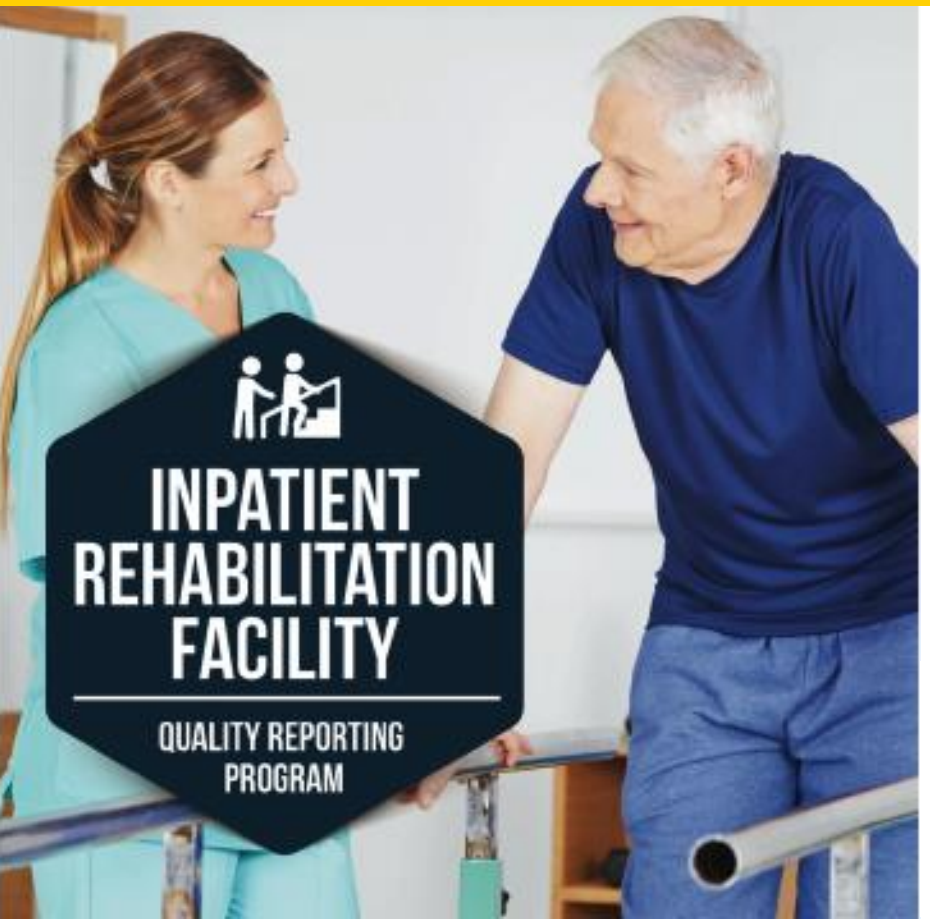
CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

Inpatient Rehabilitation Facility

Quality Reporting Program Provider Training



Section M: Skin Conditions (Pressure Ulcer/Injury)

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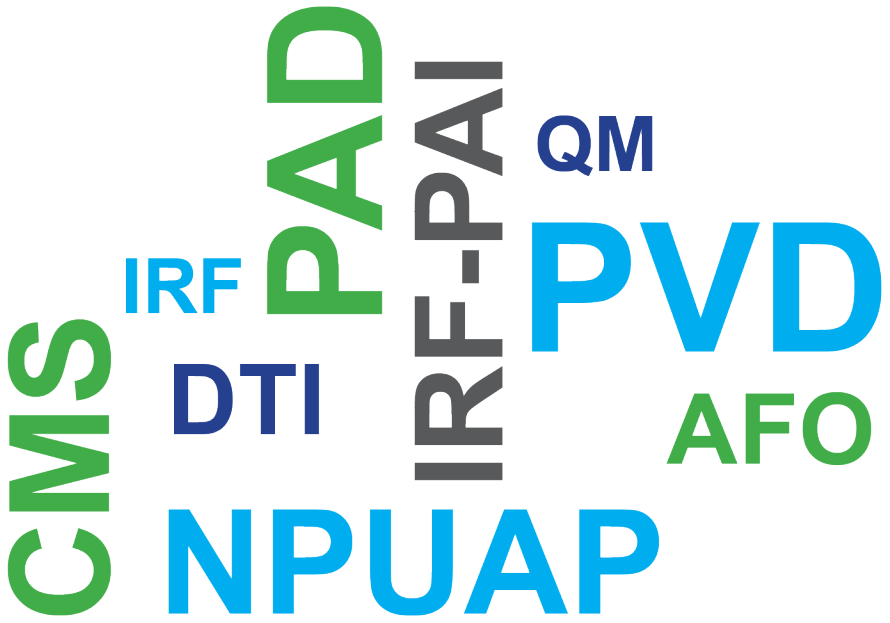
May 9, 2019

