

Skilled Nursing Facility Quality Reporting Program Provider Training



**SKILLED
NURSING
FACILITY**

**QUALITY REPORTING
PROGRAM**

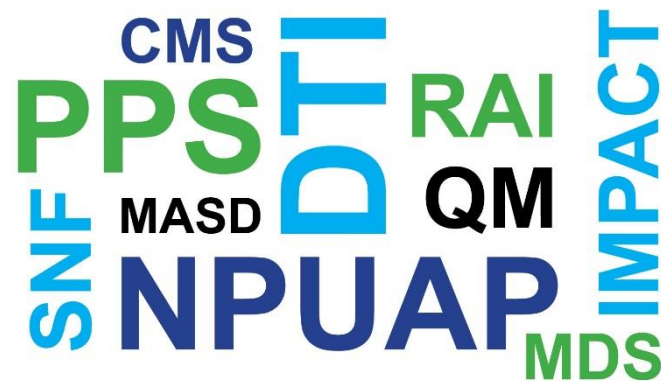
Section M: Skin Conditions Updates

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Acronyms in This Presentation

- Centers for Medicare & Medicaid Services (CMS)
- Deep Tissue Injury (DTI)
- Improving Medicare Post-Acute Care Transformation (IMPACT) Act
- Minimum Data Set (MDS)
- Moisture Associated Skin Damage (MASD)
- National Pressure Ulcer Advisory Panel (NPUAP)
- Omnibus Budget Reconciliation Act (OBRA)
- Prospective Payment System (PPS)
- Quality Measure (QM)
- Resident Assessment Instrument (RAI)
- Skilled Nursing Facility (SNF)



Overview

- Explain the intent of the Section M items
- Discuss updated coding guidance for Section M items
- Provide practice coding scenarios
- Explain how the cross-setting pressure ulcer measure, Changes in Skin Integrity Post-Acute Care: Pressure Ulcer/Injury, is calculated



Objectives

- Identify the intent of the Section M items
- Articulate the purpose of the new wording and any implications for coding
- Apply coding instructions to accurately code practice scenarios and the case study
- Recognize the elements of the cross-setting pressure ulcer quality measure (QM)



Section M: Intent

Section M: Intent

- The items in this section document the risk, presence, appearance, and change of pressure ulcers/***injuries***. This section also notes other skin ulcers, wounds, or lesions, and documents some treatment categories related to skin injury or avoiding injury.
- It is important to recognize and evaluate each resident's risk factors and to identify and evaluate all areas at risk of constant pressure.



Section M: Intent (cont.)

- A complete assessment of skin is essential to an effective pressure ulcer prevention and skin treatment program. Be certain to include in the assessment process a holistic approach.
- It is imperative to determine the etiology of all wounds and lesions, as this will determine and direct the proper treatment and management of the wound.



Section M: Skin Conditions

Item Changes

Item Changes

- The Centers for Medicare & Medicaid Services (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
 - Bed sore



Item Changes (cont. 1)

- 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 Minimum Data Set (MDS) as a Stage 2 pressure ulcer



Item Changes (cont. 2)

Section M		Skin Conditions
Report based on highest stage of existing ulcers/ injuries at their worst; do not "reverse" stage		
M0210. Unhealed Pressure Ulcers/injuries		
Enter Code <input type="checkbox"/>	Does this resident have one or more unhealed pressure ulcers/injuries? 0. No → Skip to M1030, Number of Venous and Arterial Ulcers 1. Yes → Continue to M0300, Current Number of Unhealed Pressure Ulcers/Injuries at Each Stage	
M0300. Current Number of Unhealed Pressure Ulcers/injuries at Each Stage		
Enter Number <input type="text"/>	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	



Item Changes (cont. 3)

- CMS adheres to the following guidelines:
 - Stage 1 pressure injuries and deep tissue injuries (DTIs) 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 non-removable dressing/device are termed “pressure ulcers/injuries” because they may be open or closed wounds



Item Changes (cont. 4)

New:

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

Section M	Skin Conditions
M0300. Current Number of Unhealed Pressure Ulcers/Injuries at Each Stage - Continued	
Enter Number <input type="text"/>	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



