SECTION M: SKIN CONDITIONS

Intent: The items in this section document the presence, appearance, and change of pressure ulcers. CMS recognizes that, in addition to the items included in this section of the Long-Term Care Hospital (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 for constant pressure and to determine the etiology of all skin ulcers, wounds, and lesions. Staff who are assessing skin should be well-versed in the identification and classification of wounds and pressure ulcer staging. This should determine and direct the proper treatment and appropriate skin management interventions for all patients in LTCHs.

CMS is aware of the array of terms used to describe alterations in skin integrity due to pressure. Some of these terms include: pressure ulcer, pressure injury, pressure sore, decubitus ulcer and bed sore. Acknowledging that clinicians may use and documentation may reflect any of these terms, it is acceptable to code pressure related skin conditions in Section M if different terminology is recorded in the clinical record, as long as the primary cause of the skin alteration is related to pressure. For example, if the medical record reflects the presence of a Stage 2 pressure injury, it should be coded on the LTCH CARE Data Set as a Stage 2 pressure ulcer.

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 O0100, Special Treatments, Procedures, and Programs* 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.

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.

- An existing pressure ulcer identifies patients at risk for further complications or skin injury.
- 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 Section M, terminology referring to "healed" vs. "unhealed" ulcers refers to whether the ulcer is "closed" versus "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), 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. LTCHs must code the LTCH CARE Data Set according to the instructions in this manual.
- For the LTCH CARE Data Set assessment, the initial (at admission) numerical staging of pressure ulcers and the initial numerical staging of ulcers after debridement, or an sDTI that evolves to an open ulcer, should be coded in terms of what is assessed (i.e., seen and palpated, such as visible tissue, palpable bone) as close to admission as possible.
- Pressure ulcer staging is an assessment system that provides a description and classification to help define the extent of damage to the skin and/or underlying soft tissue. This tissue damage can be visible or palpable in the ulcer bed. Pressure ulcer staging also 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 and clarify any questions from the medical record review.
3. Examine the patient and determine whether any skin ulcers are present.
    - Key areas for pressure ulcer development include the sacrum, coccyx, trochanters, ischial tuberosities, and heels. Other areas, such as bony deformities, skin under braces, and skin subjected to excess pressure, shear, or friction, are also at risk for pressure ulcers.
    - Conduct a full-body skin assessment to ensure no pressure ulcers are missed.
    - Examine the patient in a well-lit room. Adequate lighting is important for detecting changes in skin condition.
    - For any pressure ulcers identified, the wound bed should be carefully cleansed and/or irrigated prior to staging so that the extent of tissue damage can be visualized or palpated. This will ensure more accurate pressure ulcer staging. Measure the length, width and depth of the ulcer and record the stage of the ulcer based on the extent of damage to the skin and/or underlying soft tissue.
4. Identify and record any known 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.
- Code 1, Yes, if the patient had any pressure ulcer (Stage 1, 2, 3, 4, or unstageable) in the 3-day assessment period.

Coding Tips

- If a skin ulcer arises from a combination of factors that are primarily caused by pressure, then the skin ulcer should be included in this section as a pressure ulcer.
- Skin ulcers which occur at the end of life (a.k.a. Kennedy or terminal ulcers) are not captured in Section M of the LTCH CARE Data Set. The etiology of these ulcers is believed to be related to tissue perfusion issues at end of life due to organ and skin failure. Additionally, the evolution of these ulcers is not that of a typical pressure ulcer. End of life ulcers can develop and evolve rapidly, and generally appear from 6 weeks to 2 to 3 days before death. These ulcers present as pear-shaped purple areas of skin with irregular borders that are often found in the sacral and coccygeal regions in terminal/dying patients. Even though these ulcers are not captured in Section M of the LTCH CARE Data Set, they should be assessed and staged using the pressure ulcer staging system and documented in the clinical record and addressed in care planning.
- Mucosal pressure ulcers are not staged using the skin pressure ulcer staging system because anatomical tissue comparisons cannot be made. Therefore, mucosal ulcers (e.g., those related to nasogastric tubes, oxygen tubing, endotracheal tubes, urinary catheters, mucosal ulcers in the oral cavity, etc.) should not be coded on the LTCH CARE Data Set.
- If a pressure ulcer is surgically closed with a flap or graft, it should be considered a surgical wound and not a pressure ulcer, and therefore, should not be reported as a pressure ulcer on the LTCH CARE Data Set. If the flap or graft fails, it should still be considered a surgical wound until the area heals.
- If a pressure ulcer developed within the LTCH (i.e., was not present on Admission), but is noted as having healed at Discharge, code 0 at the appropriate stage in M0300 on the Discharge assessment.
- If two or more pressure ulcers were present on admission and merge into a single pressure ulcer by discharge, the resulting pressure ulcer is reported as one single pressure ulcer at the appropriate stage on the LTCH CARE Data Set.
- Patients with diabetes mellitus (DM) can have pressure, venous, arterial, or diabetic neuropathic ulcers. The primary etiology should be considered when coding whether a patient with DM 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 during the initial skin assessment that takes place following admission to the LTCH, **code M0210, Unhealed Pressure Ulcer(s), as 1**.

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 identified, determine the deepest anatomical stage, i.e., the extent of damage to the skin and/or soft tissue, and assign the appropriate pressure ulcer stage. Do not reverse or back stage. Consider current and historical levels of tissue involvement.

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. Necrotic tissue and eschar are usually firmly adherent to the base of the wound and often the sides/edges of the wound.

1. Observe or palpate the base of any identified pressure ulcers present to determine the extent of damage to the skin and/or soft tissues. The determination of which LTCH staff members may complete patient assessments should be done in accordance with facility, State, and Federal requirements.
2. Ulcer staging should be based on the extent of damage to the skin and/or soft tissue that is visible or palpable in and around the ulcer. In order to ensure the visualization of these tissues, it is important that the ulcer be carefully cleansed and/or irrigated. If after careful cleansing and/or irrigation of the pressure ulcer, the pressure ulcer's tissues remain obscured such that the extent of soft tissue damage cannot be observed or palpated, the pressure ulcer is considered to be unstageable (see Step 2, below).
3. Review the history of each pressure ulcer in the medical record. If the pressure ulcer has ever been classified at a higher numerical stage than what is observed now, it should continue to be classified at the higher numerical stage. LTCHs that carefully document and track pressure ulcers will be able to code these items more accurately.