Acronyms in This Presentation

- AFO – Ankle Foot Orthosis
- CMS – Centers for Medicare & Medicaid Services
- DTI – Deep Tissue Injury
- IRF – Inpatient Rehabilitation Facility
- IRF-PAI – Inpatient Rehabilitation Facility-Patient Assessment Instrument
- NPUAP – National Pressure Ulcer Advisory Panel
- PAD – Peripheral Arterial Disease
- PVD – Peripheral Vascular Disease
- QM – Quality Measure



Objectives

- State the intent of Section M: Skin Conditions.
- Describe the cross-setting pressure ulcer/injury quality measure (QM).
- 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 intense and/or prolonged pressure, or pressure in combination with shear. The pressure ulcer/injury can present as intact skin or an open ulcer and may be painful.

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

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

- For this measure, an ulcer/injury is considered new or worsened at discharge if the Discharge Assessment shows a Stage 2–4 or unstageable pressure ulcer/injury that was not present on admission at that stage (e.g., M0300B1–M0300B2 > 0).

Pressure Ulcer/Injury: Numerator/Denominator

Numerator = Stays in the denominator in which the Discharge Assessment indicates one or more new or worsened Stage 2-4 pressure ulcers, or unstageable pressure ulcers/injuries, compared to admission.

Denominator = Patient stays with both an Admission and Discharge Assessment (Planned or Unplanned) (Except for those that meet any exclusion criteria).

Present on Admission M0300B2–G2

Patient stay is excluded if:

Data on new or worsened Stage 2, 3, 4, and unstageable pressure ulcers/injuries, including deep tissue injuries (DTIs), are missing on the Discharge Assessment.

The patient died during the stay.

Pressure Ulcer/Injury: Measure Time Window

The measure will be calculated quarterly using a rolling 12 months of data. For public reporting, the QM 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.

Pressure Ulcer/Injury: Risk Adjustment

Admission Assessment items used to risk-adjust this quality measure:

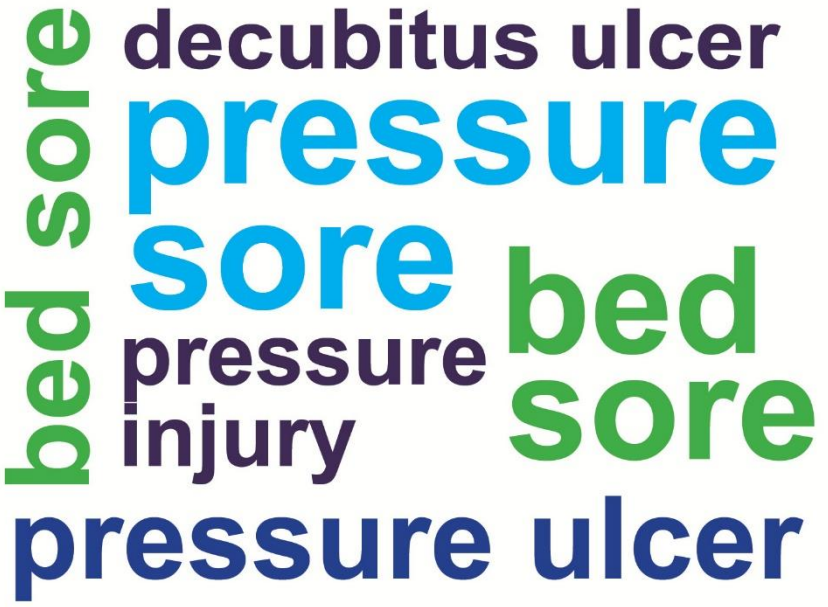
Functional Mobility Admission Performance	• GG0170C. Lying to Sitting on Side of Bed.
Bowel Continence	• H0400. Bowel Continence.
Peripheral Vascular Disease (PVD)/Peripheral Arterial Disease (PAD) or Diabetes Mellitus	• I0900. PVD or PAD. • I2900. Diabetes Mellitus.
Low Body Mass Index, based on Height and Weight	• 25A. Height. • 26A. Weight.