Item Changes (cont. 5)

New:

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

Section M	Skin Conditions
M0300. Current Number of Unhealed Pressure Ulcers/Injuries at Each Stage - Continued	
Enter Number <input type="text"/>	<p>G. Unstageable - Deep tissue injury:</p> <p>1. Number of unstageable pressure injuries presenting as deep tissue injury - If 0 → Skip to M1030, Number of Venous and Arterial Ulcers</p>



Item Changes (cont. 6)

Items Retiring October 1, 2018

- M0300B3 Date of Oldest Stage 2 Pressure Ulcer
- M0610 Dimensions of Unhealed Stage 3 or 4 Pressure Ulcers or Eschar
- M0700 Most Severe Tissue Type for Any Pressure Ulcer
- M0800 Worsening in Pressure Ulcer Since Prior Assessment (Omnibus Budget Reconciliation Act (OBRA) or Scheduled PPS) or Last Admission/Entry or Reentry
- M0900 Healed Pressure Ulcers



Section M: Skin Conditions

Coding Guidance Changes



Coding Guidance

- Definitions and guidance from the retiring items that are still relevant to coding other items in Section M have been relocated to the most appropriate location within the section and the remaining instructions removed
- Skip patterns have been updated to reflect the item sets



Definitions

- Pressure Ulcer/*Injury* Risk Factor
 - Examples of risk factors include immobility and decreased functional ability; co-morbid conditions such as end-stage renal disease, thyroid disease, or diabetes; drugs such as steroids; impaired diffuse or localized blood flow; resident refusal of care and treatment; cognitive impairment; exposure of skin to urinary and fecal incontinence; ***microclimate***, malnutrition, and hydration deficits; and a healed ulcer



Definitions (cont.)

Pressure Ulcer/*Injury*

- A pressure ulcer/*injury* is 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.***



M0100. Determination of Pressure Ulcer/*Injury* Risk

- Item Rationale
 - Health-Related Quality of Life
 - Additional external factors, such as excess moisture, ***microclimate***, and tissue exposure to urine or feces, can increase risk



M0210. Unhealed Pressure Ulcers/*Injuries*

- **Planning for Care**

- The pressure ulcer definitions used in the Resident Assessment Instrument (RAI) Manual have been adapted from those recommended by the National Pressure Ulcer Advisory Panel (NPUAP) **2016 Pressure Injury Staging System**.
- Pressure ulcer/*injury* staging is an assessment system that provides a description and classification based on **visual appearance and/or** anatomic depth of soft tissue damage. This tissue damage can be visible or palpable in the ulcer bed. Pressure ulcer/*injury* staging also informs expectations for healing times.



M0210. Unhealed Pressure Ulcers/Injuries (cont. 1)

- **Planning for Care**

- *The comprehensive care plan should be reevaluated to ensure that appropriate preventative measures and pressure ulcer/injury management principles are being adhered to when new pressure ulcers/injuries develop or when existing pressure ulcers/injuries worsen*



M0210. Unhealed Pressure Ulcers/*Injuries* (cont. 2)

- **Coding Tips**

- *If two pressure ulcers/injuries occur on the same bony prominence and are separated, at least superficially, by skin, then count them as two separate pressure ulcers/injuries. Stage and measure each pressure ulcer/injury separately.*
- *If a resident had a pressure ulcer/**injury** that healed during the look-back period of the current assessment, **do not code the ulcer/injury on the assessment.***



M0300A–G. Current Number of Unhealed Pressure Ulcers/*Injuries* at Each Stage

Steps for completing M0300A–G

1. Determine Deepest Anatomical Stage
2. Identify Unstageable Pressure Ulcers/*Injuries*
3. Determine “Present on Admission”
 - On the Admission Assessment, “on admission” means as close to the actual time of admission as possible
 - On each assessment determine the number of pressure ulcers/*injuries* present and determine the number of these that were present on admission



M0300A–G. Current Number of Unhealed Pressure Ulcers/*Injuries* at Each Stage (cont. 1)

Steps for completing M0300A–G

Step 1: Determine Deepest Anatomical Stage

- Manual instructions 3 and 4 under Step 1, which refer to backstaging and reverse staging, were added here
- The definitions for Epithelial Tissue and Granulation Tissue are also found here

For details on these instructions, please refer to Section M of the RAI Manual.



