



# IRF and LTCH Virtual Training Program – Part 2

## Section M. Skin Conditions Workshop

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# Objectives

- Summarize the data elements and coding guidance for Section M.
- Apply knowledge acquired during the IRF and LTCH Virtual Training Program – Part 1 to apply coding instructions and principles to accurately code practice scenarios.



# Section M: Coding Instructions



**For IRF and LTCH:**  
If during the Admission assessment, complete as close to the time of admission as possible.



**For LTCH:** Complete only if *A0250 = 01 Admission*.



**For IRF and LTCH:**  
If during the Discharge assessment, complete as close to the time of discharge as possible.



**For LTCH:** Complete only if *A0250 = 10 Planned Discharge*, or *A0250 = 11 Unplanned Discharge*.

**M0210**

# Unhealed Pressure Ulcers/Injuries

# M0210. Unhealed Pressure Ulcers/Injuries



M0210. Unhealed Pressure Ulcers/Injuries	
Enter Code	<p><b>Does this patient have one or more unhealed pressure ulcers/injuries?</b></p> <p>0. <b>No</b> → <i>Skip to N0415, High-Risk Drug Classes: Use and Indication</i></p> <p>1. <b>Yes</b> → <i>Continue to M0300, Current Number of Unhealed Pressure Ulcers/Injuries at Each Stage</i></p>



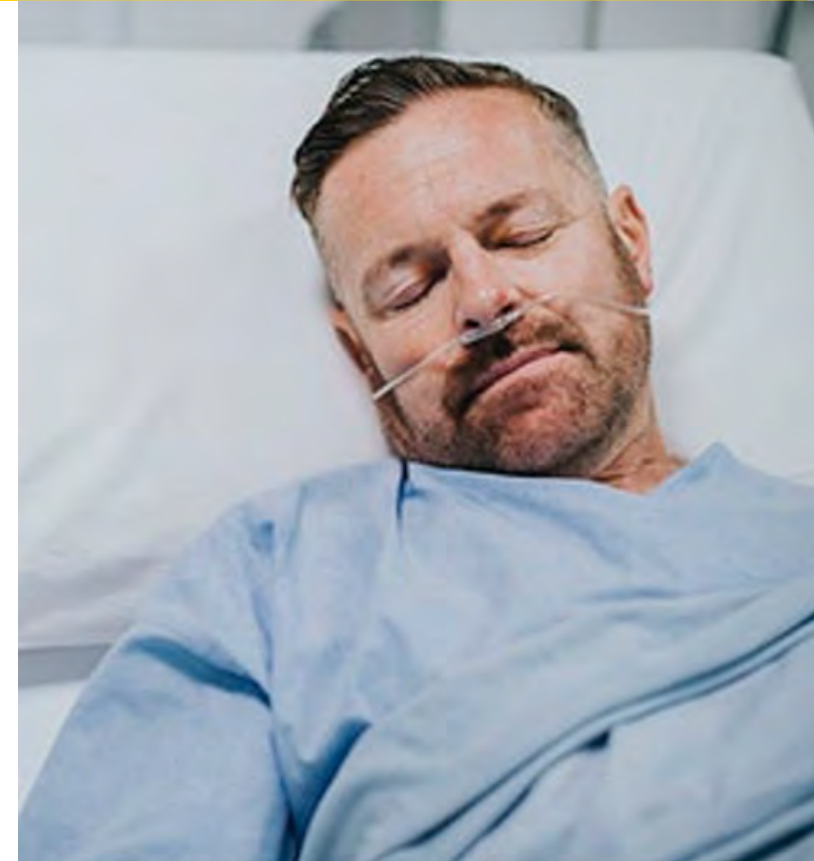
# M0210: Coding Instructions

- **Code 0, No**, if the patient did not have a pressure ulcer/injury on the first skin assessment in the 3-day assessment period (or the last skin assessment in the 3-day assessment period at discharge).
- **Code 1, Yes**, if the patient had any pressure ulcer/injury (Stage 1, 2, 3, 4, or unstageable) on the first skin assessment in the 3-day assessment period (or the last skin assessment in the 3-day assessment period at discharge).



