

SECTION M: SKIN CONDITIONS

Intent: The items in this section document the presence, appearance, and change of pressure ulcers/injuries.

CMS recognizes that, in addition to the items included in this section of the IRF-PAI, a complete and ongoing assessment of patient's skin, guided by clinical standards, is essential to an effective pressure ulcer/injury prevention and skin management program for all patients. Therefore, completion of this section does not replace a thorough assessment of each patient's risk factors for developing skin ulcers, wounds, or lesions. It is important to recognize and evaluate each patient's risk factors and to identify and evaluate all areas at risk of constant pressure. A complete assessment of skin is essential to an effective pressure ulcer/injury prevention and skin treatment program. 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.

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, and bed sore. 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, if 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 IRF-PAI as a Stage 2 pressure ulcer.

M0210. Unhealed Pressure Ulcers/Injuries

M0210. Unhealed Pressure Ulcers/Injuries	
Enter Code	Does this patient have one or more unhealed pressure ulcers/injuries?
	0. No → Skip to M0415, High-Risk Drug Classes: Use and Indication
	1. Yes → Continue to M0300, Current Number of Unhealed Pressure Ulcers/Injuries at Each Stage

Item Rationale

- The pressure ulcer/injury definitions used in this IRF-PAI Manual have been adapted from those recommended by the National Pressure Injury Advisory Panel (NPIAP) Pressure Injury Staging System.
- Pressure ulcers/injuries occur when tissue is compressed between a bony prominence and an external surface. In addition to pressure, shear force and friction are important contributors to pressure ulcer development.
- The underlying health of a patient's soft tissue affects how much pressure, shear force, or friction is needed to damage tissue. Skin and soft tissue changes associated with aging,

DEFINITION

PRESSURE ULCER/INJURY

A pressure ulcer/injury is a 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.

illness, small blood vessel disease, and malnutrition increase vulnerability to pressure ulcers/injuries.

- Additional external factors, such as excess moisture, microclimate, and tissue exposure to urine or feces, can increase risk.
- An existing pressure ulcer/injury identifies patients at risk for further complications or skin injury.
- Pressure ulcers/injuries and other wounds or lesions affect quality of life for patients because they may limit activity, be painful, require time-consuming treatments and dressing changes, and can pose a risk of infection and sepsis.
- IRFs may adopt the NPIAP guidelines in their clinical practice and documentation. However, because CMS has adapted the NPIAP guidelines for IRF-PAI purposes, the definitions do not perfectly correlate with each stage as described by the NPIAP. Therefore, IRFs must code the IRF-PAI according to the instructions and definitions in this manual.
- For the IRF-PAI assessment, the initial (at admission) numerical staging of pressure ulcers/injuries should be coded in terms of what is assessed (i.e., seen and palpated, such as visible tissue, palpable bone) as close to admission as possible.
- Pressure ulcer/injury staging is an assessment system that provides 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.
- The IRF should be aware that the patient is at higher risk of having the area of a closed pressure ulcer open up due to damage, injury, or pressure, because of the loss of tensile strength of the overlying tissue. Tensile strength of the skin overlying a closed pressure ulcer is 80% of normal skin tensile strength. The IRF should implement preventive measures that will mitigate the opening of a closed ulcer due to the fragility of the overlying tissue.

Steps for Assessment

1. Review the medical record, including skin care flow sheets or other skin monitoring forms.
2. Speak with direct care staff and the treatment nurse or wound care specialist to confirm conclusions and clarify any questions from the medical record review.
3. Examine the patient and determine whether any skin ulcers/injuries are present.
 - Key areas for pressure ulcer/injury development include the sacrum, coccyx, trochanters, ischial tuberosities, and heels. Other areas, such as bony prominences, skin under braces, and skin subjected to excess pressure, shear, or friction, are also at risk for pressure ulcers/injuries.
 - Conduct a full-body skin assessment to ensure no pressure ulcers/injuries are missed.
 - Examine the patient in a well-lit room. Adequate lighting is important for detecting skin changes.

- For any pressure ulcers/injuries identified, measure and record the deepest anatomical stage.
4. Identify any known or likely unstageable pressure ulcers/injuries.

