotic tissue (Eschar)** - black, brown, or tan tissue that adheres firmly to the wound bed or ulcer edges, may be softer or harder than surrounding skin

Item Rationale

- The presence of a pressure ulcer may affect quality of life for patients because it may limit activity, be painful, and require time-consuming treatments and dressing changes.
- Tissue type must be identified.
- Tissue characteristics of pressure ulcers should be considered when determining treatment options and choices.
- Changes in tissue characteristics over time are indicative of wound healing or degradation.

Steps for Assessment

1. Examine the wound bed or base of each pressure ulcer. Adequate lighting is important to detect skin changes.
2. There are four types of tissue that are seen in pressure ulcers as well as in other wounds. Each tissue type refers to tissue that is visible in different stages as wounds evolve and heal. The "most severe" types of tissue are those that are devitalized and non-viable (i.e. necrotic), healthier tissue includes granulation and epithelial tissue. Understanding and being able to recognize these tissue types is essential to the appropriate staging of pressure ulcers. The list found in item M0700 represents the four tissue types found in pressure ulcers from the healthiest type of tissue to the more devitalized and non-viable tissues. What is coded on the LTCH CARE Data Set is the tissue type identified that corresponds to the most devitalized/non-viable (i.e. most severe) tissue identified in the wound.

DEFINITIONS

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

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

SLOUGH TISSUE
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. Eschar is usually firmly adherent to the base of the wound and often the sides/ edges of the wound.

3. Determine the type(s) of tissue in the wound bed (e.g., epithelial, granulation, slough, eschar) and code as appropriate.

Coding Instructions for M0700

- Code 1, Epithelial tissue: if the wound is superficial and is re-epithelializing.
- Code 2, Granulation tissue: if the wound is clean (e.g., free of slough and necrotic tissue) and contains granulation tissue.
- Code 3, Slough: if there is any amount of slough present and eschar tissue is absent.
- Code 4, Necrotic tissue (Eschar): if there is any eschar tissue present.

Coding Tips and Special Populations

- Stage 2 pressure ulcers should *not* be coded as having granulation, slough, or eschar tissue because by definition, they do not have this extent of tissue damage. All Stage 2 pressure ulcers should be **coded as 1** for this item.
- If the wound bed is covered with a mix of different types of tissue, code for the most severe type. For example, if a mixture of necrotic tissue, i.e. both eschar and slough are present, code for eschar tissue.
- Code this item with a dash in the following situations:
  - Stage 1 pressure ulcer
  - Stage 2 pressure ulcer with intact blister
  - Unstageable pressure ulcer related to nonremovable dressing/device
  - Unstageable pressure ulcer related to suspected deep tissue injury

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

Coding Examples

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

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

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

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

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

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

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

   Coding: Code **M0700 as 4, Necrotic tissue (Eschar).**

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

M0800: Worsening in Pressure Ulcer Status Since Prior Assessment

M0800. Worsening in Pressure Ulcer Status Since Prior Assessment	
Indicate the number of current pressure ulcers that were **not present or were at a lesser stage** on prior assessment. If no current pressure ulcer at a given stage, enter 0	
Enter Number ☐	**A. Stage 2**
Enter Number ☐	**B. Stage 3**
Enter Number ☐	**C. Stage 4**

Item Rationale

- This item documents whether skin status, overall, has worsened since the last assessment. To track increasing skin damage, this item documents the number of new pressure ulcers and whether any pressure ulcers have increased in numerical stage (worsened) since the last assessment. Such tracking of pressure ulcers is consistent with good clinical care.
- Facilities should reevaluate the interdisciplinary care plan and ensure that appropriate preventative measures and pressure ulcer management principles are being adhered to when new pressure ulcers develop and/or worsen.

Steps for Assessment

Assessment period for this item is back to the ARD of the prior assessment.

Complete only A0250 = 10 Planned Discharge; or A0250 = 11 Unplanned Discharge.

1. Review the history of each current pressure ulcer. Specifically, compare the current stage to past stage to determine whether any pressure ulcer on the current assessment is new or at an increased numerical stage when compared with the last LTCH CARE Data Set assessment record. This allows a more accurate assessment than simply comparing total counts on the current and prior LTCH CARE Data Set assessment record.
2. For each current stage, count the number of current

DEFINITIONS

WORSENING IN PRESSURE ULCER STATUS

Pressure ulcer "worsening" is defined as a pressure ulcer that has progressed to a deeper level of tissue damage and is therefore staged at a higher number using a numerical scale of 1-4 (using the staging assessment determinations assigned to each stage; starting at stage 1, and increasing in severity to stage 4) on a discharge assessment as compared to the admission assessment. For the purposes of identifying the absence of a pressure ulcer, zero pressure ulcers is used when there is no skin breakdown or evidence of damage.

pressure ulcers that are new or have worsened since the last LTCH CARE Data Set assessment was completed.