# M0210: Practice Scenario 1

- A patient was admitted to the facility and the admission nurse completed the first skin assessment on the day of admission.
- The nurse noted that the patient currently has a Stage 2 pressure ulcer on the left lateral malleolus and documented this in the patient's medical record.







# How would you code M0210. Unhealed Pressure Ulcers/Injuries on Admission?

- A. Code 0, No, if the patient did not have a pressure ulcer/injury on the first skin assessment in the 3-day assessment period.
- B. Code 1, Yes, if the patient had any pressure ulcer/injury (Stage 1, 2, 3, 4, or unstageable) on the first skin assessment in the 3-day assessment period.







# How would you code M0210. Unhealed Pressure Ulcers/Injuries on Admission?

A. Code 0, No, if the patient did not have a pressure ulcer/injury on the first skin assessment in the 3-day assessment period.

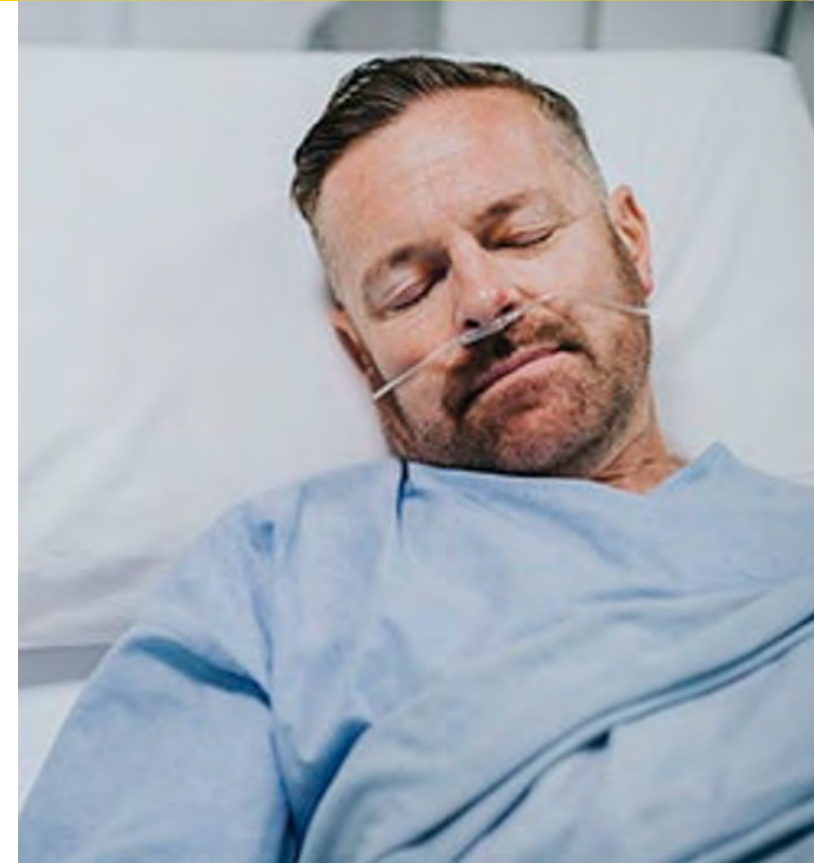


**B. Code 1, Yes, if the patient had any pressure ulcer/injury (Stage 1, 2, 3, 4, or unstageable) on the first skin assessment in the 3-day assessment period.**



# M0210: Practice Scenario 1 – Rationale

- **Coding:** The correct answer is B, **Code 1, Yes.**
- **Rationale:** On the day the patient was admitted to the facility, the admission nurse completed the first skin assessment, identifying a Stage 2 pressure ulcer on the patient's left lateral malleolus. The assessment was completed within the 3-day assessment period.



# M0210: Practice Scenario 2




- The patient has been in the facility for 20 days and will be discharged home.
- Ten days prior to discharge, the documented skin assessment noted that there was a Stage 2 pressure ulcer on the patient's left hip that was healing.
- Two days prior to discharge, the documented skin assessment stated that the Stage 2 pressure ulcer had healed.
- There were no other pressure ulcers/injuries present on discharge.