M0300A–G. Current Number of Unhealed Pressure Ulcers/*Injuries* at Each Stage (cont. 2)

Steps for completing M0300A–G

Step 2: Identify Unstageable Pressure Ulcers

- Manual instruction 2 under Step 2: ***If after careful cleansing of the pressure ulcer/injury, a pressure ulcer's/injury's anatomical tissues remain obscured such that the extent of soft tissue damage cannot be observed or palpated, the pressure ulcer/injury is considered unstageable.***
- Manual instruction 6 under Step 2: Known pressure ulcers/injuries 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/injury exists under the non-removable dressing/device.***



M0300A–G. Current Number of Unhealed Pressure Ulcers/*Injuries* at Each Stage (cont. 3)

Steps for completing M0300A–G

Step 3: Determine “Present on Admission”

- Manual instruction 4 under Step 3: ***If the pressure ulcer/injury was present on admission/entry or reentry and becomes unstageable due to slough or eschar during the resident’s stay, the pressure ulcer/injury is coded at M0300F and should not be coded as “present on admission”***
- Manual instruction 8 under Step 3: If a resident who has a pressure ulcer/***injury*** is hospitalized and the ulcer/injury increases in numerical stage ***or becomes unstageable due to slough or eschar*** during the hospitalization, it should be coded as “present on admission” upon reentry



M0300A–G. Current Number of Unhealed Pressure Ulcers/*Injuries* at Each Stage (cont. 4)

Steps for completing M0300A–G

Step 3: Determine “Present on Admission”

- Manual instruction 9 under Step 3: *If a pressure ulcer was numerically staged, then became unstageable, and is subsequently debrided sufficiently to be numerically staged, compare its numerical stage before and after it was unstageable. If the numerical stage has increased, code this pressure ulcer as **not present on admission**.*



M0300A–G. Current Number of Unhealed Pressure Ulcers/*Injuries* at Each Stage (cont. 5)

Steps for completing M0300A–G

Step 3: Determine “Present on Admission”

- Manual instruction 10 under Step 3: *If two pressure ulcers merge that were both “present on admission,” continue to code the merged pressure ulcer as “present on admission.” Although two merged pressure ulcers might increase the overall surface area of the ulcer, there needs to be an increase in numerical stage or a change to unstageable due to slough or eschar in order for it to be considered not “present on admission.”*



M0300B2–G2 Coding (on Subsequent or Discharge Assessment)

- The Present on Admission items (M0300B2–G2) address whether the pressure ulcers/injuries were:

1. Present on admission

OR

2. Acquired or worsened during the stay



Present on Admission (POA) M0300B2–G2

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



POA Coding Scenario

- Mrs. J is admitted to the 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



POA Coding Scenario (cont. 1)

5-Day PPS Assessment

Item	Admission Assessment
M0300A1. Number of Stage 1 pressure injuries	Code as 0
M0300B1. Number of Stage 2 pressure ulcers	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
M0300C2. Number of these Stage 3 pressure ulcers that were present upon admission	Skip
M0300D1. Number of Stage 4 pressure ulcers	Code as 1
M0300D2. Number of these Stage 4 pressure ulcers that were present upon admission	Code as 1



POA Coding Scenario (cont. 2)

5-Day PPS Assessment

Item	Admission Assessment
M0300E1. Number of unstageable pressure ulcers/injuries due to non-removable dressing/device	Code as 0
M0300E2. Number of these unstageable pressure ulcers/injuries due to non-removable dressing that were present upon admission	Skip
M0300F1. Number of unstageable pressure ulcers due to slough/eschar	Code as 0
M0300F2. Number of these unstageable pressure ulcers due to slough/eschar that were present upon admission	Skip



POA Coding Scenario (cont. 3)