M0300

Coding Guidance and Practice Coding Scenarios

Pressure Ulcer Terminology

- 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.



Pressure Ulcer Terminology (cont.)

CMS adheres to the following guidelines:

Stage 1 pressure injuries and DTIs are termed "pressure injuries" because they are usually 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.

M0300. Current Number of Unhealed Pressure Ulcers/Injuries at Each Stage

M0300A1–G1

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

Admission Assessment

M0300A1–G1

- Identifies number of unhealed pressure ulcers/injuries at each stage.

M0300B2–G2

- At the time of discharge, identifies if the unhealed pressure ulcers/injuries in M0300B1–G1 were present on admission or if the pressure ulcers/injuries were acquired or worsened during the stay.

Discharge Assessment

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.

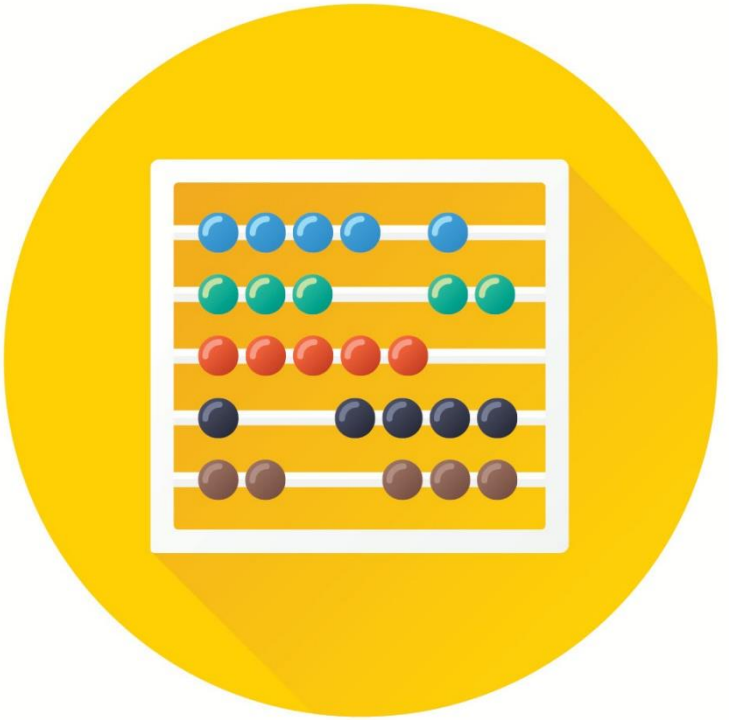
Steps for Completing M0300A–G

1. Determine deepest anatomical stage.
2. Identify unstageable pressure ulcers/injuries.

Steps for Completing M0300A–G (cont.)

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 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 ☐	**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 1. **Number of Stage 1 pressure injuries**
Enter Number ☐	**B. Stage 2:** Partial thickness loss of dermis presenting as a shallow open ulcer with a red or pink wound bed, without slough. May also present as an intact or open/ruptured blister 1. **Number of Stage 2 pressure ulcers**
Enter Number ☐	**C. Stage 3:** Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle is not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling 1. **Number of Stage 3 pressure ulcers**
Enter Number ☐	**D. Stage 4:** Full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present on some parts of the wound bed. Often includes undermining and tunneling 1. **Number of Stage 4 pressure ulcers**
Enter Number ☐	**E. Unstageable - Non-removable dressing/device:** Known but not stageable due to non-removable dressing/device 1. **Number of unstageable pressure ulcers/injuries due to non-removable dressing/device**
Enter Number ☐	**F. Unstageable - Slough and/or eschar:** Known but not stageable due to coverage of wound bed by slough and/or eschar 1. **Number of unstageable pressure ulcers due to coverage of wound bed by slough and/or eschar**
Enter Number ☐	**G. Unstageable - Deep tissue injury** 1. **Number of unstageable pressure injuries presenting as deep tissue injury**