# How would you code M0210. Unhealed Pressure Ulcers/Injuries on Discharge?

- A. Code 0, No, if the patient did not have a pressure ulcer/injury on the last skin assessment in the 3-day assessment period at discharge.
- B. Code 1, Yes, if the patient had any pressure ulcer/injury (Stage 1, 2, 3, 4, or unstageable) on the last skin assessment in the 3-day assessment period at discharge.



# How would you code M0210. Unhealed Pressure Ulcers/Injuries on Discharge?

-  **A. Code 0, No, if the patient did not have a pressure ulcer/injury on the last skin assessment in the 3-day assessment period at discharge.**
- B. Code 1, Yes, if the patient had any pressure ulcer/injury (Stage 1, 2, 3, 4, or unstageable) on the last skin assessment in the 3-day assessment period at discharge.**



# M0210: Practice Scenario 2 – Rationale



- **Coding:** The correct answer is A, **Code 0, No.**
- **Rationale:** The last skin assessment was completed 2 days prior to discharge, which was within the 3-day assessment period. The assessment revealed that the Stage 2 pressure ulcer on the patient's right hip had healed.
  - Healed pressure ulcers are not reported on the IRF-PAI or LCDS.



# M0300

## Current Number of Unhealed Pressure Ulcers/Injuries at Each Stage



# 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>

# 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"/>	<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> <i>If 0 → Skip to M0300C, Stage 3</i>
Enter Number <input type="text"/>	<b>2. Number of <u>these</u> Stage 2 pressure ulcers that were present upon admission</b>
Enter Number <input type="text"/>	<b>C. Stage 3:</b> Full thickness tissue loss. Subcutaneous fat may be visible present but does not obscure the depth of tissue loss. May include slough and/or eschar. <b>1. Number of Stage 3 pressure ulcers</b> <i>If 0 → Skip to M0300D, Stage 4</i>
Enter Number <input type="text"/>	<b>2. Number of <u>these</u> Stage 3 pressure ulcers that were present upon admission</b>
Enter Number <input type="text"/>	<b>D. Stage 4:</b> Full thickness tissue loss with exposed bone, tendon or muscle, or necrotic wound bed. Often includes undermining and tunneling. <b>1. Number of Stage 4 pressure ulcers</b> <i>If 0 → Skip to M0300E, Unstageable - Non-removable dressing/device</i>
Enter Number <input type="text"/>	<b>2. Number of <u>these</u> Stage 4 pressure ulcers that were present upon admission</b>



M0300. Current Number of Unhealed Pressure Ulcers/Injuries at Each Stage - Continued	
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> <i>If 0 → Skip to M0300F, Unstageable - Slough and/or eschar</i>
Enter Number <input type="text"/>	<b>2. 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
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> <i>If 0 → Skip to M0300G, Unstageable - Deep tissue injury</i>
Enter Number <input type="text"/>	<b>2. Number of <u>these</u> unstageable pressure ulcers that were present upon admission</b> - enter how many were noted at the time of admission
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> <i>If 0 → Skip to N0415, High-Risk Drug Classes: Use and Indication</i>
Enter Number <input type="text"/>	<b>2. Number of <u>these</u> unstageable pressure injuries that were present upon admission</b> - enter how many were noted at the time of admission



# Section M: Coding Instructions



**For IRF and LTCH:**  
If during the Admission assessment, complete as close to the time of admission as possible.



**For LTCH:** Complete only if *A0250 = 01 Admission*.



**For IRF and LTCH:**  
If during the Discharge assessment, complete as close to the time of discharge as possible.



**For LTCH:** Complete only if *A0250 = 10 Planned Discharge*, or *A0250 = 11 Unplanned Discharge*.

# Definition – Present on Admission

## Present on Admission



For each pressure ulcer/injury that is present at discharge, determine whether the pressure ulcer/injury was present at the time of admission **and not acquired while the patient was in the care of the IRF/LTCH.** Consider current and historical levels of tissue involvement.