Coding Instructions for M0800

- 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.

Coding Tips

- Coding this item will be easier for long-term care hospitals that document and follow pressure ulcer status on a routine basis.
- If a numerically staged pressure ulcer increases in numerical staging it is considered worsened.
- If an ulcer was unstageable on admission, and is able to be numerically staged at discharge, do not code as worsened on the discharge assessment.
- If a previously staged 3 or 4 pressure ulcer becomes unstageable due to slough or eschar, do not code as worsened.
- If a numerically staged pressure ulcer becomes unstageable and is debrided sufficiently to be numerically restaged, compare its stage before and after it was deemed unstageable. If the pressure ulcer's stage has increased in numerical staging, it is considered worsened and should be, coded as such in this item.
- If two pressure ulcers merge, do not code as worsened. Although two merged pressure ulcers might increase the overall surface area of the ulcer, it would need to have increased in numerical staging due to visibility/palpation of deeper levels of tissue damage in order for it to be considered as "worsened."
- If a pressure ulcer is acquired during a stay of more than 3 calendar days at another hospital/facility, a new LTCH CARE Data Set admission assessment is completed. On this new admission assessment, the pressure ulcer is coded as present on admission and not included in a count of worsening pressure ulcers on the discharge assessment.
- If a pressure ulcer worsens during a stay of more than 3 calendar days at another hospital/facility, a new LTCH CARE Data Set admission assessment is completed. On this new admission assessment, the pressure ulcer is coded as present on admission and not included in a count of worsening pressure ulcers on the discharge assessment.
- If a pressure ulcer increases in numerical stage (worsens) at time of discharge, it would then it is included in counts of worsening pressure ulcers on the discharge assessment.
- The following guidance is provided regarding present on admission pressure ulcers 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, if that reassessed stage is higher than the previous numerical stage, the pressure ulcer is considered to have worsened and is no longer considered POA.

- 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, if that reassessed stage is the same as the previous numerical stage, the pressure ulcer is considered NOT to have worsened and is still considered POA.
- 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 since 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.

Coding Examples

1. A patient has a pressure ulcer on the right ischial tuberosity that was Stage 2 on the admission assessment and by discharge has increased in numerical staging to a Stage 3 pressure ulcer.

   Coding:

Item	Admission Assessment	Discharge Assessment
M0300B1, Number of Stage 2 pressure ulcers	**Code as 1**	**Code as 0**
M0300B2, Number of these Stage 2 pressure ulcers that were present upon admission	**Code as 1**	**Leave blank**
M0300C1, Number of Stage 3 pressure ulcers	**Code as 0**	**Code as 1**
M0300C2, Number of these Stage 3 pressure ulcers that were present upon admission	**Code as 0**	**Code as 0**
M0800A, Worsening in Pressure Ulcer Status Since Prior Assessment – Stage 2	**N/A**	**Code as 0**
M0800B, Worsening in Pressure Ulcer Status Since Prior Assessment – Stage 3	**N/A**	**Code as 1**
M0800C, Worsening in Pressure Ulcer Status Since Prior Assessment – Stage 4	**N/A**	**Code as 0**

   Rationale: The Stage 3 pressure ulcer that is present on discharge worsened from a Stage 2 to a Stage 3 during the patient's LTCH stay. Therefore, **M0300B1 and M0300B2 are coded as 1** on the admission assessment. On the discharge assessment, **M0300C1 is coded as 1 and M0300C2 is coded as 0** because this Stage 3 pressure ulcer was not present on admission. Since the Stage 2 pressure ulcer worsened to a Stage 3 during the LTCH stay, **M0800B should be coded as 1** on the discharge assessment.

2. A patient is admitted with an unstageable pressure ulcer due to slough/eschar on the sacrum, which is debrided 3 weeks later and numerically staged as a Stage 4 pressure ulcer.

