

# Quality Reporting Program Provider Training



## Section M: Skin Conditions (Pressure Ulcer/Injury)

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# Acronyms in This Presentation

- Ankle Foot Orthosis (AFO)
- Centers for Medicare & Medicaid Services (CMS)
- Deep Tissue Injury (DTI)
- Gastrostomy Tube (G-tube)
- Inpatient Rehabilitation Facility (IRF)
- Inpatient Rehabilitation Facility Patient Assessment Instrument (IRF-PAI)
- Long-Term Care Hospital (LTCH)



# Acronyms in This Presentation (cont.)

- LTCH Continuity Assessment Record and Evaluation (LTCH CARE) Data Set
- National Pressure Ulcer Advisory Panel (NPUAP)
- Peripheral Arterial Disease (PAD)
- Peripheral Vascular Disease (PVD)
- Post-Acute Care (PAC)
- Quality Measure (QM)
- Quality Reporting Program (QRP)
- Skilled Nursing Facility (SNF)



# Overview

- Define Section M: Skin Conditions
- Explain the intent of Section M
- Explain new items and/or changes
- Discuss coding instructions for items
- Review practice coding scenarios



# Objectives

- State the intent of the changes to Section M
- Describe the new pressure ulcer/injury quality measure (QM)
- Articulate the purpose of the new wording and any implications for coding
- Apply coding instructions to accurately code practice scenarios and the case study



# Intent

- Document the presence, appearance, and change in status of pressure ulcers/injuries based on a complete and ongoing assessment of patient's skin guided by clinical standards
- Promote effective pressure ulcer/injury prevention and skin management program for all patients

## **PRESSURE ULCER/INJURY:**

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.

# Changes in Skin Integrity Post-Acute Care: Pressure Ulcer/Injury

IRF-PAI v2.0

LTCH CARE Data Set v4.00 | Section M | May 2018



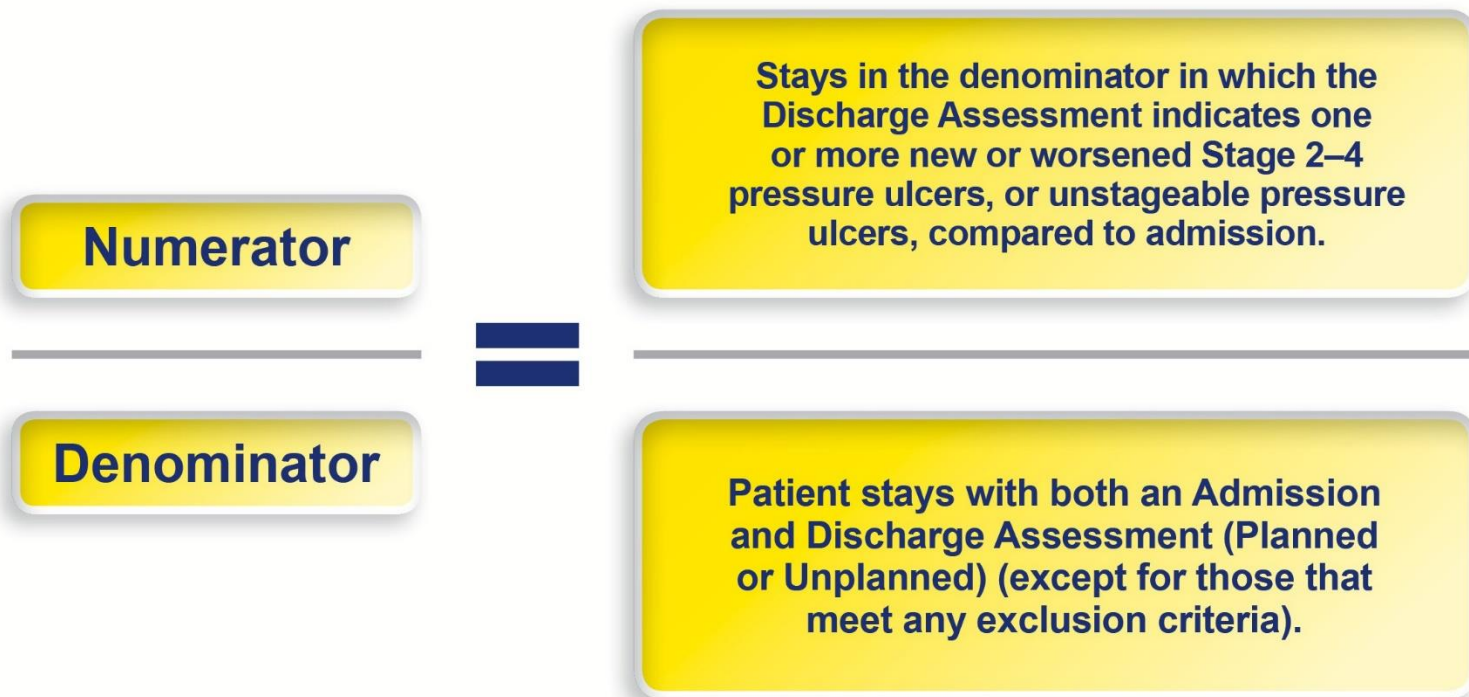
# Changes in Skin Integrity Post-Acute Care: Pressure Ulcer/Injury