# M0300: Practice Scenario 3

- A patient was admitted to the facility. During the initial skin assessment on admission, the assessing nurse found a Stage 2 pressure ulcer on the right elbow and a Stage 2 pressure ulcer on the left hip.
- Due to a progressively degenerative condition, the patient has poor mobility.
- During the 3-day admission assessment period, the patient was observed to be resistant to changing positions and at times refused to transfer out of the wheelchair. Early interventions were instituted for pressure reduction when sitting in the wheelchair.
- Seven days after admission, the patient was assessed to have developed a Stage 1 pressure injury on his coccyx despite these early interventions.



# M0300: Practice Scenario 3 (cont.)

- Throughout the stay, the patient continued to be resistant to changing positions or getting out of the wheelchair. In addition, the patient refused to use any pressure relief cushions despite being offered various options.
- One day before discharge, the assessing nurse completed the last skin assessment and documented the following:
  - The Stage 2 pressure ulcer on the right elbow has healed.
  - The Stage 2 pressure ulcer on the left hip healed, but then reopened to a Stage 2.
  - The coccyx ulcer has progressed to a Stage 2.
- The patient will be receiving home health services for continued wound care on discharge.





# How would you code M0300. Current Number of Unhealed Pressure Ulcers at Each Stage on Admission?


- A. M0300A1 (Stage 1) would be coded as 1; M0300B1 (Stage 2) would be coded as 2.
- B. M0300A1 (Stage 1) would be coded as 1; M0300B1 (Stage 2) would be coded as 0.
- C. M0300A1 (Stage 1) would be coded as 0; M0300B1 (Stage 2) would be coded as 1.
- D. M0300A1 (Stage 1) would be coded as 0; M0300B1 (Stage 2) would be coded as 2.







# How would you code M0300. Current Number of Unhealed Pressure Ulcers at Each Stage on Admission?

- A. M0300A1 (Stage 1) would be coded as 1; M0300B1 (Stage 2) would be coded as 2.
- B. M0300A1 (Stage 1) would be coded as 1; M0300B1 (Stage 2) would be coded as 0.
- C. M0300A1 (Stage 1) would be coded as 0; M0300B1 (Stage 2) would be coded as 1.
-  **D. M0300A1 (Stage 1) would be coded as 0; M0300B1 (Stage 2) would be coded as 2.**

# M0300: Practice Scenario 3 – Admission Rationale

- **Answer:** The answer is D, **M0300A1 (Stage 1)** would be coded as 0; **M0300B1 (Stage 2)** would be coded as 2.
- **Rationale:** During the initial skin assessment on admission, a Stage 2 pressure ulcer on the right elbow and a Stage 2 pressure ulcer on the left hip were documented. Therefore, M0300B1 would be coded as 2. The development of the Stage 1 pressure injury on the patient's coccyx was not identified as part of the first skin assessment that was conducted on admission, but 7 days later. Therefore, M0300A1 would be coded as 0.



# How would you code M0300. Current Number of Unhealed Pressure Ulcers at Each Stage on Discharge?

- A. M0300B1 (Stage 2) would be coded as 3; M0300B2 (Stage 2, Present on admission) would be coded as 2.
- B. M0300B1 (Stage 2) would be coded as 2; M0300B2 (Stage 2, Present on admission) would be coded as 2.
- C. M0300B1 (Stage 2) would be coded as 2; M0300B2 (Stage 2, Present on admission) would be coded as 1.
- D. M0300B1 (Stage 2) would be coded as 1; M0300B2 (Stage 2, Present on admission) would be coded as 1.





# How would you code M0300. Current Number of Unhealed Pressure Ulcers at Each Stage on Discharge?

- A. M0300B1 (Stage 2) would be coded as 3; M0300B2 (Stage 2, Present on admission) would be coded as 2.
- B. M0300B1 (Stage 2) would be coded as 2; M0300B2 (Stage 2, Present on admission) would be coded as 2.
- C. M0300B1 (Stage 2) would be coded as 2; M0300B2 (Stage 2, Present on admission) would be coded as 1.**
- D. M0300B1 (Stage 2) would be coded as 1; M0300B2 (Stage 2, Present on admission) would be coded as 1.