Step 2: Identify Unstageable Pressure Ulcers

1. Visualization of the wound bed is necessary for accurate staging. Therefore, ensure that the ulcer is carefully cleansed and/or irrigated prior to staging so that the extent of tissue damage can be visualized or palpated. This will ensure more accurate pressure ulcer staging.
2. Pressure ulcers that have eschar (tan, black, or brown) or slough (yellow, tan, gray, green, or brown) tissue present such that the extent of soft tissue damage cannot be visualized or palpated in the wound bed should be classified as unstageable. Illustration of an unstageable pressure ulcer can be accessed at http://www.npuap.org/wp-content/uploads/2012/03/NPUAP-Unstage2.jpg.
    - It is important to note that eschar and scabs are different both physically and chemically. Eschar is a collection of dead tissue within the wound that is flush with the surface of the wound. A scab is made up of dried blood cells and serum, sits on top of the skin, and forms over exposed wounds such as wounds with granulating surfaces (like pressure

ulcers, lacerations and evulsions, etc.). A scab is evidence of wound healing. A pressure ulcer that was staged as a 2 and now has a scab indicates it is a healing stage 2, and therefore, staging should not change. Eschar characteristics and the level of damage it causes to tissues is what makes it easy to distinguish from a scab. It is extremely important to have staff who are trained in wound assessment and who are able to distinguish scabs from eschar.

3. If the wound bed is only partially covered by eschar or slough, and the extent of soft tissue damage can be visualized or palpated, the ulcer should be numerically staged, and should not be coded as unstageable.
4. A pressure ulcer with intact skin that is an 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.
5. **Known** pressure ulcers covered by a non-removable 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 non-removable dressing/device.

Step 3: Determine "Present on Admission"

*Any pressure ulcer identified and coded on the Admission assessment is assumed to be "**present on admission**," per the definition of "on admission".*

*For each pressure ulcer identified and coded in items M0300B1-G1 on **discharge**, (Planned or Unplanned), determine whether that pressure ulcer was present at the time of admission **at that stage**. Consider current and historical levels of tissue involvement in order to accurately code the "present on admission" items (M0300B2-G2) on discharge.*

1. Review the medical record for the history of the ulcer.
2. Review for location and stage of pressure ulcers at the time of admission. For **each** pressure ulcer identified on **admission**, code the number of pressure ulcers at each stage in items M0300A-G1 on the Admission assessment. Any pressure ulcer identified and coded in M0300A-G1 on the Admission assessment, is assumed to be "**present on admission**".
3. Review for location and stage of pressure ulcers at the time of discharge. For **each** pressure ulcer identified on **discharge**, code the number of pressure ulcers at each stage in items M0300A-G1 on the Discharge assessment. Then for each pressure ulcer identified in M0300B1-G1 on discharge, determine whether that pressure ulcer was present at the time of admission at that stage.

- If the pressure ulcer that is assessed on discharge was "present on admission" at the same stage it is on discharge, then the pressure ulcer is considered to be, and would be coded as, "**present on admission**" in items M0300B2-G2 on the Discharge assessment. If the pressure ulcer that is assessed on discharge was **not** present on admission at the same stage it is on discharge, then the pressure ulcer is

DEFINITION

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

considered to be **not** present on admission, and would be coded as "0" in items M0300B2-G2 on the Discharge assessment.

- If the pressure ulcer that is assessed on discharge was "present on admission" and subsequently increased in numerical stage during the patient's stay, the pressure ulcer is coded at that higher stage on discharge. That higher stage **should neither be considered, nor coded as** "**present on admission**" in items M0300B2-G2 on the Discharge assessment. In this instance, the discharge "present on admission" item for that higher numerical stage would be coded as "0."
- If on admission a pressure ulcer was unstageable, but becomes and remains numerically stageable later in the patient's stay, it **should be considered and coded as "present on admission" on the Discharge assessment at the stage at which it first becomes numerically stageable**. However, if that same pressure ulcer subsequently **increases** in numerical stage, it would be coded at that higher stage and **should not be considered nor coded as "present on admission" on the Discharge assessment.** In this instance, the discharge "present on admission" item for that higher numerical stage would be coded as "0."
- If on admission a pressure ulcer was numerically stageable, but becomes and remains unstageable by discharge, it would be coded in the appropriate unstageable item (M0300E1-G1) on the Discharge assessment. Since the pressure ulcer that is assessed on discharge was not present on admission at the same stage it is on discharge, the unstageable pressure ulcer **is neither considered nor coded as "present on admission" on the Discharge assessment**. In this instance, the discharge "present on admission" item for the unstageable pressure ulcer would be coded as "0."
- If a patient is discharged to another facility/hospital and a current pressure ulcer increases in numerical stage during a patient visit/stay longer than 3 calendar days at the other hospital/facility, on the patient's new Admission assessment, it **is coded at the higher stage and should be coded as "present on admission"**. Clinical assessments performed on patients in the LTCH should be completed according to accepted clinical practice and comply with facility policy and State and Federal regulations. The 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.
- 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, and 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 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.

- If a pressure ulcer is documented as healed during the stay, **but prior to discharge** a pressure ulcer is identified at the same anatomical location as the previously documented healed ulcer, the facility staff, including the physician, should determine if the previous ulcer reopened, or if it is a new pressure ulcer. If it is determined that the previous ulcer has reopened, it should not be considered as healed and should be staged at its previously identified highest numerical stage until it is fully healed. If the reopened pressure ulcer was originally "present on admission" (POA) and has not worsened, it would still be considered POA. However, if the reopened pressure ulcer has worsened (that is, the current stage of the reopened pressure ulcer is a higher numerical stage than it was before it was considered healed), it must be coded at its new higher numerical stage, and would no longer be considered POA. If the reopened pressure ulcer does not heal before discharge, the facility must code the status of the pressure ulcer on the Discharge assessment according to the instructions in Section M. If it is determined that the pressure ulcer is a new pressure ulcer, and does not heal before discharge, it should be staged and coded on the Discharge assessment according to the instructions in Section M as would be done for any new pressure ulcer that develops during the stay.

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.

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

M0300A: Number of Stage 1 Pressure Ulcers

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

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 is one of multiple factors that should lead providers to initiate pressure ulcer prevention interventions.

Steps for Assessment

1. Perform a full-body (head to toe) skin assessment focusing on bony prominences and pressure-bearing areas (e.g., sacrum, buttocks, heels, ankles).
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. Use more than one descriptor to determine the difference between Stage 1 and sDTIs as relying on only one is inadequate. 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 pressure ulcers may be difficult to detect in individuals with dark skin tones. Look for temperature or color changes.

Coding Instructions for M0300A

Complete if A0250 = 01 Admission, 10 Planned Discharge, or 11 Unplanned Discharge

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

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

Note: The graphic above reflects items contained in the Planned Discharge and Unplanned Discharge LTCH CARE Data Set. The admission assessment no longer includes M0300X2 items.