- M0300 items will be used to calculate the new quality measure “Changes in Skin Integrity Post-Acute Care: Pressure Ulcer/Injury,” with data collection beginning:
  - July 1, 2018, for Long-Term Care Hospitals (LTCHs)
  - October 1, 2018, for Inpatient Rehabilitation Facilities (IRFs)
- For this measure, an ulcer is considered new or worsened at discharge if the Discharge Assessment shows a Stage 2–4 or unstageable pressure ulcer that was not present on admission at that stage (e.g., M0300B1–M0300B2 > 0)





# Changes in Skin Integrity Post-Acute Care: Pressure Ulcer/Injury (cont. 1)



# Changes in Skin Integrity Post-Acute Care: Pressure Ulcer/Injury (cont. 2)

## Denominator Exclusions:

1. Patient stay is excluded if data on new or worsened Stage 2, 3, 4, and unstageable pressure ulcers, including deep tissue injuries, are missing on the Discharge Assessment
2. Patient stay is excluded if the patient died during the stay

# Changes in Skin Integrity Post-Acute Care: Pressure Ulcer/Injury (cont. 3)

## Measure Time Window:

- The measure will be calculated quarterly using a rolling 12 months of data. For public reporting, the quality measure score reported for each quarter is calculated using a rolling 12 months of data
- All patient stays during the 12 months, except those that meet the exclusion criteria, are included in the denominator and are eligible for inclusion in the numerator
- For patients with multiple stays during the 12-month time window, each stay is eligible for inclusion in the measure

# Changes in Skin Integrity Post-Acute Care: Pressure Ulcer/Injury (cont. 4)

Items from the Admission Assessment used to risk-adjust this quality measure:

Functional Mobility  
Admission  
Performance.

- GG0170C. Mobility; Lying to Sitting on Side of Bed

Bowel Continence.

- H0400. Bowel Continence

Peripheral Vascular  
Disease/Peripheral  
Arterial Disease or  
Diabetes Mellitus.

- I0900. Peripheral Vascular Disease (PVD) or Peripheral Arterial Disease (PAD); or
- I2900. Diabetes Mellitus

Low Body Mass Index,  
based on Height and  
Weight.

- K0200A. Height; and
- K0200B. Weight

# Section M: Skin Conditions

## Changes

# Item Changes

- Centers for Medicare & Medicaid Services (CMS) is aware of the array of terms used to describe alterations in skin integrity due to pressure, including pressure ulcer, pressure injury, pressure sore, decubitus ulcer, and bed sore
- It is acceptable to code pressure-related skin conditions in Section M if different terminology is recorded in the clinical record, if the primary cause of the skin alteration is related to pressure



# Item Changes (cont. 1)

- CMS adheres to the following guidelines:
  - Stage 1 pressure injuries and deep tissue injuries are termed “pressure injuries” because they are closed wounds
  - Stage 2, 3, or 4 pressure ulcers, or unstageable ulcers due to slough or eschar, are termed “pressure ulcers” because they are usually open wounds
  - Unstageable ulcers/injuries due to nonremovable dressing/device are termed “pressure ulcers/injuries” because they may be open or closed wounds



