

Practice Coding Scenarios

Section M: Skin Conditions Updates

Present on Admission Practice Coding Scenario

- Mrs. J is admitted to the skilled nursing facility (SNF) 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.
- Mrs. J is discharged with an unstageable pressure ulcer due to slough/eschar.

M0300 Practice Coding Scenario 1

- A resident develops a Stage 2 pressure ulcer while at the nursing facility. The resident is hospitalized due to pneumonia for 8 days and returns with a Stage 3 pressure ulcer in the same location. How would you code M0300C1 and M0300C2 on the 5-Day PPS assessment?

M0300 Practice Coding Scenario 2

- A resident is admitted to a nursing facility with a short leg cast to the right lower extremity.
- He has no visible wounds on admission but arrives with documentation that a pressure ulcer exists under the cast.
- Two weeks after admission to the nursing facility, the physician removes the cast.
- Following the removal of the cast, the right heel is observed and assessed as a Stage 3 pressure ulcer, which remains until the subsequent assessment.

M0300 Practice Coding Scenario 3

- Mr. M. was admitted to the nursing facility with eschar tissue covering both the right and left heels, as well as a Stage 2 pressure ulcer on the coccyx.
- Mr. M's pressure ulcers were reassessed before the subsequent assessment, 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).

M0300 Practice Coding Scenario 4

- A resident is admitted to the nursing facility with a blood-filled blister on the right heel. After further assessment of the surrounding tissues, it is determined that the heel blister is a deep tissue injury (DTI). Three weeks 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 the subsequent assessment, the right heel remains at Stage 3.

Practice Coding Scenarios

M0300 Practice Coding Scenario 5

- Mr. H was admitted with a known pressure ulcer/injury due to a non-removable dressing. Ten days after admission, the surgeon removes the dressing, and a Stage 2 pressure ulcer is identified. Two weeks later, the pressure ulcer is determined to be a full thickness ulcer and is at that point Stage 3. It remains Stage 3 at the time of the next assessment.