# M0300: Practice Scenario 3 – Discharge Rationale

- **Answer:** The answer is C, **M0300B1 (Stage 2) would be coded as 2; M0300B2 (Stage 2, Present on admission) would be coded as 1.**
- **Rationale:** The discharge skin assessment documented that:
  - The Stage 2 pressure ulcer on the right elbow that was present on admission has healed, so this is not recorded on the discharge assessment.
  - The Stage 2 pressure ulcer on the left hip that was present on admission had healed, but then reopened to a Stage 2. This ulcer is reported at its worst stage, a Stage 2, and as present on admission because on discharge it was not presenting at a higher numerical stage, nor did it become unstageable.
  - The Stage 1 pressure injury on the coccyx that was identified 7 days after admission has progressed to a Stage 2 pressure ulcer. Since this pressure ulcer was not identified on admission, then at discharge, it is documented as **not** present on admission.





# M0300: Practice Scenario 4



- A patient develops a Stage 2 pressure ulcer on the sacrum *while* at the IRF/LTCH. Due to cardiac complications, the patient is discharged and admitted to an acute care hospital for the treatment of an acute myocardial infarction.
- The patient returns to the IRF/LTCH more than three days later for continued care. The patient now has a Stage 3 pressure ulcer on the sacrum in the same location.
- On the day of discharge from the IRF/LTCH to home, the nurse conducts the last skin assessment and documents that the pressure ulcer on the sacrum is healing but remains a Stage 3 pressure ulcer.

# How would you code M0300. Current Number of Unhealed Pressure Ulcers at Each Stage on Discharge #1?

- A. M0300B1 (Stage 2) would be coded as 1; M0300B2 (Stage 2, Present on admission) would be coded as 0.
- B. M0300B1 (Stage 2) would be coded as 1; M0300B2 (Stage 2, Present on admission) would be coded as 1.
- C. M0300B1 (Stage 2) would be coded as 0; M0300B2 (Stage 2, Present on admission) would be coded as 0.



# How would you code M0300. Current Number of Unhealed Pressure Ulcers at Each Stage on Discharge #1?



- A. M0300B1 (Stage 2) would be coded as 1; M0300B2 (Stage 2, Present on admission) would be coded as 0.**
- B. M0300B1 (Stage 2) would be coded as 1; M0300B2 (Stage 2, Present on admission) would be coded as 1.
- C. M0300B1 (Stage 2) would be coded as 0; M0300B2 (Stage 2, Present on admission) would be coded as 0.

# M0300: Practice Scenario 4 – Discharge #1 Rationale



- **Answer:** The answer is A, **M0300B1 (Stage 2)** would be coded as 1; **M0300B2 (Stage 2)** would be coded as 0.
- **Rationale:** The patient, while at the IRF/LTCH, developed a Stage 2 pressure ulcer, which is documented on the patient's first discharge. This pressure ulcer is not considered "present on admission" because it developed while the patient was in the IRF/LTCH and considered facility acquired.

# How would you code M0300. Current Number of Unhealed Pressure Ulcers at Each Stage on Admission (Second stay)?

- A. M0300B1 (Stage 2) would be coded as 1; M0300C1 (Stage 3) would be coded as 0.
- B. M0300B1 (Stage 2) would be coded as 0; M0300C1 (Stage 3) would be coded as 1.
- C. M0300B1 (Stage 2) would be coded as 1; M0300B2 (Stage 3) would be coded as 1.