# Item Changes (cont. 2)

## New:

- The term “**injuries**” has been added to items: M0210, M0300, M0300A, M0300E–M0300E2, and M0300G–M0300G2

Section M	Skin Conditions
Report based on highest stage of existing ulcers/ <b>injuries</b> at their worst; do not "reverse" stage.	
<b>M0210. Unhealed Pressure Ulcers/<b>injuries</b></b>	
Enter Code <input type="checkbox"/>	Does this patient have one or more unhealed pressure ulcers/ <b>injuries</b> ? 0. No → Skip to N2001, Drug Regimen Review 1. Yes → Continue to M0300, Current Number of Unhealed Pressure Ulcers/Injuries at Each Stage
<b>M0300. Current Number of Unhealed Pressure Ulcers/<b>injuries</b> at Each Stage</b>	
Enter Number <input type="checkbox"/>	A. <b>Stage 1:</b> 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 1. Number of Stage 1 pressure <b>injuries</b>



# Item Changes (cont. 3)

## New:

- The term “**device**” was added to items: M0300E–M0300E2

Enter Number <input type="text"/>	<b>E. Unstageable - Non-removable dressing/device:</b> Known but not stageable due to non-removable dressing/ <b>device</b>  1. Number of unstageable pressure ulcers/injuries due to non-removable dressing/ <b>device</b>
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# Item Changes (cont. 4)

## New:

- Removed the term “suspected deep tissue injury in evolution” and replaced with “**deep tissue injury**” to items M0300G and M0300G1

Enter Number <input type="checkbox"/>	G. Unstageable - Deep tissue injury
	1. Number of unstageable pressure injuries presenting as deep tissue injury

# Item Changes (cont. 5)

- M0800A–M0800F, Worsening in Pressure Ulcer/Injury Status Since Admission, items have been removed



# Section M: Skin Conditions

## Coding Guidance and Coding Scenarios

# M0300. Current Number of Unhealed Pressure Ulcers/Injuries

## Admission Assessment

- M0300A1–G1
  - Identifies number of unhealed pressure ulcers/injuries at each stage
  - Establishes the patient's baseline assessment

## Discharge Assessment (For LTCH: Planned or Unplanned)

- M0300A1–G1
  - Identifies number of unhealed pressure ulcers/injuries at each stage
- M0300A2–G2
  - At the time of discharge, identifies if the unhealed pressure ulcers/injuries in M0300A1–G1 were present on admission or if the pressure ulcers/injuries were acquired or worsened during the stay

# Medical Documentation

- Use documentation from the previous setting to inform about the original stage of a pressure ulcer/injury
- Review the history of each pressure ulcer/injury in the patient's medical record



# Steps for Completing M0300A–G

1. Determine Deepest Anatomical Stage
2. Identify Unstageable Pressure Ulcers/Injuries
3. For the Discharge Assessment, determine the number of pressure ulcers/injuries that were present on admission

*For detailed instructions, refer to Section M in the LTCH Quality Reporting Program (QRP) Manual and the Quality Indicator Section of the Inpatient Rehabilitation Facility Patient Assessment Instrument (IRF-PAI) Manual*



# M0300. Current Number of Unhealed Pressure Ulcers/Injuries at Each Stage (Admission)

M0300. Current Number of Unhealed Pressure Ulcers/Injuries at Each Stage	
Enter Number <input type="text"/>	<b>A. Stage 1:</b> 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  <b>1. Number of Stage 1 pressure injuries</b>
Enter Number <input type="text"/>	<b>B. Stage 2:</b> 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  <b>1. Number of Stage 2 pressure ulcers</b>
Enter Number <input type="text"/>	<b>C. Stage 3:</b> 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  <b>1. Number of Stage 3 pressure ulcers</b>
Enter Number <input type="text"/>	<b>D. Stage 4:</b> 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  <b>1. Number of Stage 4 pressure ulcers</b>
Enter Number <input type="text"/>	<b>E. Unstageable - Non-removable dressing/device:</b> Known but not stageable due to non-removable dressing/device  <b>1. Number of unstageable pressure ulcers/injuries due to non-removable dressing/device</b>
Enter Number <input type="text"/>	<b>F. Unstageable - Slough and/or eschar:</b> Known but not stageable due to coverage of wound bed by slough and/or eschar  <b>1. Number of unstageable pressure ulcers due to coverage of wound bed by slough and/or eschar</b>
Enter Number <input type="text"/>	<b>G. Unstageable - Deep tissue injury</b>  <b>1. Number of unstageable pressure injuries presenting as deep tissue injury</b>