Coding Instructions

If admission assessment, complete as close to the time of admission as possible. If discharge assessment, complete as close to the time of discharge as possible.

- **Code 0, No**, if the patient did not have a pressure ulcer/injury on the first skin assessment in the 3-day assessment period at admission (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 at admission (or the last skin assessment in the 3-day assessment period at discharge).

DEFINITION

ON ADMISSION

As close to the actual time of admission as possible.

Coding Tips

- If an ulcer/injury arises from a combination of factors that are primarily caused by pressure, then the ulcer/injury should be included in this section as a pressure ulcer/injury.
- Mucosal pressure ulcers are not staged using the skin pressure ulcer staging system because anatomical tissue comparisons cannot be made. Therefore, mucosal ulcers (e.g., those related to nasogastric tubes, nasal oxygen tubing, endotracheal tubes, urinary catheters, mucosal ulcers in the oral cavity, etc.) should not be coded on the IRF-PAI.
- If a pressure ulcer/injury is surgically closed with a flap or graft, it should be considered a surgical wound and not a pressure ulcer/injury, and therefore should not be reported as a pressure ulcer on the IRF-PAI. If the flap or graft fails, it should be considered a surgical wound until healed.
- Scabs and eschar are different both physically and chemically. Eschar is a collection of dead tissue within the wound that is flush with the surface of the wound. A scab is made up of dried blood cells and serum, sits on the top of the skin, and forms over exposed wounds such as wounds with granulating surfaces (like pressure ulcers, lacerations, evulsions, etc.). A scab is evidence of wound healing. A pressure ulcer that was staged as a Stage 2 and now has a scab indicates it is a healing Stage 2, and therefore, staging should not change. Eschar characteristics and the level of damage it causes to tissues is what makes it easy to distinguish from a scab. It is extremely important to have staff who are trained in wound assessment and who are able to distinguish scabs from eschar.
- Review for location and stage at the time of admission. If the pressure ulcer/injury was observed at the time of admission and subsequently increased in numerical stage during the patient's stay, the pressure ulcer/injury is coded at the initial stage on the admission assessment, and the higher stage should not be coded on the admission assessment.

- If a pressure ulcer/injury is noted as having healed at discharge, do not code the healed ulcer/injury on the discharge assessment.
- If two or more pressure ulcers/injuries were observed at the time of admission and merge into a single pressure ulcer/injury by discharge, the resulting pressure ulcer/injury is reported as one single pressure ulcer/injury at the appropriate stage on the IRF-PAI.
- Patients with diabetes mellitus (DM) can have pressure, venous, arterial, or diabetic neuropathic ulcers. The primary etiology should be considered when coding whether a patient with DM has an ulcer/injury that is caused by pressure or other factors.
 - **Example:** If a patient with DM has a heel ulcer from pressure and the ulcer/injury is present during the initial skin assessment that takes place following admission to the IRF, **code M0210, Unhealed Pressure Ulcers/Injuries, as 1, Yes** and proceed to code item M0300, Current Number of Unhealed Pressure Ulcers/Injuries at Each Stage as appropriate for the pressure ulcer.
 - **Example:** If a patient with DM has an ulcer on the plantar (bottom) surface of the foot closer to the metatarsals and the ulcer is present during the initial skin assessment that takes place following admission to the IRF, **code M0210, Unhealed Pressure Ulcers/Injuries, as 0, No**. It is not likely that pressure is the primary cause of the patient's ulcer when the ulcer is in this location.

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

Steps for Completing M0300A–G

Step 1: Determine Deepest Anatomical Stage

For each pressure ulcer/injury, determine the deepest anatomical stage. At admission, code based on findings from the first skin assessment that is conducted on or after and as close to the admission as possible. Do not reverse or back-stage. Consider current and historical levels of tissue involvement.