Part A PPS Discharge

Item	Discharge Assessment
M0300B1. Number of Stage 2 pressure ulcers	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
M0300C2. Number of these Stage 3 pressure ulcers that were present upon admission	Skip
M0300D1. Number of Stage 4 pressure ulcers	Code as 0
M0300D2. Number of these Stage 4 pressure ulcers that were present upon admission	Skip



POA Coding Scenario (cont. 4)

Part A PPS Discharge

Item	Discharge Assessment
M0300E1. Number of unstageable pressure ulcers/injuries due to non-removable dressing/device	Code as 0
M0300E2. Number of these unstageable pressure ulcers/injuries due to non-removable dressing that were present upon admission	Skip
M0300F1. Number of unstageable pressure ulcers due to slough/eschar	Code as 1
M0300F2. Number of these unstageable pressure ulcers due to slough/eschar that were present upon admission	Code as 0



POA Coding Scenario (cont. 5)

Rationale:

- At admission, Mrs. J had a Stage 4 pressure ulcer on the left hip, so:
 - **M0300D1 is coded as 1** on the Admission Assessment
 - **M0300D2 is coded as 1** on the Admission Assessment
- The Stage 4 pressure ulcer on the left hip developed eschar and is unable to be assessed and numerically staged on discharge, so:
 - **M0300D1 is coded as 0** on the Discharge Assessment
 - **M0300D2 is Skipped** on the Discharge Assessment



POA Coding Scenario (cont. 6)

Rationale (cont.):

- The Stage 4 pressure ulcer on the left hip 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, so:
 - **M0300F1 is coded as 1** on the Discharge Assessment
 - **M0300F2 is coded as 0** on the Discharge Assessment



M0300A. Stage 1 Pressure Injuries

Section M	Skin Conditions
M0300. Current Number of Unhealed Pressure Ulcers/Injuries at Each Stage	
<div>Enter Number <input type="text"/></div>	<p>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</p> <p>1. Number of Stage 1 pressure injuries</p>

- Coding Instructions:
 - Enter the number of Stage 1 pressure injuries that are currently present
 - Enter 0 if no Stage 1 pressure injuries are currently present



M0300B. Stage 2 Pressure Ulcers

<p>Enter Number</p> <input type="text"/>	<p>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</p>
<p>Enter Number</p> <input type="text"/>	<p>1. Number of Stage 2 pressure ulcers - If 0 → Skip to M0300C, Stage 3</p> <p>2. Number of <u>these</u> Stage 2 pressure ulcers that were present upon admission/entry or reentry - enter how many were noted at the time of admission/entry or reentry</p>

- ***Coding Tips***

- ***Stage 2 pressure ulcers by definition have partial-thickness loss of the dermis. Granulation tissue, slough, and eschar are not present in Stage 2 pressure ulcers.***



M0300C. Stage 3 Pressure Ulcers

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 these Stage 3 pressure ulcers that were present upon admission/entry or reentry - enter how many were noted at the time of admission/entry or reentry

- **Item Rationale**

- Planning for Care

- *Tissue characteristics of pressure ulcers should be considered when determining treatment options and choices*
 - *Changes in tissue characteristics over time are indicative of wound healing or degeneration*

- Examples have been added to M0300C Stage 3 pressure ulcers



M0300D. Stage 4 Pressure Ulcers

Section M	Skin Conditions
M0300. Current Number of Unhealed Pressure Ulcers/Injuries at Each Stage	
<div>Enter Number <input type="text"/></div> <div>Enter Number <input type="text"/></div>	<p>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</p> <p>1. Number of Stage 4 pressure ulcers - If 0 → Skip to M0300E, Unstageable - Non-removable dressing/device</p> <p>2. Number of <u>these</u> Stage 4 pressure ulcers that were present upon admission/entry or reentry - enter how many were noted at the time of admission/entry or reentry</p>