INPATIENT REHABILITATION FACILITY QUALITY REPORTING PROGRAM

M0300A1–G1 Coding Instructions

M0300A1, M0300B1, M0300C1, M0300D1, M0300E1, M0300F1 and M0300G1 are completed upon admission and at discharge.

- **Enter the number** of pressure ulcers/injuries 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)

Section M	Skin Conditions
M0300. Current Number of Unhealed Pressure Ulcers/Injuries 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. **1. Number of Stage 1 pressure injuries**
Enter Number ☐ Enter Number ☐	**B. Stage 2:** Partial thickness loss of dermis presenting as a shallow open ulcer with a red or pink wound bed, without slough. May also present as an intact or open/ruptured blister. **1. Number of Stage 2 pressure ulcers** *If 0 → Skip to M0300C, Stage 3* **2. Number of <u>these</u> Stage 2 pressure ulcers that were present upon admission** - enter how many were noted at the time of admission
Enter Number ☐ Enter Number ☐	**C. Stage 3:** Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle is not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling. **1. Number of Stage 3 pressure ulcers** *If 0 → Skip to M0300D, Stage 4* **2. Number of <u>these</u> Stage 3 pressure ulcers that were present upon admission** - enter how many were noted at the time of admission
Enter Number ☐ Enter Number ☐	**D. Stage 4:** Full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present on some parts of the wound bed. Often includes undermining and tunneling. **1. Number of Stage 4 pressure ulcers** *If 0 → Skip to M0300E, Unstageable - Non-removable dressing/device* **2. Number of <u>these</u> Stage 4 pressure ulcers that were present upon admission** - enter how many were noted at the time of admission

INPATIENT REHABILITATION FACILITY QUALITY REPORTING PROGRAM

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

Section M	Skin Conditions
M0300. Current Number of Unhealed Pressure Ulcers/Injuries at Each Stage - Continued	
Enter Number ☐ Enter Number ☐	**E. Unstageable - Non-removable dressing/device:** Known but not stageable due to non-removable dressing/device 1. **Number of unstageable pressure ulcers/injuries due to non-removable dressing/device** *If 0 → Skip to M0300F, Unstageable - Slough and/or eschar* 2. **Number of <u>these</u> unstageable pressure ulcers/injuries that were present upon admission** - enter how many were noted at the time of admission
Enter Number ☐ Enter Number ☐	**F. Unstageable - Slough and/or eschar:** Known but not stageable due to coverage of wound bed by slough and/or eschar 1. **Number of unstageable pressure ulcers due to coverage of wound bed by slough and/or eschar** *If 0 → Skip to M0300G, Unstageable - Deep tissue injury* 2. **Number of <u>these</u> unstageable pressure ulcers that were present upon admission** - enter how many were noted at the time of admission
Enter Number ☐ Enter Number ☐	**G. Unstageable - Deep tissue injury** 1. **Number of unstageable pressure injuries presenting as deep tissue injury** *If 0 → Skip to N2005, Medication Intervention* 2. **Number of <u>these</u> unstageable pressure injuries that were present upon admission** - enter how many were noted at the time of admission