# M0300A1–G1 Coding Instructions

*IRF and LTCH: Completed at admission and discharge*

*(LTCH: A0250 = 01 Admission, 10 Planned Discharge, or 11 Unplanned Discharge)*

- **Enter the number** of pressure injuries/ulcers that are currently present
- **Enter 0** if no pressure ulcers/injuries are present



# M0300. Current Number of Unhealed Pressure Ulcers/Injuries at Each Stage (Discharge)

M0300. Current Number of Unhealed Pressure Ulcers/Injuries at Each Stage	
Enter Number <input type="text"/>	<b>A. Stage 1:</b> 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  <b>1. Number of Stage 1 pressure injuries</b>
Enter Number <input type="text"/>  Enter Number <input type="text"/>	<b>B. Stage 2:</b> 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  <b>1. Number of Stage 2 pressure ulcers</b> - If 0 → <i>Skip to M0300C, Stage 3</i>  <b>2. Number of <u>these</u> Stage 2 pressure ulcers that were present upon admission</b> - enter how many were noted at the time of admission
Enter Number <input type="text"/>  Enter Number <input type="text"/>	<b>C. Stage 3:</b> 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  <b>1. Number of Stage 3 pressure ulcers</b> - If 0 → <i>Skip to M0300D, Stage 4</i>  <b>2. Number of <u>these</u> Stage 3 pressure ulcers that were present upon admission</b> - enter how many were noted at the time of admission
Enter Number <input type="text"/>  Enter Number <input type="text"/>	<b>D. Stage 4:</b> 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  <b>1. Number of Stage 4 pressure ulcers</b> - If 0 → <i>Skip to M0300E, Unstageable - Non-removable dressing/device</i>  <b>2. Number of <u>these</u> Stage 4 pressure ulcers that were present upon admission</b> - enter how many were noted at the time of admission

# M0300. Current Number of Unhealed Pressure Ulcers/Injuries at Each Stage (Discharge) (cont.)

Enter Number <input type="text"/> Enter Number <input type="text"/>	<p><b>E. Unstageable - Non-removable dressing/device:</b> Known but not stageable due to non-removable dressing/device</p> <ol style="list-style-type: none"> <li><b>Number of unstageable pressure ulcers/injuries due to non-removable dressing/device</b> - If 0 → Skip to M0300F, Unstageable - Slough and/or eschar</li> <li><b>Number of <u>these</u> unstageable pressure ulcers/injuries that were present upon admission</b> - enter how many were noted at the time of admission</li> </ol>
Enter Number <input type="text"/> Enter Number <input type="text"/>	<p><b>F. Unstageable - Slough and/or eschar:</b> Known but not stageable due to coverage of wound bed by slough and/or eschar</p> <ol style="list-style-type: none"> <li><b>Number of unstageable pressure ulcers due to coverage of wound bed by slough and/or eschar</b> If 0 → Skip to M0300G, Unstageable - Deep tissue injury</li> <li><b>Number of <u>these</u> unstageable pressure ulcers that were present upon admission</b> - enter how many were noted at the time of admission</li> </ol>
<b>M0300. Current Number of Unhealed Pressure Ulcers/Injuries at Each Stage - Continued</b>	
Enter Number <input type="text"/> Enter Number <input type="text"/>	<p><b>G. Unstageable - Deep tissue injury</b></p> <ol style="list-style-type: none"> <li><b>Number of unstageable pressure injuries presenting as deep tissue injury</b> - If 0 → Skip to N2005, Medication Intervention</li> <li><b>Number of <u>these</u> unstageable pressure injuries that were present upon admission</b> - enter how many were noted at the time of admission</li> </ol>

# M0300B2–G2 Coding Instructions

*IRF and LTCH: Completed only at discharge  
(LTCH: A0250 = 10 Planned Discharge or 11  
Unplanned Discharge)*

- **Enter the number** of pressure ulcers/injuries that were present on admission (see instructions starting on M-4 under **Steps for Completing M0300A–G, Step 3: Determine “Present on Admission”**)
- **Enter 0** if no pressure ulcers/injuries were noted at the time of admission