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 timeframe.
- 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 there are potential complications. In this situation, the patient's overall clinical condition should be reassessed.

Steps for Assessment

1. Perform a full-body (head to toe) skin assessment focusing on bony prominences and pressure-bearing areas (e.g., sacrum, buttocks, heels, ankles).
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 an sDTI rather than a Stage 2 pressure ulcer.
4. Stage 2 pressure ulcers will *generally* lack the surrounding characteristics found with an sDTI.

Coding Instructions for M0300B1: Number of Stage 2 Pressure Ulcers

Complete if A0250 = 01 Admission, 10 Planned Discharge, or 11 Unplanned Discharge

- 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.

Coding Instructions for M0300B2: Number of these Stage 2 Pressure Ulcers that were Present upon Admission

Complete only if A0250 = 10 Planned Discharge or A0250=11 Unplanned Discharge

- Enter the number of these Stage 2 pressure ulcers (M0300B1) that were present upon admission (see instructions starting on M-4 under **Steps for Completing M0300A-G, Step 3: Determine "Present on Admission"**).
- Enter 0, if no Stage 2 pressure ulcers were first noted at the time of admission.

Coding Tips

- A Stage 2 pressure ulcer presents as a shiny or dry shallow ulcer *without slough* or bruising.
- Do *not* code skin tears, tape burns, moisture-associated skin damage, or excoriation here.
- When a pressure ulcer presents as an intact blister, examine the adjacent and surrounding area for signs of deep tissue injury. When a deep tissue injury *is* determined, **do not code as a Stage 2**.

M0300C: Stage 3 Pressure Ulcers

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

Note: The graphic above reflects items contained in the Planned Discharge and Unplanned Discharge LTCH CARE Data Set. The admission assessment no longer includes M0300X2 items.

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.

Steps for Assessment

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

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.

Coding Instructions for M0300C1: Number of Stage 3 Pressure Ulcers

Complete if A0250 = 01 Admission, 10 Planned Discharge, or 11 Unplanned Discharge

- 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.

Coding Instructions for M0300C2: Number of These Stage 3 Pressure Ulcers that were Present upon Admission:

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

- Enter the number of these Stage 3 pressure ulcers (M0300C1) that were present upon admission (see instructions starting on M-4 under **Steps for Completing M0300A-G, Step 3: Determine "Present on Admission"**).
- 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 that were present upon admission		**Skip**
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**

Rationale: On the Admission assessment, the Stage 2 pressure ulcer was "present on admission" and is therefore **coded as 1 in M0300B1 on the Admission assessment**. On the Discharge assessment, the designation of "present on admission" in M0300B2 requires that the pressure ulcer be at the same location *and* not have increased in numerical stage. The (Stage 2) pressure ulcer increased in numerical stage (to Stage 3) after admission. So, **M0300B1 would be coded as 0 on the Discharge assessment, and M0300B2 would be skipped because there is no Stage 2 pressure ulcer on discharge. M0300C1 would have been coded as 0 on the Admission assessment because there were no Stage 3 pressure ulcers that were present on admission. However, on the Discharge assessment, M0300C1 would be coded as 1,** and **M0300C2 would be coded as 0** because the Stage 3 pressure ulcer that is present on discharge 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 that were present upon admission		**Code as 0**		**Skip**
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 that were present upon admission		**Skip**		**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** on the second Discharge assessment because the Stage 3 pressure ulcer was "present on admission" on the *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 that were present upon admission		**Code as 1**
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**

   Rationale: Two of the pressure ulcers on the coccyx that were present on admission have merged, but have remained at the same stage as they were at the time of admission (therefore **M0300B1 is coded as 3 on Admission and 1** *at discharge*). The third Stage 2 pressure ulcer that increased in numerical staging to a Stage 3 has developed an increased extent of tissue damage in the time since admission; therefore, on the Discharge assessment, **M0300C1 is coded as 1 and M0300C2 is coded as 0**.

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 10 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 that were present upon admission		**Code as 0**	
M0300C1, Number of Stage 3 pressure ulcers	**Code as 0**	**Code as 0**	**Code as 1**
M0300C2, Number of these Stage 3 pressure ulcers that were present upon admission		**Skip**	

   Rationale: Two Stage 2 pressure ulcers developed during the first LTCH stay and are **coded on discharge in M0300B1 as 2 and in M0300B2 as 0**. On return from the hospital, the Stage 2 pressure ulcer on the coccyx that was present prior to the patient's transfer to a short-stay acute-care hospital is **coded as 1 in M0300B1** on the patient's *second* admission to

the LTCH. There is a new Stage 3 pressure ulcer that developed during the hospital stay; therefore, **M0300C1 is coded as 1** on the patient's *second* admission to the LTCH. The Stage 2 pressure ulcer on the left lateral malleolus has healed and is not coded 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, upon reassessment of the ulcer, the LTCH notes that the extent of tissue damage in the Stage 2 pressure now includes loss of adipose tissue which is now visible in the ulcer. Therefore, the ulcer is staged as a Stage 3 pressure ulcer. The patient is discharged 3 weeks later with a healing 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		**Skip**
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**

   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; therefore, any new pressure ulcer formation, increase in numerical staging that occurred at the short-stay acute-care hospital should not be coded as "present on admission." The Stage 2 pressure ulcer that was present on admission was **coded on the Admission assessment as 1 in M0300B1**. On Discharge, the Stage 3 pressure ulcer was not present upon the patient's admission to the LTCH; therefore, **M0300C1 should be coded as 1 and 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 upon return, the LTCH received documentation from the acute-care hospital and confirmed via assessment at the LTCH, that the Stage 2 ulcer, which was present prior to discharge, now has the extent of tissue loss consistent with a Stage 3 pressure ulcer. Therefore, the ulcer is staged as a Stage 3 pressure ulcer.

   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 that were present upon admission		**Code as 0**	
M0300C1, Number of Stage 3 pressure ulcers	**Code as 0**	**Code as 0**	**Code as 1**
M0300C2, Number of these Stage 3 pressure ulcers that were present upon admission		**Skip**	

Rationale: There were no pressure ulcers identified on admission. Therefore, items **M0300B1 and M0300C1 on the first Admission assessment are coded as 0**. **On the first Discharge assessment, M0300B1 is coded as 1** because there was one Stage 2 pressure ulcer identified on discharge. **M0300B2 was coded as 0 on Discharge** because the Stage 2 that developed in the LTCH was not present on admission to the LTCH. When the patient returned on the second admission to the LTCH, it was noted that the Stage 2 pressure ulcer that was present prior to transfer to the short-stay acute-care hospital had tissue damage consistent with the extent of tissue loss of a Stage 3 pressure ulcer. Thus, while the patient was hospitalized at another facility that lasted longer than 3 calendar days, **M0300C1 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.