# How would you code M0300. Current Number of Unhealed Pressure Ulcers at Each Stage on Admission (Second stay)?

A. M0300B1 (Stage 2) would be coded as 1; M0300C1 (Stage 3) would be coded as 0.



**B. M0300B1 (Stage 2) would be coded as 0; M0300C1 (Stage 3) would be coded as 1.**

C. M0300B1 (Stage 2) would be coded as 1; M0300B2 (Stage 3) would be coded as 1.



# M0300: Practice Scenario 4 – Admission (Second Stay) Rationale



- **Answer:** The answer is B, **M0300B1 (Stage 2)** would be coded as 0; **M0300C1 (Stage 3)** would be coded as 1.
- **Rationale:** Upon return to the IRF/LTCH for the patient's second stay, a skin assessment was completed on admission. The nurse documented that there was a Stage 3 pressure ulcer on the sacrum in the same location as the previous Stage 2 pressure ulcer. When a patient is discharged to another facility/hospital for longer than 3 calendar days, subsequently returns, and a current pressure ulcer increases in numerical stage or becomes unstageable due to slough or eschar, it is coded at the higher stage (or unstageable status) on the patient's Admission assessment for the second IRF/LTCH stay.

# How would you code M0300. Current Number of Unhealed Pressure Ulcers at Each Stage on Discharge #2?

- A. M0300C1 (Stage 3) would be coded as 1; M0300C2 (Stage 3, Present on admission) would be coded as 1.
- B. M0300C1 (Stage 3) would be coded as 1; M0300C2 (Stage 3, Present on admission) would be coded as 0.
- C. M0300C1 (Stage 3) would be coded as 0; M0300C2 (Stage 3, Present on admission) would be coded as 0.



# How would you code M0300. Current Number of Unhealed Pressure Ulcers at Each Stage on Discharge #2?



- A. **M0300C1 (Stage 3) would be coded as 1; M0300C2 (Stage 3, Present on admission) would be coded as 1.**
- B. M0300C1 (Stage 3) would be coded as 1; M0300C2 (Stage 3, Present on admission) would be coded as 0.
- C. M0300C1 (Stage 3) would be coded as 0; M0300C2 (Stage 3, Present on admission) would be coded as 0.



# M0300: Practice Scenario 4 – Discharge #2 Rationale



- **Answer:** The answer is A, **M0300C1 (Stage 3)** would be coded as 1; **M0300C2 (Stage 3, Present on admission)** would be coded as 1.
- **Rationale:** The day of discharge to home, the nurse conducts the last skin assessment and documents that the patient has a healing Stage 3 pressure ulcer on the sacrum. This pressure ulcer is considered as present on admission because it increased in numerical stage between the first discharge and subsequent admission back to the IRF/LTCH. This pressure ulcer did not increase in numerical size or become unstageable prior to the second discharge from the facility.

# M0300: Practice Scenario 5

- A patient is being readied by the discharge nurse for discharge tomorrow and will be followed by home health services.
- The discharge nurse reviewed the first skin assessment completed on the day of admission to the facility. It documented a Stage 2 pressure ulcer on the right hip and a nonremovable immobilizer on the patient's right leg.
- There was also documentation sent from the hospital with the patient indicating there was a known Stage 2 pressure ulcer on the right medial malleolus covered by the nonremovable immobilizer and a Stage 2 pressure ulcer on the right hip.





# How would you code M0300. Current Number of Unhealed Pressure Ulcers at Each Stage on Admission?

- A. M0300B1 (Stage 2) would be coded as 1; M0300E1 (Unstageable – non-removable dressing/device) would be coded as 1.
- B. M0300C1 (Stage 3) would be coded as 1; M0300E1 (Unstageable – non-removable dressing/device) would be coded as 1.
- C. M0300B1 (Stage 2) would be coded as 1; M0300C1 (Stage 3) would be coded as 1.
- D. M0300B1 (Stage 2) would be coded as 1; the ulcer under the immobilizer is not coded because it cannot be assessed on admission.





# How would you code M0300. Current Number of Unhealed Pressure Ulcers at Each Stage on Admission?



- A. **M0300B1 (Stage 2) would be coded as 1; M0300E1 (Unstageable – non-removable dressing/device) would be coded as 1.**
- B. M0300C1 (Stage 3) would be coded as 1; M0300E1 (Unstageable – non-removable dressing/device) would be coded as 1.
- C. M0300B1 (Stage 2) would be coded as 1; M0300C1 (Stage 3) would be coded as 1.
- D. M0300B1 (Stage 2) would be coded as 1; the ulcer under the immobilizer is not coded because it cannot be assessed on admission.