- **Coding Tips**

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



M0300F. Unstageable Due to Slough or Eschar

Section M	Skin Conditions
M0300. Current Number of Unhealed Pressure Ulcers/Injuries at Each Stage - Continued	
Enter Number <input type="text"/>	F. Unstageable - Slough and/or eschar: Known but not stageable due to coverage of wound bed by slough and/or eschar
Enter Number <input type="text"/>	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/entry or reentry - enter how many were noted at the time of admission/entry or reentry

- Coding Tips
 - Pressure ulcers that are covered with slough and/or eschar, ***and the wound bed cannot be visualized***, should be coded as unstageable because the true anatomic depth of soft tissue damage (and therefore stage) cannot be determined. Only until enough slough and/or eschar is removed to expose the anatomic depth of soft tissue damage involved, can the stage of the wound be determined.
 - *New examples have been added to M0300F.*

M1040. Other Ulcers, Wounds and Skin Problems

Section M		Skin Conditions	
M1040. Other Ulcers, Wounds and Skin Problems			
↓ Check all that apply			
Foot Problems			
<input type="checkbox"/>	A. Infection of the foot (e.g., cellulitis, purulent drainage)		
<input type="checkbox"/>	B. Diabetic foot ulcer(s)		
<input type="checkbox"/>	C. Other open lesion(s) on the foot		
Other Problems			
<input type="checkbox"/>	D. Open lesion(s) other than ulcers, rashes, cuts (e.g., cancer lesion)		
<input type="checkbox"/>	E. Surgical wound(s)		
<input type="checkbox"/>	F. Burn(s) (second or third degree)		
<input type="checkbox"/>	G. Skin tear(s)		
<input type="checkbox"/>	H. Moisture Associated Skin Damage (MASD) (e.g., incontinence-associated dermatitis [IAD], perspiration, drainage)		
None of the Above			
<input type="checkbox"/>	Z. None of the above were present		



M1040. Other Ulcers, Wounds and Skin Problems (cont.)

M1040D Open Lesion(s) Other Than Ulcers, Rashes, Cuts

- Definition: Most typically skin **lesions** that develop as a result of diseases and conditions such as syphilis and cancer.

Coding Tips

- ***Open lesions that develop as part of a disease or condition and are not coded elsewhere on the MDS, such as wounds, boils, cysts, and blisters, should be coded in this item.***
- Do not code rashes, **abrasions**, or cuts/lacerations here. Although not recorded on the MDS assessment, these skin conditions should be considered in the plan of care.



M1040G. Skin Tear(s)

M1040G Skin Tear(s)

Coding Tips

- ***Do not code cuts/lacerations or abrasions here. Although not recorded on the MDS, these skin conditions should be considered in the plan of care.***



M1040H. Moisture Associated Skin Damage (MASD)

- **MASD** is also referred to as ***maceration and includes*** incontinence-associated dermatitis, intertriginous dermatitis, periwound moisture-associated dermatitis, and peristomal moisture-associated dermatitis

DEFINITION:
Moisture Associated Skin Damage (MASD)

is superficial skin damage caused by sustained exposure to moisture, such as incontinence, wound exudate, or perspiration.



M1040H. Moisture Associated Skin Damage (MASD) (cont. 1)

- ***Moisture exposure and MASD are risk factors for pressure ulcer/injury development.*** Provision of optimal skin care and early identification and treatment of minor cases of MASD can help avoid progression and skin breakdown.
- ***MASD without skin erosion is characterized by red/bright red color (hyperpigmentation), and the surrounding skin may be white (hypopigmentation). The skin damage is usually blanchable and diffuse and has irregular edges. Inflammation of the skin may also be present.***



M1040H. Moisture Associated Skin Damage (MASD) (cont. 2)

- ***MASD with skin erosion has superficial/partial thickness skin loss and may have hyper or hypopigmentation; the tissue is blanchable and diffuse and has irregular edges. Inflammation of the skin may also be present. Necrosis is not found in MASD.***
- ***If pressure and moisture are both present, code the skin damage as a pressure ulcer/injury in M0300.***



M1040H. Moisture Associated Skin Damage (MASD) (cont. 3)

- ***If there is tissue damage extending into the subcutaneous tissue or deeper and/or necrosis is present, code the skin damage as a pressure ulcer in M0300***