# Present on Admission M0300B2–G2

- The present on admission items (M0300B2–G2) are coded at discharge
- Address whether the pressure ulcers/injuries observed at discharge were:

1. Present on admission

OR

2. Acquired or worsened during the stay

# Present on Admission M0300B2–G2 (cont.)

- A pressure ulcer/injury reported at discharge and coded as **not Present on Admission** on the Discharge Assessment would be interpreted as new or worsened
- A pressure ulcer/injury reported at discharge and coded as **Present on Admission** on the Discharge Assessment, would **not** be considered new or worsened



# Pressure Ulcers: Program Interruption

- If a patient is transferred from the post-acute care (PAC) setting and returns within 3 days (including the day of transfer), the transfer is considered a program interruption and is **not** considered a new admission
- Therefore, any new pressure ulcer/injury formation, or increase in numerical staging that occurs during the program interruption should not be coded as “present on admission”



# Coding Scenario 1

- A patient is admitted to the PAC setting with a Stage 2 pressure ulcer to the left hip. The patient is transported to an acute care hospital and returns to the PAC setting within 2 days
- Upon return to the PAC setting, the left hip pressure ulcer is a full thickness ulcer assessed to be a Stage 3. The patient is discharged to home with this Stage 3 pressure ulcer



# Coding Scenario 1 (cont. 1)

Item	Admission Assessment	Discharge Assessment
<b>M0300B1.</b> Number of Stage 2 pressure ulcers		
<b>M0300B2.</b> Number of these Stage 2 pressure ulcers that were present upon admission		
<b>M0300C1.</b> Number of Stage 3 pressure ulcers		
<b>M0300C2.</b> Number of these Stage 3 pressure ulcers that were present upon admission		

# Unstageable Pressure Ulcers/Injuries

- Visual inspection of the wound bed is necessary for accurate staging
- Pressure ulcers that have eschar or slough tissue present such that the anatomic depth of soft tissue damage cannot be visually inspected or palpated in the wound bed should be classified as unstageable

# Unstageable Pressure Ulcers/Injuries (cont.)

- If the wound bed is only **partially** covered by eschar or slough, and the extent of soft tissue damage can be visually inspected or palpated, the ulcer should be numerically staged and should not be coded as unstageable

# Coding Scenario 2

- A patient is admitted to the PAC setting with a Stage 4 pressure ulcer on her left hip
- When the pressure ulcer is reassessed at discharge, it is entirely covered with eschar and the wound bed cannot be assessed. The patient is discharged with an unstageable pressure ulcer due to slough/eschar



# Coding Scenario 2 (cont. 1)

Item	Admission Assessment	Discharge Assessment
<b>M0300B1.</b> Number of Stage 2 pressure ulcers		
<b>M0300B2.</b> Number of these Stage 2 pressure ulcers that were present upon admission		
<b>M0300C1.</b> Number of Stage 3 pressure ulcers		
<b>M0300C2.</b> Number of these Stage 3 pressure ulcers that were present upon admission		
<b>M0300D1.</b> Number of Stage 4 pressure ulcers		
<b>M0300D2.</b> Number of these Stage 4 pressure ulcers that were present upon admission		

# Coding Scenario 2 (cont. 2)

Item	Admission Assessment	Discharge Assessment
<b>M0300E1.</b> Number of unstageable pressure ulcers/injuries due to non-removable dressing/device		
<b>M0300E2.</b> Number of these unstageable pressure ulcers/injuries due to non-removable dressing that were present upon admission		
<b>M0300F1.</b> Number of unstageable pressure ulcers due to slough/eschar		
<b>M0300F2.</b> Number of these unstageable pressure ulcers due to slough/eschar that were present upon admission		

# Non-Removable Dressing/Device

- Non-removable dressing/device refers to a dressing or device that may not be removed from the patient **per physician's order**



# Non-Removable Dressing/Device (cont. 1)

- Known pressure ulcers/injuries covered by a non-removable dressing/device should be coded as unstageable
  - These pressure ulcers/injuries are considered “unstageable due to the inability to further assess the documented pressure ulcer/injury that is covered by the non-removable dressing/device