7. A patient enters the LTCH with a Stage 2 pressure ulcer. On day 2 of the patient's stay, the pressure ulcer is reassessed as a Stage 3 pressure ulcer due to the presence of adipose tissue. The pressure ulcer has not healed by the time of discharge, 2 weeks later.

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		**Skip**
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**

Rationale: The Stage 2 pressure ulcer was present on admission, so **M0300B1 is coded as 1** on the Admission assessment. Even though the LTCH identified further tissue damage in the pressure ulcer that was consistent with a Stage 3 pressure ulcer during the 3-day assessment period, it is the initial stage of the pressure ulcer should be captured because it reflects the patient's condition at the time of admission. On the Discharge assessment, **M0300C1 should be coded as 1** and **M0300C2 should be coded as 0** because the Stage 3 pressure ulcer was not present, at that stage, on admission.

8. A patient is admitted to an LTCH with one large Stage 3 pressure ulcer on the coccyx. At the time of discharge, there is some epithelialization in the center of the pressure ulcer. ,

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 that were present upon admission		**Skip**
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**

Rationale: At the time of discharge, the Stage 3 pressure ulcer on the coccyx that was present on admission has begun to show some healing at the center. Because this ulcer is healing and has not fully closed, it remains a Stage 3 pressure ulcer on discharge. It will continue

to be considered a Stage 3 pressure ulcer until it heals; therefore **M0300C1 is coded as 1** and **M0300C2 is coded as 1** on the Discharge assessment.

9. A patient is admitted to the LTCH with nine Stage 2 pressure ulcers. During the patient's stay, he develops two additional Stage 2 pressure ulcers. One of the "new" pressure ulcers heals by the time of discharge, but the patient is discharged with 10 Stage 2 pressure ulcers.

   Coding:

Item	Admission Assessment	Discharge Assessment
M0300B1, Number of Stage 2 pressure ulcers	**Code as 9**	**Code as 9**
M0300B2, Number of these Stage 2 pressure ulcers that were present upon admission		**Code as 9**
M0300C1, Number of Stage 3 pressure ulcers	**Code as 0**	**Code as 0**
M0300C2, Number of these Stage 3 pressure ulcers that were present upon admission		**Skip**

   Rationale: Because there were nine Stage 2 pressure ulcers present on admission, **M0300B1 is coded as 9** on the Admission assessment. At the time of discharge, the patient had 10 Stage 2 pressure ulcers. However, because there is space to enter only one digit in M0300B1, **M0300B1 would be coded as 9** on the Discharge assessment. **M0300B2 would be coded as 9** on the Discharge assessment because nine of the ten Stage 2 pressure ulcers that are present on discharge were present on admission.

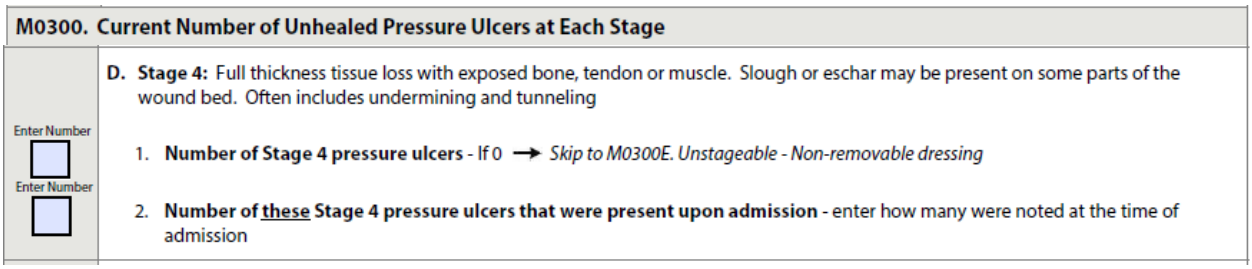
10. A patient is admitted to the LTCH with one non-healing Stage 3 pressure ulcer. The patient is transferred to another facility for a flap procedure to close the pressure ulcer and returns to the LTCH 2 calendar days following the transfer. The patient is discharged with the flap, which is healing nicely.

    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 that were present upon admission		**Skip**
M0300C1, Number of Stage 3 pressure ulcers	**Code as 1**	**Code as 0**
M0300C2, Number of these Stage 3 pressure ulcers that were present upon admission		**Skip**

    Rationale: The non-healing Stage 3 pressure ulcer is present on admission, so **M0300C1 is coded as 1** on the Admission assessment. On the Discharge assessment, **M0300C1 is coded 0** because a flap has been used to close the Stage 3 pressure ulcer. A flap used to close a pressure ulcer would essentially render the pressure ulcer as "closed," and would now be considered a surgical wound.

M0300D: Stage 4 Pressure Ulcers



Note: The graphic above reflects items contained in the Planned Discharge and Unplanned Discharge LTCH CARE Data Set. The admission assessment no longer includes M0300X2 items.

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.

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 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.

Steps for Assessment

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

Coding Instructions for M0300D1: Number of Stage 4 Pressure Ulcers

Complete if A0250 = 01 Admission, 10 Planned Discharge, or 11 Unplanned Discharge

- 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.

Coding Instructions for M0300D2: Number of These Stage 4 Pressure Ulcers that were Present upon Admission

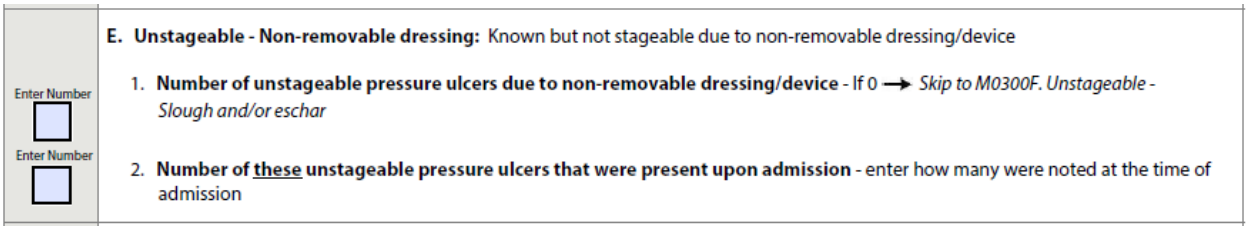
Complete only if A0250 = 10 Planned Discharge or A0250=11 Unplanned Discharge.