INPATIENT REHABILITATION FACILITY QUALITY REPORTING PROGRAM

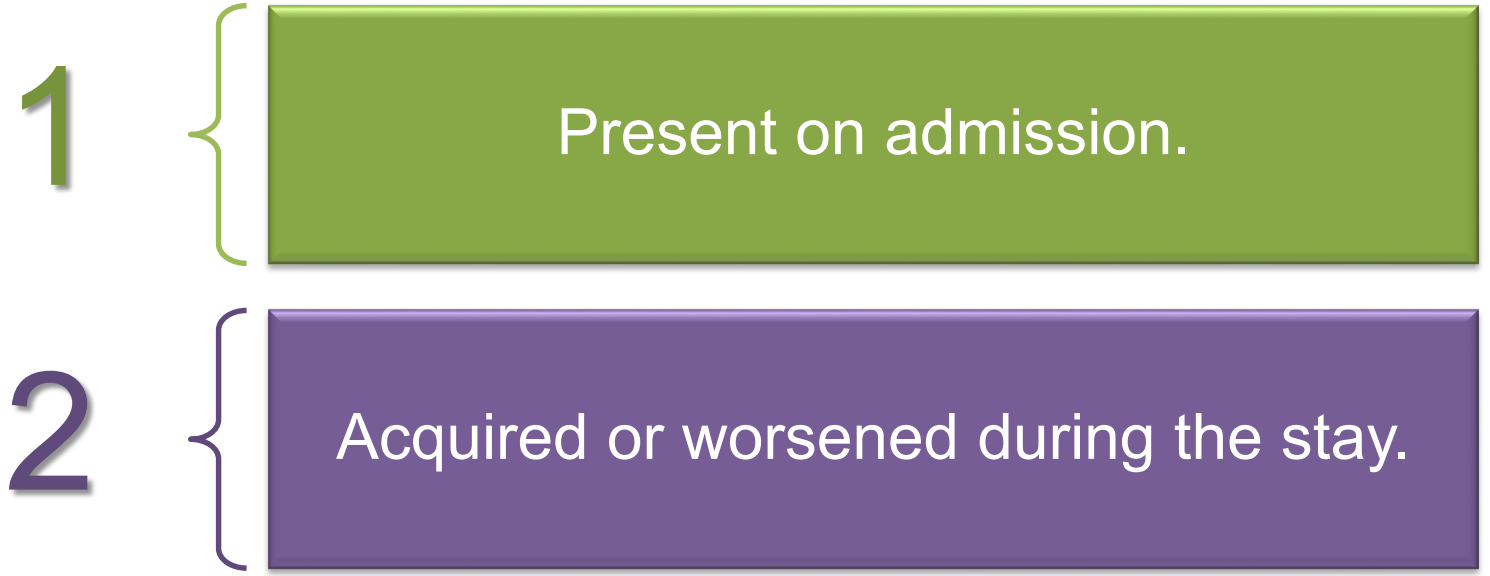
M0300B2–G2 Coding Instructions

M0300B2, M0300C2, M0300D2, M0300E2, M0300F2 and M0300G2 are completed only at discharge.

- **Enter the number** of these pressure ulcers/injuries that were present on admission.
  - See instructions 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 and address whether the pressure ulcers/injuries observed at discharge were:



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 inpatient rehabilitation facility (IRF) to an acute care hospital 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.”

Practice Coding Scenario 1

- A patient is admitted to the IRF with a Stage 2 pressure ulcer on the left hip. The patient is transported to an acute care hospital and returns to the IRF within 2 days.
- Upon return to the IRF 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.

Q1 How would you code M0300 on the Admission Assessment?

A. M0300B1. Stage 2 = **1**.

B. M0300C1. Stage 3 = **1**.

C. M0300D1. Stage 4 = **2**.

D. M0300G1. Unstageable – DTI = **1**.

Q2 How would you code M0300 on the Discharge Assessment?

A. M0300B1. Stage 2 = **1**.

B. M0300C1. Stage 3 = **1**.

C. M0300D1. Stage 4 = **2**.

D. M0300G1. Unstageable – DTI = **1**.

Q3 Number of these Stage 3 pressure ulcers that were present upon admission?

A. M0300C2 = **0**.

B. M0300C2 = **1**.

C. M0300C2 = **2**.

D. M0300C2 = **Skip**.

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.
- 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.

INPATIENT REHABILITATION FACILITY QUALITY REPORTING PROGRAM

Practice Coding Scenario 2

- A patient is admitted to the IRF 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.

Q4 How would you code M0300 on the Admission Assessment?