# Non-Removable Dressing/Device (cont. 2)

- “Known” refers to when documentation is available indicating that a pressure ulcer/injury exists under the non-removable dressing/device
- Presence of the pressure ulcer/injury should have been previously documented in the patient medical record



# Coding Scenario 3

- A patient is admitted to the PAC setting with documentation in the medical record of a sacral pressure ulcer/injury. This ulcer/injury is covered with a non-removable dressing; therefore, this pressure ulcer/injury is unstageable
- On Day 5 of the stay, the dressing is removed by the physician and assessment reveals a Stage 3 pressure ulcer
- On Day 10 of the stay, the pressure ulcer is covered with eschar and is assessed as unstageable. The eschar-covered ulcer is unchanged at the time of discharge

# Coding Scenario 3 (cont. 1)

Item	Admission Assessment	Discharge Assessment
<b>M0300B1.</b> Number of Stage 2 pressure ulcers		
<b>M0300B2.</b> Number of these Stage 2 pressure ulcers that were present upon admission		
<b>M0300C1.</b> Number of Stage 3 pressure ulcers		
<b>M0300C2.</b> Number of these Stage 3 pressure ulcers that were present upon admission		
<b>M0300D1.</b> Number of Stage 4 pressure ulcers		
<b>M0300D2.</b> Number of these Stage 4 pressure ulcers that were present upon admission		

# Coding Scenario 3 (cont. 2)

Item	Admission Assessment	Discharge Assessment
<b>M0300E1.</b> Number of unstageable pressure ulcers/injuries due to non-removable dressing/device		
<b>M0300E2.</b> Number of these unstageable pressure ulcers/injuries due to non-removable dressing that were present upon admission		
<b>M0300F1.</b> Number of unstageable pressure ulcers due to slough and/or eschar		
<b>M0300F2.</b> Number of these unstageable pressure ulcers due to slough and/or eschar that were present upon admission		

# Coding Scenario 4

- A patient is admitted to the PAC setting with a Stage 3 pressure ulcer on her coccyx
- On Day 5 of her PAC stay the ulcer is assessed as a Stage 4 pressure ulcer. She is seen at the wound clinic and returns to the PAC setting with a dressing and orders that the dressing is to remain intact until the next clinic visit
- The patient is discharged to a Skilled Nursing Facility (SNF) prior to the follow-up wound clinic visit. At the time of discharge, this ulcer is covered with a non-removable dressing



# Coding Scenario 4 (cont. 1)

Item	Admission Assessment	Discharge Assessment
<b>M0300B1.</b> Number of Stage 2 pressure ulcers		
<b>M0300B2.</b> Number of these Stage 2 pressure ulcers that were present upon admission		
<b>M0300C1.</b> Number of Stage 3 pressure ulcers		
<b>M0300C2.</b> Number of these Stage 3 pressure ulcers that were present upon admission		
<b>M0300D1.</b> Number of Stage 4 pressure ulcers		
<b>M0300D2.</b> Number of these Stage 4 pressure ulcers that were present upon admission		

# Coding Scenario 4 (cont. 2)

Item	Admission Assessment	Discharge Assessment
<b>M0300E1.</b> Number of unstageable pressure ulcers/injuries due to non-removable dressing/device		
<b>M0300E2.</b> Number of these unstageable pressure ulcers/injuries due to non-removable dressing that were present upon admission		
<b>M0300F1.</b> Number of unstageable pressure ulcers due to slough/eschar		
<b>M0300F2.</b> Number of these unstageable pressure ulcers due to slough/eschar that were present upon admission		

# Healed Pressure Ulcers/Injuries

- Terminology referring to “healed” vs. “unhealed” ulcers/injuries refers to whether the ulcer/injury is “closed” vs. “open”
- Stage 1 pressure injuries, deep tissue injuries (DTIs), and unstageable pressure ulcers—although covered with tissue, eschar, or slough—would not be considered healed



# Coding Scenario 5

- The patient's skin assessment on admission to PAC reveals no pressure ulcers or injuries
- On Day 5, the patient record identifies a Stage 2 pressure ulcer on the right elbow
- On discharge, the patient's skin assessment reveals a healed Stage 2 pressure ulcer on the right elbow



# Coding Scenario 5 (cont. 1)

Item	Admission Assessment	Discharge Assessment
<b>M0210.</b> Unhealed Pressure Ulcers/Injuries		