- Enter the number of these Stage 4 pressure ulcers (M0300D1) that were present upon admission (see instructions starting on M-4 under **Steps for Completing M0300A-G, Step 3: Determine "Present on Admission"**).
- 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.
- In Stage 4 pressure ulcers, exposed bone/tendon/muscle is visible or directly palpable.
- Cartilage serves the same anatomical function as bone. Therefore, pressure ulcers that have exposed cartilage should be classified as a Stage 4 pressure ulcer.

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



Note: The graphic above reflects items contained in the Planned Discharge and Unplanned Discharge LTCH CARE Data Set. The admission assessment no longer includes M0300X2 items.

Item Rationale

- Although the wound bed cannot be visualized due to the non-removable dressing/device—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

***Documentation of an existing pressure ulcer is needed to complete this item*.**

DEFINITION

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

1. Review the medical record for documentation of a pressure ulcer covered by a non-removable dressing/device. Do not assume that there is a pressure ulcer that is covered by a non-removable dressing/device.
2. Determine the number of documented pressure ulcers that are covered by a non-removable dressing/device. Examples of non-removable dressings/devices include a dressing that is not to be removed per physician's order (such as those used in negative-pressure wound therapy [NPWT]), an orthopedic device, or a cast. These ulcers are considered "unstageable" due to the inability to further assess the documented pressure ulcer that is covered by a non-removable dressing/device.

Coding Instructions for M0300E1: Number of Unstageable Pressure Ulcers Related to Non-Removable Dressing/Device

Complete if A0250 = 01 Admission, 10 Planned Discharge, or 11 Unplanned Discharge

- Enter the number of pressure ulcers that are unstageable related to non-removable dressing/device.
- Enter 0, if no unstageable pressure ulcers related to non-removable dressing/device are present.

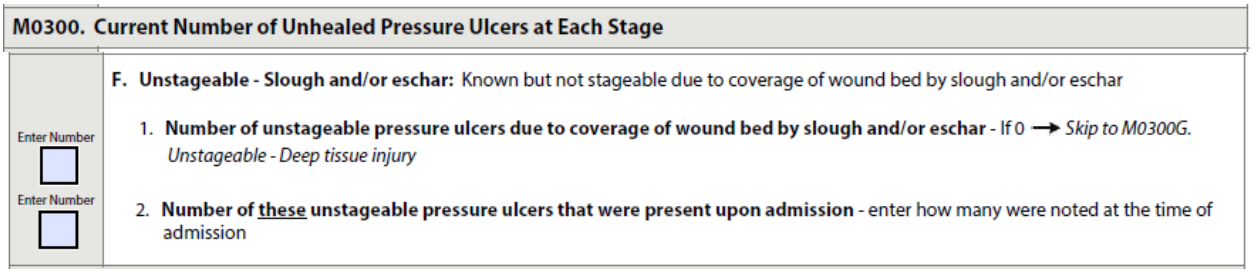
Coding Instructions for M0300E2: Number of These Unstageable Pressure Ulcers Related to Non-Removable Dressing that were Present upon Admission:

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

- Enter the number of these unstageable pressure ulcers due to a non-removable dressing/device (M0300E1) that were present upon admission (see instructions starting on M-4 under **Steps for Completing M0300A-G, Step 3: Determine "Present on Admission"**).

- Enter 0, if no unstageable pressure ulcers related to non-removable dressing/device were first noted at the time of admission.

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



Note: The graphic above reflects items contained in the Planned Discharge and Unplanned Discharge LTCH CARE Data Set. The admission assessment no longer includes M0300X2 items.

Item Rationale

- Pressure ulcers may affect quality of life for patients because it may limit activity, be painful, and require time-consuming treatments and dressing changes.
- Pressure ulcers that present as unstageable require care planning that includes, in the absence of ischemia, debridement of necrotic and dead tissue and restaging once this tissue is removed.
- Visualization of the wound bed is necessary for accurate pressure ulcer staging. Therefore, prior to staging, ensure that the ulcer is carefully cleansed and/or irrigated. If after careful cleansing and/or irrigation of the pressure ulcer, the pressure ulcer's tissues remain obscured and therefore the extent of soft tissue damage cannot be observed or palpated, the pressure ulcer is considered to be unstageable.
- The presence of pressure ulcers and other skin changes should be accounted for in the interdisciplinary care plan.

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.

Coding Instructions for M0300F1: Number of Unstageable Pressure Ulcers Related to Slough and/or Eschar

Complete if A0250 = 01 Admission, 10 Planned Discharge, or 11 Unplanned Discharge

- 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: Number of These Unstageable Pressure Ulcers Related to Slough and/or Eschar that were Present upon Admission

Complete only if A0250 = 10 Planned discharge or A0250=11 Unplanned discharge.

- Enter the number of these unstageable pressure ulcers due to coverage of wound bed by slough and/or eschar (M0300F1) that were present upon admission (see instructions starting on M-4 under **Steps for Completing M0300A-G, Step 3: Determine "Present on Admission"**).
- Enter 0, if no unstageable pressure ulcers related to slough and/or eschar were first noted at the time of admission.

Coding Tips

DEFINITION

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

- Pressure ulcers that are covered with slough and/or eschar such that the tissues within the ulcer cannot be assessed, should be coded as unstageable because the extent of soft tissue damage (and therefore, the numerical stage) cannot be determined. Only until enough slough and/or eschar are removed to expose the extent of soft tissue damage 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.
- Once the pressure ulcer is cleansed, irrigated and/or debrided of enough slough and/or eschar such that the extent of soft tissue damage 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 the LTCH with eschar tissue identified on both the right and left heels, as well as a Stage 2 pressure ulcer to the coccyx. The patient's pressure ulcers are

reassessed before discharge, and the Stage 2 coccyx pressure ulcer had healed. The left heel eschar became fluctuant, showed signs of infection, had to be debrided at the bedside and 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 that were present upon admission		**Skip**
M0300C1, Number of Stage 3 pressure ulcers	**Code as 0**	**Code as 0**
M0300C2, Number of these Stage 3 pressure ulcers that were present upon admission		**Skip**
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 1**
M0300E1, Number of unstageable pressure ulcers due to non-removable dressing/device	**Code as 0**	**Code as 0**
M0300E2, Number of these unstageable pressure ulcers due to non-removable dressing/device that were present upon admission		**Skip**
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 that were present upon admission		**Code as 1**

Rationale: Both heels cannot be numerically staged at admission because the extent of tissue damage cannot be determined due to the eschar present, so **M0300F1 is coded as 2** on the Admission assessment. The Stage 2 pressure ulcer on the coccyx healed, so **M0300B1 is coded as 1** on the Admission assessment and **M0300B1 is coded as 0** on the Discharge assessment. The left heel eschar that was debrided is coded as a Stage 4 at discharge, so **M0300D1 is coded as 1.** This ulcer is **coded in M0300D2 as 1**, "present on admission," on the Discharge assessment because the first time an unstageable ulcer is able to be numerically staged, it is "present on admission" at the stage it is first assessed. The right heel eschar remained stable and intact, so both **M0300F1 and M0300F2** are **coded as 1** on the Discharge assessment.