A. M0300C1. Stage 3 = **1**.

B. M0300D1. Stage 4 = **1**.

C. M0300F1. Unstageable – slough and/or eschar = **1**.

D. M0300G1. Unstageable – DTI = **1**.

Q5 How would you code M0300 on the Discharge Assessment?

A. M0300C1. Stage 3 = **1**.

B. M0300D1. Stage 4 = **1**.

C. M0300F1. Unstageable – slough and/or eschar = **1**.

D. M0300G1. Unstageable – DTI = **1**.

Q6 Was this unstageable pressure ulcer due to slough and/or eschar present on admission?

A. Yes, code M0300F2 = **1**.

B. No, code M0300F2 = **0**.

C. Skip M0300F2.

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 includes, for example, a primary surgical dressing that cannot be removed, an orthopedic device, or a cast.

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.
- Review the medical record for documentation of a pressure ulcer/injury covered by a non-removable dressing/device. Do not assume that there is a pressure ulcer/injury that is covered by a non-removable dressing/device.

Practice Coding Scenario 3

- A patient is admitted to the IRF 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 4 of the IRF stay, the dressing is removed by the physician and assessment reveals a Stage 3 pressure ulcer.
- On Day 9 of the IRF stay, the pressure ulcer is covered with eschar and is assessed as unstageable. The eschar-covered ulcer is unchanged at the time of discharge.

Q7 How would you code M0300 on the Admission Assessment?

A. M0300C1. Stage 3 = **1**.

B. M0300E1. Unstageable – Non-removable dressing/device = **1**.

C. M0300F1. Unstageable – Slough and/or eschar = **1**.

D. M0300G1. Unstageable – DTI = **1**.

Q8 How would you code M0300 on the Discharge Assessment?

A. M0300C1. Stage 3 = **1**.

B. M0300E1. Unstageable – Non-removable dressing/device = **1**.

C. M0300F1. Unstageable – Slough and/or eschar = **1**.

D. M0300G1. Unstageable – DTI = **1**.

Q9 Was this unstageable pressure ulcer due to slough and/or eschar present on admission?

A. Yes, code M0300F2 = **1**.

B. No, code M0300F2 = **0**.

C. Skip M0300F2.

Practice Coding Scenario 4

- A patient is admitted to the IRF with a Stage 3 pressure ulcer on her coccyx.
- On Day 5 of her IRF stay, the ulcer is assessed as a Stage 4 pressure ulcer. She is seen at the wound clinic and returns to the IRF 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 prior to the follow-up wound clinic visit. At the time of discharge, this ulcer is covered with a non-removable dressing.

Q 10 How would you code M0300 on the Admission Assessment?

A. M0300C1. Stage 3 = **1.**

B. M0300D1. Stage 4 = **1.**

C. M0300E1. Unstageable – Non-removable dressing/device = **1.**

D. M0300F1. Unstageable – Slough and/or eschar = **1.**

Q 11 How would you code M0300 on the Discharge Assessment?

A. M0300C1. Stage 3 = **1**.

B. M0300D1. Stage 4 = **1**.

C. M0300E1. Unstageable – Non-removable dressing/device = **1**.

D. M0300F1. Unstageable – Slough and/or eschar = **1**.

Q 12 Was this unstageable pressure ulcer/injury due to Non-removable dressing/device present on admission?