# Coding Scenario 6

- A patient is admitted to the PAC setting with a Stage 1 pressure injury on the coccyx
- The skin assessment of the tissues surrounding this injury on Day 6 is consistent with a DTI
- This DTI remains intact at the time of discharge to home 3 days later

# Coding Scenario 6 (cont. 1)

Item	Admission Assessment	Discharge Assessment
<b>M0300A1.</b> Number of Stage 1 pressure ulcers		
<b>M0300B1.</b> Number of Stage 2 pressure ulcers		
<b>M0300B2.</b> Number of these Stage 2 pressure ulcers that were present upon admission		
<b>M0300C1.</b> Number of Stage 3 pressure ulcers		
<b>M0300C2.</b> Number of these Stage 3 pressure ulcers that were present upon admission		
<b>M0300D1.</b> Number of Stage 4 pressure ulcers		
<b>M0300D2.</b> Number of these Stage 4 pressure ulcers that were present upon admission		

# Coding Scenario 6 (cont. 2)

Item	Admission Assessment	Discharge Assessment
<b>M0300E1.</b> Number of unstageable pressure ulcers/injuries due to non-removable dressing/device		
<b>M0300E2.</b> Number of these unstageable pressure ulcers/injuries due to non-removable dressing/device that were present upon admission		
<b>M0300F1.</b> Number of unstageable pressure ulcers due to slough/eschar		
<b>M0300F2.</b> Number of these unstageable pressure ulcers due to slough/eschar that were present upon admission		
<b>M0300G1.</b> Number of unstageable pressure injuries with deep tissue injury		
<b>M0300G2.</b> Number of these unstageable pressure injuries with deep tissue injury that were present upon admission		

# Medical Device Related Pressure Ulcers

- When an ulcer/injury is caused due to the use of a medical device, assess the area to determine if pressure is the primary cause. These ulcers/injuries generally conform to the pattern or shape of the device
- If pressure is determined to be the primary cause, use the staging system to stage the ulcer/injury and code in Section M of the LTCH CARE Data Set or IRF-PAI. If the ulcer/injury is not due to pressure, do not code it in Section M

# Coding Scenario 7

- A patient is admitted to PAC with a right ankle foot orthosis (AFO) to compensate for weakness and foot drop
- On the initial skin assessment, the clinician notes a Stage 2 pressure ulcer at the right calf, that conforms to the shape of the AFO. The orthotist is consulted and the AFO is adjusted
- The ulcer heals before discharge and no other pressure ulcers/injuries are present

# Coding Scenario 7 (cont. 1)

Item	Admission Assessment	Discharge Assessment
<b>M0210.</b> Unhealed Pressure Ulcers/Injuries		
<b>M0300B1.</b> Number of Stage 2 pressure ulcers		
<b>M0300B2.</b> Number of these Stage 2 pressure ulcers that were present upon admission		



# Mucosal Ulcers

- Mucosal pressure ulcers are not staged using the skin pressure ulcer/injury 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) should not be coded on the LTCH CARE Data Set or IRF-PAI

# Kennedy Ulcers

- Skin ulcers that occur at the end of life are known as Kennedy or terminal ulcers
  - Kennedy (terminal) skin ulcers are not captured in Section M
  - Related to tissue perfusion issues due to organ and skin failure
- Evolution and appearance differ from a typical pressure ulcer/injury

# Summary

- To be inclusive of updated terminology supported by NPUAP, the term **“injuries”** has been added in the Section M heading of the following items:
  - M0210
  - M0300 and M0300A
  - M0300E, M0300E1, and M0300E2
  - M0300G, M0300G1, and M0300G2

# Summary (cont.)

- Removed the term “suspected deep tissue injury in evolution” and replaced with **“deep tissue injury”** to items:
  - M0300G and M0300G1
- To improve clarity, the term “device” was added to items:
  - M0300E, M0300E1, and M0300E2
- Removed items M0800A–M0800F

# Action Plan

- Review Section M intent, rationale, and steps for assessment
- Review the changes in the language to Section M
- Practice coding a variety of scenarios with staff





# Questions?

**IRF-PAI v2.0**

**LTCH CARE Data Set v4.00 | Section M | May 2018**