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

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 that were present upon admission		**Skip**
M0300C1, Number of Stage 3 pressure ulcers	**Code as 0**	**Code as 0**
M0300C2, Number of these Stage 3 pressure ulcers that were present upon admission		**Skip**
M0300D1, Number of Stage 4 pressure ulcers	**Code as 1**	**Code as 2**
M0300D2, Number of these Stage 4 pressure ulcers that were present upon admission		**Code as 1**

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

3. 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. The patient 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 pressure ulcer 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 was assessed to have further tissue damage consistent with a Stage 4 pressure ulcer, as was the coccyx pressure ulcer. There was also a new Stage 3 pressure ulcer identified on the patient's left buttock.

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		**Skip**
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 0**
M0300D1, Number of Stage 4 pressure ulcers	**Code as 0**	**Code as 2**
M0300D2, Number of these Stage 4 pressure ulcers present upon admission		**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 (**M0300B1 and M0300C1 were coded as 1** on the Admission assessment) both had further tissue damage and were staged as Stage 4; therefore, on the Discharge assessment, **M0300D1 is coded as 2** and **M0300D2 is coded as 0**. The new Stage 3 pressure ulcer identified on the left buttock area is coded in **M0300C1 as 1** and in

M0300C2 as 0 on the Discharge assessment because it is a new Stage 3 pressure ulcer that was not present on admission.

4. Patient is admitted to an LTCH with a short leg cast to the right lower extremity. The patient has no visible wounds on admission, but arrives with documentation that a pressure ulcer exists on the right heel under the cast. Two weeks after admission to the LTCH, the cast is removed by the physician. The pressure ulcer is assessed and determined to be a Stage 3 pressure ulcer, 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 upon admission		**Skip**
M0300C1, Number of Stage 3 pressure ulcers	**Code as 0**	**Code as 1**
M0300C2, Number of these Stage 3 pressure ulcers present upon admission		**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 upon admission		**Skip**
M0300E1, Number of Unstageable pressure ulcers due to non-removable dressing/device	**Code as 1**	**Code as 0**
M0300E2, Number of Unstageable pressure ulcers due to non-removable dressing/device present upon admission		**Skip**

   Rationale: Because the patient came to the LTCH with documentation that a pressure ulcer was present under the cast and 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 as 1 for M0300E1** on the Admission assessment. On discharge, **M0300C1 is coded as 1** and **M0300C2 is coded as 1** because even though a Stage 3 pressure ulcer was not technically assessed on admission, the ulcer was able to be staged only after removal of the cast; therefore, it is coded as present on admission at the stage it was first able to be assessed and numerically staged.

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

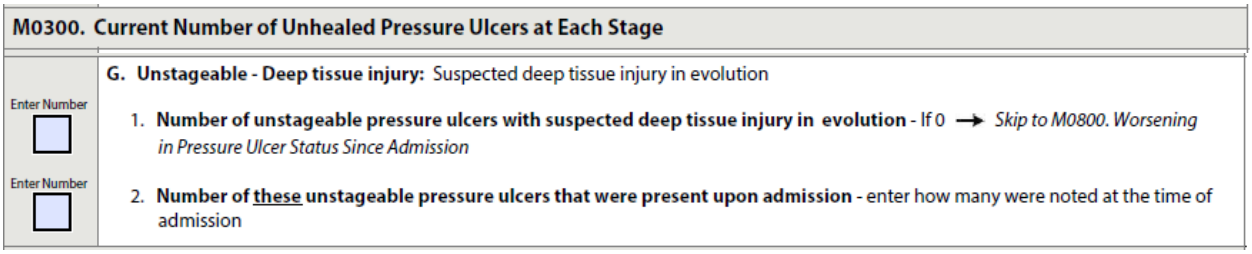
   Coding:

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 that were present upon admission		**Skip**
M0300C1, Number of Stage 3 pressure ulcers	**Code as 0**	**Code as 0**

Item	Admission Assessment	Discharge Assessment
M0300C2, Number of these Stage 3 pressure ulcers that were present upon admission		**Skip**
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 1**
M0300E1, Number of unstageable pressure ulcers due to non-removable dressing/device	**Code as 0**	**Code as 0**
M0300E2, Number of these unstageable pressure ulcers due to non-removable dressing/device that were present upon admission		**Skip**
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 that were present upon admission		**Skip**

Rationale: The patient presented with an unstageable pressure ulcer on admission. After surgical debridement, the pressure ulcer is assessed and staged as a Stage 4. On discharge, **M0300D1 and M0300D2 are coded as 1. M0300D2 is coded as 1** because the pressure ulcer that was unstageable on admission was debrided and numerically staged. This pressure ulcer is considered as present on admission at the stage it is first able to be assessed and numerically staged.

M0300G: Unstageable Pressure Ulcers Related to Suspected Deep Tissue Injury



Note: The graphic above reflects items contained in the Planned Discharge and Unplanned Discharge LTCH CARE Data Set. The admission assessment no longer includes M0300X2 items.

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 of an sDTI is imperative.

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

DEFINITION

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

Steps for Assessment

1. Perform a full-body (head to toe) skin assessment focusing on bony prominences and pressure-bearing areas (e.g., sacrum, buttocks, heels, ankles).
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 an 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 an sDTI.
6. Clearly document assessment findings in the patient's medical record, and track and document appropriate wound-care planning and management.

Coding Instructions for M0300G1: Number of Unstageable Pressure Ulcers Related to Suspected Deep Tissue Injury

Complete if A0250 = 01 Admission, 10 Planned Discharge, or 11 Unplanned Discharge.

- Enter the number of unstageable pressure ulcers related to sDTI. 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 sDTI.
- Enter 0, if no unstageable pressure ulcers related to sDTI are present.

Coding Instructions for M0300G2: Number of These Unstageable Pressure Ulcers Related to Suspected Deep Tissue Injury that were Present upon Admission

Complete only if A0250 = 10 Planned discharge or A0250 = 11 Unplanned discharge.