Coding:

Item	Admission Assessment	Discharge Assessment
M0300D1, Number of Stage 4 pressure ulcers	**Code as 0**	**Code as 1**
M0300D2. Number of these Stage 4 pressure ulcers that were present upon admission	**Code as 0**	**Code as 1**
M0300F1, Number of unstageable pressure ulcers due to coverage of wound bed by slough/eschar	**Code as 1**	**Code as 0**
M0300F2, Number of these unstageable pressure ulcers that were present upon admission	**Code as 1**	**Leave blank**
M0800A, Worsening in Pressure Ulcer Status Since Prior Assessment – Stage 2	**N/A**	**Code as 0**
M0800B, Worsening in Pressure Ulcer Status Since Prior Assessment – Stage 3	**N/A**	**Code as 0**
M0800C, Worsening in Pressure Ulcer Status Since Prior Assessment – Stage 4	**N/A**	**Code as 0**

Rationale: The unstageable pressure ulcer was present on admission. Therefore, **M0300F1 and M0300F2 are coded as 1** on the admission assessment. After debridement, the pressure ulcer was numerically staged as a Stage 4. On the discharge assessment, **M0300D1 and M0300D2 are coded as 1** because this pressure ulcer was first staged as a Stage 4 after debridement. M0800C is coded as 0 because the pressure ulcer did not worsen, but was first time the ulcer was able to be numerically staged after debridement, therefore it should not be counted as worsening on the discharge assessment.

3. On admission, the patient has documentation of a Stage 2 pressure ulcer on the sacrum and a Stage 3 pressure ulcer on the right heel. A review of skin care flow sheets on discharge indicate a Stage 3 pressure ulcer on the sacrum, a Stage 4 pressure ulcer on the right heel, as well as a Stage 2 pressure ulcer on the left trochanter.

Coding:

Item	Admission Assessment	Discharge Assessment
M0300B1, Number of Stage 2 pressure ulcers	**Code as 1**	**Code as 1**
M0300B2, Number of these Stage 2 pressure ulcers that were present upon admission	**Code as 1**	**Code as 0**
M0300C1, Number of Stage 3 pressure ulcers	**Code as 1**	**Code as 1**
M0300C2, Number of these Stage 3 pressure ulcers that were present upon admission	**Code as 1**	**Code as 0**
M0300D1, Number of Stage 4 pressure ulcers	**Code as 0**	**Code as 1**
M0300D2, Number of these Stage 4 pressure ulcers that were present upon admission	**Leave blank**	**Code as 0**
M0800A, Worsening in Pressure Ulcer Status Since Prior Assessment – Stage 2	**N/A**	**Code as 1**
M0800B, Worsening in Pressure Ulcer Status Since Prior Assessment – Stage 3	**N/A**	**Code as 1**
M0800C, Worsening in Pressure Ulcer Status Since Prior Assessment – Stage 4	**N/A**	**Code as 1**

Rationale: Because both the Stage 2 sacral ulcer and Stage 3 right heel pressure ulcer were present on admission, **M0300B1, M0300B2, M0300C1 and M0300C2 are coded as 1** on the admission assessment. On discharge, it is noted that the Stage 2 sacral pressure ulcer worsened to a Stage 3, the Stage 3 right heel pressure ulcer worsened to a stage 4, and a new pressure ulcer developed at the left trochanter, staged as a stage 2. On the discharge assessment**, M0300B1 is coded as 1 and M0300B2 is coded as 0** because this left trochanter pressure ulcer is new. **M0300C1 is coded as 1 and M0300C2 is coded as 0** because the Stage 2 sacral ulcer worsened to a Stage 3 during the LTCH stay. Similarly, **M0300D1 is coded as 1 and M0300D2 is coded as 0** because the Stage 3 right heel pressure ulcer worsened to a Stage 4 during the LTCH stay. **M0800A would be coded 1** on the discharge assessment because the new Stage 2 pressure ulcer on the left trochanter was not present on the admission assessment. **M0800B and M0800C would be coded as 1** on the discharge assessment for the worsening in pressure ulcer status of the sacral and right heel pressure ulcers.

4. A patient develops a Stage 3 pressure ulcer while at the LTCH. The wound bed is subsequently covered with slough and hence the pressure ulcer becomes unstageable. At the time of discharge from the LTCH, 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.

Coding:

Item	Admission Assessment	Discharge Assessment
M0300C1, Number of Stage 3 pressure ulcers	**Code as 0**	**Code as 1**
M0300C2, Number of these Stage 3 pressure ulcers present upon admission	**Leave blank**	**Code as 0**
M0800A, Worsening in Pressure Ulcer Status Since Prior Assessment – Stage 2	**N/A**	**Code as 0**
M0800B, Worsening in Pressure Ulcer Status Since Prior Assessment – Stage 3	**N/A**	**Code as 1**
M0800C, Worsening in Pressure Ulcer Status Since Prior Assessment – Stage 4	**N/A**	**Code as 0**

Rationale: On the discharge assessment, **M0300C1 is coded as 1 and M0300C2 is coded as 0** because the Stage 3 pressure ulcer developed in the LTCH and was therefore not present on admission. **M0800B is coded as 1** on discharge assessment because the Stage 3 pressure ulcer noted on discharge was not present on the admission assessment but developed in the LTCH.