# M0300: Practice Scenario 5 – Admission Rationale

- **Answer:** The answer is A, **M0300B1 (Stage 2)** would be coded as 1; **M0300E1 (Unstageable – non-removable dressing/device)** would be coded as 1.
- **Rationale:** On admission, the first skin assessment was completed, and it was documented that there was a Stage 2 pressure ulcer on the right hip and a known Stage 2 pressure ulcer on the right medical malleolus underneath a nonremovable immobilizer.
  - When a pressure ulcer is known but covered by a nonremovable dressing/device, it should be coded as unstageable due to nonremovable dressing/device.



# M0300: Practice Scenario 6



- The patient was admitted to the IRF/LTCH with a blood-filled blister on the right heel. After further assessment of the surrounding tissues, the nurse documents on the first skin assessment that the heel blister is a deep tissue injury (DTI).
- 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.
- The nurse completes the last skin assessment the day before discharge and documents that the right heel remains at a Stage 3.

# How would you code M0300. Current Number of Unhealed Pressure Ulcers at Each Stage on Admission?

- A. M0300B1 (Stage 2) would be coded as 1
- B. M0300G1 (Unstageable – DTI) would be coded as 1.
- C. M0300C1 (Stage 3) would be coded as 1.
- D. M0300 is completed with dashes because the anatomical tissues within the wound cannot be assessed.





# How would you code M0300. Current Number of Unhealed Pressure Ulcers at Each Stage on Admission?



- A. M0300B1 (Stage 2) would be coded as 1
- B. M0300G1 (Unstageable – DTI) would be coded as 1.**
- C. M0300C1 (Stage 3) would be coded as 1.
- D. M0300 is completed with dashes because the anatomical tissues within the wound cannot be assessed.

# M0300: Practice Scenario 6 – Admission Rationale




- **Answer:** The answer is B, **M0300G1 (Unstageable – DTI)** would be coded as 1.
- **Rationale:** After a thorough clinical and skin examination, an assessment of the right heel and surrounding tissues revealed a skin injury consistent with what constitutes a DTI. For the Admission assessment, **M0300G1 is coded with a 1** because the DTI was observed at the time of the first complete skin assessment.

# How would you code M0300. Current Number of Unhealed Pressure Ulcers at Each Stage on Discharge?

- A. M0300C1 (Stage 3) would be coded as 1 and M0300C2 (Stage 3, Present on admission) would be coded as 0
- B. M0300C1 (Stage 3) would be coded as 0 and M0300C2 (Stage 3, Present on admission) would be coded as 0.
- C. M0300C1 (Stage 3) would be coded as 1 and M0300C2 (Stage 3, Present on admission) would be coded as 1.
- D. M0300G1 (DTI) would be coded as 1 and M300G2 would be coded as 1.

# How would you code M0300. Current Number of Unhealed Pressure Ulcers at Each Stage on Discharge?

- A. M0300C1 (Stage 3) would be coded as 1 and M0300C2 (Stage 3, Present on admission) would be coded as 0
- B. M0300C1 (Stage 3) would be coded as 0 and M0300C2 (Stage 3, Present on admission) would be coded as 0.
-  **C. M0300C1 (Stage 3) would be coded as 1 and M0300C2 (Stage 3, Present on admission) would be coded as 1.**
- D. M0300G1 (DTI) would be coded as 1 and M300G2 would be coded as 1.



# M0300: Practice Scenario 6 – Discharge Rationale



- **Answer:** The answer is C, **M0300C1 (Stage 3)** would be coded as 1 and **M0300C2 (Stage 3, Present on admission)** would be coded as 1.
- **Rationale:** The heel DTI blister is drained, tissue debrided, and subsequently numerically staged as a Stage 3.
  - Because this was the first time the ulcer was able to be assessed and numerically staged, and it remained at that stage at the time of discharge, it is considered to have been present on admission. Therefore, **M0300C1 is coded 1** and **M0300C2 is coded 1**.