- Enter the number of these unstageable pressure ulcers with sDTI (M0300G1) that were present upon admission (see instructions starting on M-4 under **Steps for Completing M0300A-G, Step 3: Determine "Present on Admission"**).
- Enter 0, if no unstageable pressure ulcers related to sDTI were first noted at the time of admission.

Coding Tips

- Once an 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 injuries 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 an 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 an sDTI. Four days after admission, the right heel blister is drained and conservatively debrided at the bedside. After debridement, the right heel is staged as a Stage 3 pressure ulcer. On discharge, the right heel remains at Stage 3 and the sacral area eschar remains dry and stable. The sacral area continues to be assessed as an sDTI at 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 that were present upon admission		**Skip**
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 1**
M0300D1, Number of Stage 4 pressure ulcers	**Code as 0**	**Code as 0**
M0300D2, Number of these Stage 4 pressure ulcers that were present upon admission		**Skip**

Item	Admission Assessment	Discharge Assessment
M0300E1, Number of unstageable pressure ulcers due to non-removable dressing/device	**Code as 0**	**Code as 0**
M0300E2, Number of these unstageable pressure ulcers due to non-removable dressing/device that were present upon admission		**Skip**
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 that were present upon admission		**Skip**
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 that were present upon admission		**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 were determined to be consistent with what constitutes an sDTI. For the Admission assessment, **M0300G1 is coded with a 2** because there were two sDTIs, both present on admission. Once the heel sDTI is drained, debrided, and numerically staged, **M0300C1 and M0300C2 are coded as 1** on the Discharge assessment. **M0300C1 is coded as 1** on the Discharge assessment because the heel sDTI was debrided and were able to be numerically staged. Because this was the first time the ulcer was able to be assessed and numerically staged, it is considered to be present on admission. **M0300G1 is coded as 1** on the Discharge assessment because the sacral sDTI is dry and stable and cannot be numerically staged, and **M0300G2 is coded as 1** on the Discharge assessment, because of the 2 sDTIs that were present on admission only one remains an sDTI on discharge.

M0800: Worsening in Pressure Ulcer Status Since Admission

M0800. Worsening in Pressure Ulcer Status Since Admission	
Indicate the number of current pressure ulcers that were **not present or were at a lesser stage** on admission. 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**
Enter Number ☐	**D. Unstageable - Non-removable dressing**
Enter Number ☐	**E. Unstageable - Slough and/or eschar**
Enter Number ☐	**F. Unstageable - Deep tissue injury**

Item Rationale

- This item documents whether skin status, overall, has worsened since the Admission 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.
- The interdisciplinary care plan should be reevaluated to ensure adherence to the appropriate preventative measures and pressure ulcer management principles when new pressure ulcers develop and/or worsen.

Steps for Assessment

This item refers back to the pressure ulcer coding on the Admission assessment.

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

1. Review the history of each current Stage 2–4 and unstageable pressure ulcer.
2. For each current Stage 2–4 or unstageable pressure ulcer, compare the number and status of pressure ulcers as documented on the Admission assessment with the number and status of current pressure ulcers to determine those that were not present (i.e., are new), or have worsened since admission.

Coding Instructions for M0800

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

Coding Tips

- Coding this item will be easier for LTCHs that document and follow pressure ulcer status on a routine basis throughout the LTCH stay.
- If a pressure ulcer increases in numerical stage from admission to discharge, it is considered worsened and would be included in counts of worsening pressure ulcers on the Discharge assessment.
- If a previous Stage 1 or 2 pressure ulcer further deteriorates and eventually becomes unstageable due to slough or eschar during the LTCH stay, it *should be coded as worsened* because the ulcer

DEFINITION

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.

would have moved from either intact (in the case of a Stage 1 ulcer) or partial thickness (in the case of a Stage 2 ulcer) to a full thickness wound.

- If a previous Stage 3 or 4 pressure ulcer is unstageable due to slough or eschar on discharge, *do not code as worsened*. However, if a previously numerically staged pressure ulcer becomes unstageable and is debrided sufficiently to be numerically staged *by discharge*, 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 a pressure ulcer was unstageable on admission, and is able to be numerically staged only at discharge, code the appropriate stage in M0300 but do not code this ulcer as worsened on the Discharge assessment because it will be the first time that the pressure ulcer was able to be numerically staged.
- If two pressure ulcers merge, do not code as worsened. Although two merged pressure ulcers might increase the overall surface area of the ulcer, the ulcer would need to have increased in numerical staging in order for it to be considered as worsened.
- The following guidance is provided regarding pressure ulcers that were present upon admission (POA) that were numerically staged, become unstageable, are debrided, and subsequently become numerically stageable:
    - 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 staged 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.
    - 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 staged 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.
    - 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 staged 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 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		**Skip**
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**
M0800A, Worsening in Pressure Ulcer Status Since Admission – Stage 2		**Code as 0**
M0800B, Worsening in Pressure Ulcer Status Since Admission – Stage 3		**Code as 1**
M0800C, Worsening in Pressure Ulcer Status Since Admission – Stage 4		**Code as 0**
M0800D, Worsening in Pressure Ulcer Status Since Admission – Unstageable - Non-removable dressing/device		**Code as 0**
M0800E, Worsening in Pressure Ulcer Status Since Admission – Unstageable - Slough and/or Eschar		**Code as 0**
M0800F, Worsening in Pressure Ulcer Status Since Admission – Unstageable - Deep tissue injury		**Code as 0**

Rationale: The Stage 3 pressure ulcer that is present on discharge increased in numerical stage from a Stage 2 to a Stage 3 during the patient's LTCH stay. Therefore, **M0300B1 is coded as 1** on the Admission assessment and **M0300B1 is coded as 0** on the Discharge assessment. **M0300C1 is coded as 1** and **M0300C2 is coded as 0** on the Discharge assessment 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 and remained a Stage 4 until discharge.

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 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		**Skip**

Item	Admission Assessment	Discharge Assessment
M0800A, Worsening in Pressure Ulcer Status Since Admission – Stage 2		**Code as 0**
M0800B, Worsening in Pressure Ulcer Status Since Admission – Stage 3		**Code as 0**
M0800C, Worsening in Pressure Ulcer Status Since Admission – Stage 4		**Code as 0**
M0800D, Worsening in Pressure Ulcer Status Since Admission – Unstageable - Non-removable dressing/device		**Code as 0**
M0800E, Worsening in Pressure Ulcer Status Since Admission– Unstageable - Slough and/or Eschar		**Code as 0**
M0800F, Worsening in Pressure Ulcer Status Since Admission – Unstageable - Deep tissue injury		**Code as 0**

Rationale: The unstageable pressure ulcer was present on admission. Therefore, **M0300F1 is coded as 1** on the Admission assessment **and M0300F2 is skipped** on the Discharge 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 it was the 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. A patient is admitted to an LTCH 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.