M1200G. Application of Non-Surgical Dressings (With or Without Topical Medications) Other Than to Feet

Section M	Skin Conditions
M1200. Skin and Ulcer/Injury Treatments	
↓ Check all that apply	
<input type="checkbox"/>	A. Pressure reducing device for chair
<input type="checkbox"/>	B. Pressure reducing device for bed
<input type="checkbox"/>	C. Turning/repositioning program
<input type="checkbox"/>	D. Nutrition or hydration intervention to manage skin problems
<input type="checkbox"/>	E. Pressure ulcer/injury care
<input type="checkbox"/>	F. Surgical wound care
<input type="checkbox"/>	G. Application of nonsurgical dressings (with or without topical medications) other than to feet
<input type="checkbox"/>	H. Applications of ointments/medications other than to feet
<input type="checkbox"/>	I. Application of dressings to feet (with or without topical medications)
<input type="checkbox"/>	Z. None of the above were provided



M1200G. Application of Non-Surgical Dressings (With or Without Topical Medications) Other Than to Feet (cont.)

- This category may include but is not limited to dry gauze dressings, dressings moistened with saline or other solutions, transparent dressings, hydrogel dressings, and dressings with hydrocolloid or hydroactive particles used to treat a skin condition, compression bandages, etc. Non-surgical dressings do not include adhesive bandages (e.g., BAND-AID® bandages, **wound closure strips**).



Section M: Skin Conditions

Practice Scenarios

M0300 Pressure Ulcer 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?

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

Enter Number

Enter Number

1. Number of Stage 3 pressure ulcers - If 0 → Skip to M0300D, Stage 4

2. Number of these Stage 3 pressure ulcers that were present upon admission/entry or reentry - enter how many were noted at the time of admission/entry or reentry



How would you code M0300C1 on the 5-Day PPS assessment?

Number of Stage 3 pressure ulcers.

- A. 0
- B. 1
- C. Enter a dash (–)



How would you code M0300C2 on the 5-Day PPS assessment?

Number of these Stage 3 pressure ulcers that were present upon admission/entry or reentry.

- A. 0
- B. 1
- C. Enter a dash (–)



M0300 Pressure Ulcer 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 cast is removed by the physician
- 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



How would you code M0300C1 on the subsequent assessment?

Number of Stage 3 pressure ulcers.

- A. **0**
- B. **1**
- C. **Enter a dash (–)**



How would you code M0300C2 on the subsequent assessment?

Number of these Stage 3 pressure ulcers that were present upon admission/entry or reentry.

- A. 0
- B. 1
- C. Enter a dash (–)



M0300 Pressure Ulcer 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)



How would you code M0300D1 on the subsequent assessment?

Number of Stage 4 pressure ulcers.

- A. **0**
- B. **1**
- C. **Enter a dash (–)**



How would you code M0300D2 on the subsequent assessment?

Number of these Stage 4 pressure ulcers that were present upon admission/entry or reentry.

- A. 0
- B. 1
- C. Enter a dash (–)



How would you code M0300F1 on the subsequent assessment?

Number of unstageable pressure ulcers – slough and/or eschar.

- A. 0
- B. 1
- C. Enter a dash (–)



How would you code M0300F2 on the subsequent assessment?

Number of these unstageable pressure ulcers – slough and/or eschar that were present upon admission/entry or reentry.

- A. 0
- B. 1
- C. Enter a dash (–)



M0300 Pressure Ulcer 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 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.



How would you code M0300C1 on the subsequent assessment?

Number of Stage 3 pressure ulcers.

- A. **0**
- B. **1**
- C. **Enter a dash (–)**



How would you code M0300C2 on the subsequent assessment?

Number of these Stage 3 pressure ulcers that were present upon admission/entry or reentry.

- A. 0
- B. 1
- C. Enter a dash (–)



M0300 Pressure Ulcer 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.



How would you code M0300C1 on the subsequent assessment?

Number of Stage 3 pressure ulcers.

- A. **0**
- B. **1**
- C. **Enter a dash (–)**



How would you code M0300C2 on the subsequent assessment?