A. Yes, code M0300E2 = **1**.

B. No, code M0300E2 = **0**.

C. Skip M0300E2.

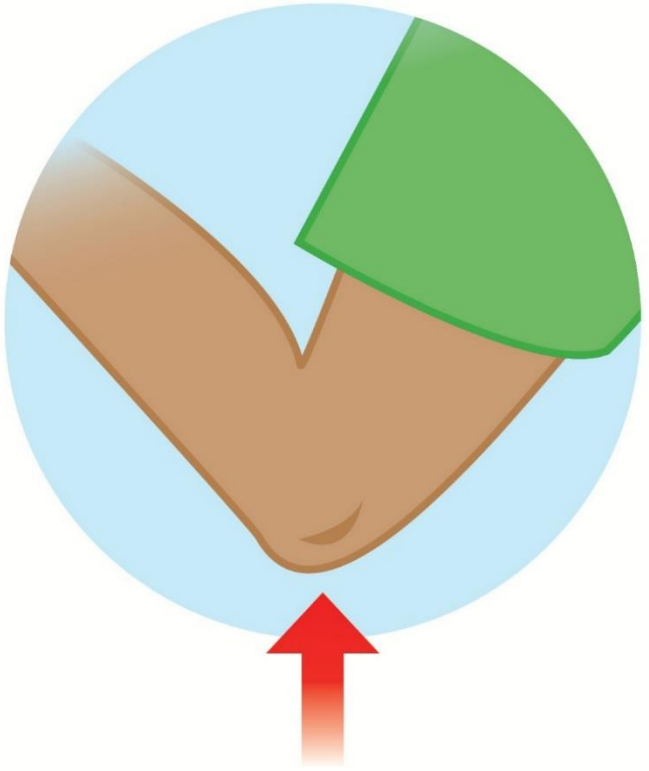
Healed Pressure Ulcers/Injuries

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, and unstageable pressure ulcers—although covered with tissue, eschar, or slough—would not be considered healed.

Practice Coding Scenario 5

- The patient's skin assessment on admission to the IRF reveals no pressure ulcers or injuries.
- On Day 5, while conducting a skin assessment, a Stage 2 pressure ulcer is identified on the right elbow.
- On discharge, the patient's skin assessment reveals a healed Stage 2 pressure ulcer on the right elbow.



Q 13 How would you code M0210 on the Admission Assessment? Does this patient have one or more unhealed pressure ulcers/injuries?

A. **0, No.**

B. **1, Yes.**

Q 14

How would you code M0210 on the Discharge Assessment? Does this patient have one or more unhealed pressure ulcers/injuries?

A. **0, No.**

B. **1, Yes.**

Practice Coding Scenario 6

- A patient is admitted to the IRF 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.

Q15 How would you code M0300 on the Admission Assessment?

A. M0300A1. Stage 1 = **1**.

B. M0300B1. Stage 2 = **1**.

C. M0300F1. Unstageable – Slough and/or eschar = **1**.

D. M0300G1. Unstageable – DTI = **1**.

Q16 How would you code M0300 on the Discharge Assessment?

A. M0300A1. Stage 1 = **1.**

B. M0300B1. Stage 2 = **1.**

C. M0300F1. Unstageable – Slough and/or eschar = **1.**

D. M0300G1. Unstageable – DTI = **1.**

Q 17 Was this unstageable pressure injury present on admission?

A. Yes, code M0300G2 = **1.**

B. No, code M0300G2 = **0.**

C. Skip M0300G2.

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 IRF-PAI.
- If the ulcer/injury is not due to pressure, do not code it in Section M.

Practice Coding Scenario 7

- A patient is admitted to the IRF 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.

Q 18

How would you code M0210 on the Admission Assessment? Does this patient have one or more unhealed pressure ulcers/injuries?

A. 0, No.

B. 1, Yes.

Q 19 How would you code M0300 on the Admission Assessment?

A. M0300A1. Stage 1 = **1**.

B. M0300B1. Stage 2 = **1**.

C. M0300E1. Unstageable – Non-removable dressing/device = **1**.

D. M0300G1. Unstageable – DTI = **1**.

Q20

How would you code M0210 on the Discharge Assessment? Does this patient have one or more unhealed pressure ulcers/injuries?

A. **0, No.**

B. **1, Yes.**

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 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.

Evolution and appearance differ from a typical pressure ulcer/injury.

- Related to tissue perfusion issues due to organ and skin failure.

Summary

- “Changes in Skin Integrity Post-Acute Care: Pressure Ulcer/Injury” is a cross-setting quality measure.
- Data collection for this measure began on October 1, 2018, using data elements that already existed on the IRF-PAI.
- This measure replaces “Percent of Residents or Patients with Pressure Ulcers That Are New or Worsened (NQF #0678).”

Summary (cont.)

- For this measure, an ulcer/injury is considered new or worsened at discharge if the Discharge Assessment shows a Stage 2–4 or unstageable pressure ulcer/injury that was not present on admission at that stage.

Record Your Action Plan Ideas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