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 that were present upon admission		**Skip**
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**
M0800A, Worsening in Pressure Ulcer Status Since Admission – Stage 2		**Code as 0**
M0800B, Worsening in Pressure Ulcer Status Since Admission – Stage 3		**Code as 1**
M0800C, Worsening in Pressure Ulcer Status Since Admission – Stage 4		**Code as 0**
M0800D, Worsening in Pressure Ulcer Status Since Admission – Unstageable - Non-removable dressing/device		**Code as 0**
M0800E, Worsening in Pressure Ulcer Status Since Admission– Unstageable - Slough and/or Eschar		**Code as 0**
M0800F, Worsening in Pressure Ulcer Status Since Admission – Unstageable - Deep tissue injury		**Code as 0**

Rationale: At the time of discharge, the two Stage 2 pressure ulcers that were present on admission merged and increased in numerical staging to Stage 3 by discharge. Therefore, **M0300B1 is coded as 2 on the Admission assessment and M0300B1 is coded**

as 0 on the Discharge assessment. M0300C1 is coded as 0 on the Admission assessment and M0300C1 is coded as 1 on the Discharge assessment**.** Since the two Stage 2 pressure ulcers merged and increased in numerical staging to Stage 3, the ulcer is no longer considered as present on admission, so on the Discharge assessment **M0300C2 is coded as 0**. Since the Stage 2 pressure ulcers merged and worsened to one Stage 3 pressure ulcer during the LTCH stay, **M0800B should be coded as 1** on the Discharge assessment.

4. 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, and 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 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 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		**Code as 0**
M0800A, Worsening in Pressure Ulcer Status Since Admission – Stage 2		**Code as 1**
M0800B, Worsening in Pressure Ulcer Status Since Admission – Stage 3		**Code as 1**
M0800C, Worsening in Pressure Ulcer Status Since Admission – Stage 4		**Code as 1**
M0800D, Worsening in Pressure Ulcer Status Since Admission – Unstageable - Non-removable dressing/device		**Code as 0**
M0800E, Worsening in Pressure Ulcer Status Since Admission – Unstageable - Slough and/or Eschar		**Code as 0**
M0800F, Worsening in Pressure Ulcer Status Since Admission – Unstageable - Deep tissue injury		**Code as 0**

Rationale: Because both the Stage 2 sacral ulcer and Stage 3 right-heel pressure ulcer were present on admission, **M0300B1 and M0300C1 are coded as 1** on the Admission assessment. On discharge, it is noted that the Stage 2 sacral pressure ulcer increased in numerical stage to a Stage 3, the Stage 3 right heel pressure ulcer increased in numerical stage to a Stage 4, and a new pressure ulcer developed at the left trochanter, staged as a Stage 2. Therefore, on the Discharge assessment**, M0300B1 is coded as 1** and **M0300B2 is coded as 0** because the left trochanter pressure ulcer is new and was not present on admission. **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 and this ulcer was not a Stage 3 on admission. **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 and this ulcer was not a Stage 4 on admission. **M0800A would be coded 1** on the Discharge assessment because the Stage 2

pressure ulcer on the left trochanter developed in the LTCH and therefore is coded as new. **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.

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

   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 that were present upon admission		**Code as 0**
M0800A, Worsening in Pressure Ulcer Status Since Admission – Stage 2		**Code as 0**
M0800B, Worsening in Pressure Ulcer Status Since Admission – Stage 3		**Code as 1**
M0800C, Worsening in Pressure Ulcer Status Since Admission – Stage 4		**Code as 0**
M0800D, Worsening in Pressure Ulcer Status Since Admission – Unstageable - Non-removable dressing/device		**Code as 0**
M0800E, Worsening in Pressure Ulcer Status Since Admission – Unstageable - Slough and/or Eschar		**Code as 0**
M0800F, Worsening in Pressure Ulcer Status Since Admission – Unstageable - Deep tissue injury		**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 (as reflected by code 0 in M0300C1 on the Admission assessment). **M0800B is coded as 1** on the Discharge assessment because the Stage 3 pressure ulcer is noted on discharge. Even though the Stage 3 pressure ulcer was not considered worsened after it was numerically staged after debridement, the ulcer developed in the LTCH and therefore is coded as a new pressure ulcer that was not present on admission.

6. A patient was admitted to the LTCH from the acute-care hospital with two Stage 2 pressure ulcers, one on each heel. After 2 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, suggestive of an sDTI. 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 LTCH against medical advice.

Coding:

Item	Admission Assessment	Discharge Assessment
M0300B1, Number of Stage 2 pressure ulcers	**Code as 2**	**Code as 1**
M0300B2, Number of these Stage 2 pressure ulcers that were present upon admission		**Code as 1**
M0300G1, Number of unstageable pressure ulcers with suspected deep tissue injury		**Code as 1**
M0300G2, Number of these Unstageable pressure ulcers with suspected deep tissue injury that were present upon admission		**Code as 0**
M0800A, Worsening in Pressure Ulcer Status Since Admission – Stage 2		**Code as 0**
M0800B, Worsening in Pressure Ulcer Status Since Admission – Stage 3		**Code as 0**
M0800C, Worsening in Pressure Ulcer Status Since Admission – Stage 4		**Code as 0**
M0800D, Worsening in Pressure Ulcer Status Since Admission – Unstageable - Non-removable dressing/device		**Code as 0**
M0800E, Worsening in Pressure Ulcer Status Since Admission – Unstageable - Slough and/or Eschar		**Code as 0**
M0800F, Worsening in Pressure Ulcer Status Since Admission – Unstageable - Deep tissue injury		**Code as 1**

Rationale: On the Admission assessment, **M0300B1 is coded as 2** because the initial assessment identified two Stage 2 pressure ulcers that were present on admission. **M0300B1 and M0300B2 is coded as 1, and M0300G1 is coded as 1** on the Discharge assessment because, although two Stage 2 pressure ulcers were identified on admission, one of the Stage 2 pressure ulcers developed into an sDTI which remained so at discharge. **M0300G2 is coded as 0** on the Discharge assessment because the sDTI was not present at that stage on admission; it was staged as a Stage 2 pressure ulcer. **M0800F is coded as 1** because a Stage 2 that becomes an sDTI has clinically deteriorated from a partial thickness wound to tissue damage that involves full-thickness structures.