Number of these Stage 3 pressure ulcers that were present upon admission/entry or reentry.

- A. 0
- B. 1
- C. Enter a dash (–)



Cross-Setting Pressure Ulcer Measure Changes in Skin Integrity Post-Acute Care: Pressure Ulcer/Injury QM

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

- Measure Description:
 - This cross-setting QM reports the percentage of patients/residents with Stage 2–4 pressure ulcers or unstageable pressure ulcers due to slough/eschar, non-removable dressing/device, or DTI, that are new or worsened since admission
 - Meets the requirements of the Improving Medicare Post-Acute Care Transformation (IMPACT) Act by addressing the domain of skin integrity and changes in skin integrity



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

- M0300 items will be used to calculate this QM with data collection beginning:
 - October 1, 2018 for Skilled Nursing Facilities (SNFs)



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

Numerator

Medicare Part A stays for which the Discharge Assessment indicates one or more new or worsened Stage 2–4 pressure ulcers, or unstageable pressure ulcers due to slough/eschar, non-removable dressing/device, or DTI, compared to admission.

Denominator

Medicare Part A stays in the selected time window for SNF residents ending during the selected time window, except those who meet the exclusion criteria.



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

Denominator Exclusions

- Resident stay is excluded if data on new or worsened Stage 2, 3, 4, and unstageable pressure ulcers, including DTIs, are missing at discharge; i.e., (M0300B1 = [-] or M0300B2 = [-]) and (M0300C1 = [-] or M0300C2 = [-]) and (M0300D1 = [-] or M0300D2 = [-] and (M0300E1 = [-] or M0300E2 = [-]) and (M0300F1 = [-] or M0300F2 = [-] and (M0300G1 = [-] or M0300G2 = [-])
- Resident stay is excluded if the resident died during the SNF stay



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

Risk Adjustment

Items from the PPS 5-Day Assessment used to risk-adjust this QM:

Functional Mobility
Admission Performance

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

Bowel Incontinence

- H0400. Bowel Continence

Peripheral Vascular
Disease/Peripheral Arterial
Disease or Diabetes Mellitus

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

Low Body Mass Index,
Based on Height and
Weight

- K0200A. Height
- K0200B. Weight



Changes in Skin Integrity Post-Acute Care: Pressure Ulcer/Injury (cont. 5)

SNF Time Window

- The QM 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 Medicare Part A SNF stays, except those that meet the exclusion criteria, during the 12 months are included in the denominator and are eligible for inclusion in the numerator.
- For residents with multiple stays during the 12-month time window, each stay is eligible for inclusion in the measure.



Summary

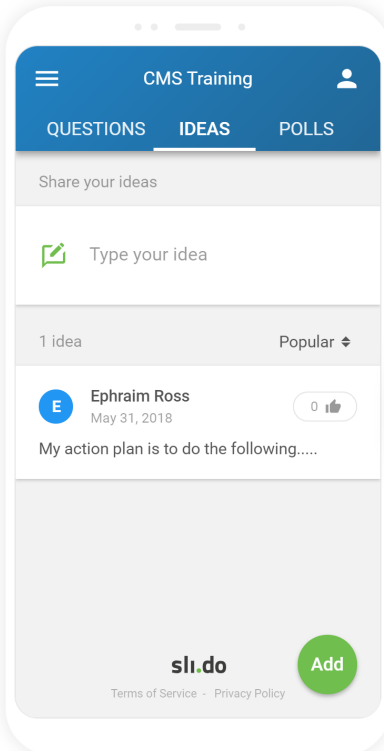
- Section M has updated coding guidance and examples
- The cross-setting pressure ulcer measure: Changes in Skin Integrity Post-Acute Care: Pressure Ulcer/Injury QM reports the percentage of patients/residents with Stage 2–4 pressure ulcers or unstageable pressure ulcers due to slough/eschar, non-removable dressing/device, or DTI, that are new or worsened since admission
 - This measure is a cross-setting QM to meet the requirements of the IMPACT Act, addressing the domain of skin integrity and changes in skin integrity



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