# M0300: Practice Scenario 7

- The patient is admitted to the IRF/LTCH and the admitting nurse conducts the first skin assessment. Upon completion of the assessment, the nurse documents that a DTI with intact skin was identified on the patient's right hip.
- At the skin assessment completed 2 days before discharge, the assessing nurse documents that the previous DTI has become unstageable due to slough obscuring the entire wound bed.
- The DTI never evolved to be numerically staged while the patient was at the facility.




# How would you code M0300. Current Number of Unhealed Pressure Ulcers at Each Stage on Admission?

- A. M0300F1 (Unstageable – Slough/Eschar) would be coded as 1.
- B. M0300G1 (Unstageable – DTI) would be coded as 0.
- C. M0300G1 (Unstageable – DTI) would be coded as 1.
- D. M0300 is completed with dashes because the anatomical tissues within the wound cannot be assessed.



# How would you code M0300. Current Number of Unhealed Pressure Ulcers at Each Stage on Admission?

- A. M0300F1 (Unstageable – Slough/Eschar) would be coded as 1.
- B. M0300G1 (Unstageable – DTI) would be coded as 0.
-  **C. M0300G1 (Unstageable – DTI) would be coded as 1.**
- D. M0300 is completed with dashes because the anatomical tissues within the wound cannot be assessed.

# M0300: Practice Scenario 7 – Admission Rationale

- **Answer:** The answer is C, **M0300G1 (Unstageable – DTI)** would be coded as 1.
- **Rationale:** After the nurse examined the patient's skin, identification of an intact area of skin injury consistent with what constitutes a DTI was present at the right hip and surrounding tissues. For the Admission assessment, **M0300G1 is coded with a 1** because a DTI was observed at the time of the first complete skin assessment.



# How would you code M0300. Current Number of Unhealed Pressure Ulcers at Each Stage on Discharge?

- A. M0300F1 (Unstageable – Slough and/or Eschar) would be coded as 1 and M0300F2 (Unstageable – Slough and/or Eschar, Present on admission) would be coded as 1.
- B. M0300F1 (Unstageable – Slough and/or Eschar) would be coded as 0 and M0300F2 (Unstageable – Slough and/or Eschar, Present on admission) would be coded as 0.
- C. M0300G1 (Unstageable – DTI) would be coded as 1 and M0300G2 (Unstageable – DTI, Present on admission) would be coded as 0.





# How would you code M0300. Current Number of Unhealed Pressure Ulcers at Each Stage on Discharge?



- A. **M0300F1 (Unstageable – Slough and/or Eschar) would be coded as 1 and M0300F2 (Unstageable – Slough and/or Eschar, Present on admission) would be coded as 1.**
- B. M0300F1 (Unstageable – Slough and/or Eschar) would be coded as 0 and M0300F2 (Unstageable – Slough and/or Eschar, Present on admission) would be coded as 0.
- C. M0300G1 (Unstageable – DTI) would be coded as 1 and M0300G2 (Unstageable – DTI, Present on admission) would be coded as 0.



# M0300: Practice Scenario 7 – Discharge Rationale

- **Answer:** The answer is A, **M0300F1 (Unstageable – Due to Slough and/or Eschar)** would be coded as 1 and **M0300F2 (Unstageable – Due to Slough and/or Eschar, Present on admission)** would be coded as 1.
- **Rationale:** At the skin assessment completed 2 days before discharge, the assessing nurse documents that the previous DTI has become unstageable due to slough obscuring the wound bed.
  - Because the DTI that was observed on admission did not evolve to be numerically staged but became unstageable due to slough, it is considered to have been present on admission. Therefore, **M0300F1 is coded 1** and **M0300F2 is coded 1** on discharge.



# Key Insights

- Complete Section M items as close to the admission and discharge as possible, following the instructions in the guidance manual.
- In order to code skin conditions correctly, the etiology of any wound must be determined.
- In order to properly stage a pressure ulcer, one must be able to visualize the tissues involved as much as possible.