1. Observe or palpate the base of any identified pressure ulcers/injuries present to determine the anatomic depth of soft tissue damage involved. Assessment should be done in accordance with facility, State, and Federal requirements on which IRF staff members may complete patient assessments.
2. Ulcer/injury staging should be based on the ulcer/injury's deepest anatomic soft tissue damage that is visible or palpable. If a pressure ulcer/injury's tissues are obscured such that the depth of soft tissue damage cannot be observed, it is considered unstageable (see Step 2, below).
3. Review the history of each pressure ulcer/injury in the medical record. If the stageable pressure ulcer/injury was previously classified at a higher numerical stage than what is observed now, it should continue to be classified at the higher numerical stage until healed, unless it becomes unstageable. IRFs that carefully document and monitor pressure ulcers/injuries will be able to code this item more accurately.
4. Pressure ulcers do not heal in a reverse sequence, that is, the body does not replace the types and layers of tissue (e.g., muscle, fat, and dermis) that were lost during pressure ulcer development before they re-epithelialize. Stage 3 and 4 pressure ulcers fill with granulation tissue. This replacement tissue is never as strong as the tissue that was lost and hence is more prone to future breakdown.
5. Clinical standards do not support reverse staging or back-staging as a way to document healing as it does not accurately characterize what is physiologically occurring as the ulcer heals. For example, over time, even though a Stage 4 pressure ulcer has been healing and contracting such that it is less deep, wide, and long, the tissues that were lost (muscle, fat, dermis) will never be replaced with the same type of tissue. Previous standards using reverse staging or back-staging would have permitted identification of this pressure ulcer as a stage 3, then a stage 2, and so on, when it reached a depth consistent with these stages. Clinical standards now would require that this ulcer continue to be documented as a Stage 4 pressure ulcer until it has completely healed, unless it becomes unstageable. IRFs can document the

DEFINITIONS

EPITHELIAL TISSUE

New skin that is light pink and shiny (even in persons with darkly pigmented skin). In Stage 2 pressure ulcers, epithelial tissue may be seen in the center and at the edges of the ulcer. In full thickness Stage 3 and 4 pressure ulcers, epithelial tissue advances from the edges of the wound.

GRANULATION TISSUE

Red tissue with "cobblestone" or bumpy appearance; bleeds easily when injured.

healing of pressure ulcers using descriptive characteristics of the wound (i.e., depth, width, presence or absence of granulation tissue, etc.) or by using a validated pressure ulcer healing tool. Once a pressure ulcer has healed, it is documented as a healed pressure ulcer at its highest numerical stage – in this example, a healed Stage 4 pressure ulcer. For care planning purposes, this healed Stage 4 pressure ulcer would remain at increased risk for future breakdown or injury and would require continued monitoring and preventative care.

6. A previously closed pressure ulcer that opens again should be reported at its worst stage, unless currently presenting at a higher stage or unstageable.

Step 2: Identify Unstageable Pressure Ulcers/Injuries

1. Visualization of the wound bed is necessary for accurate staging.
2. If a pressure ulcer/injury's anatomical tissues are obscured such that the extent of soft tissue damage cannot be observed or palpated, the pressure ulcer/injury is considered unstageable.
3. Pressure ulcers that have eschar (tan, black, or brown) or slough (yellow, tan, gray, green, or brown) tissue present such that the anatomic depth of soft tissue damage cannot be visualized or palpated in the wound bed should be classified as unstageable, as illustrated at <https://cdn.ymaws.com/npiap.com/resource/resmgr/NPIAP-Staging-Poster.pdf>
4. If the wound bed is only partially covered by eschar or slough, and the anatomical depth of tissue damage can be visualized or palpated, numerically stage the ulcer, and do not code this as unstageable.
5. A pressure injury with intact skin that is a deep tissue injury (DTI) should **not** be coded as a Stage 1 pressure injury. It should be coded as unstageable, as illustrated at <https://cdn.ymaws.com/npiap.com/resource/resmgr/NPIAP-Staging-Poster.pdf>
6. **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 states a pressure ulcer/injury exists under the non-removable dressing/device.

Step 3: Determine "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**. Consider current and historical levels of tissue involvement.*

1. Review the medical record for the history of the ulcer/injury.
2. If a patient has a pressure ulcer that was documented on admission, and at discharge is documented at the same stage, it would be considered as "present on admission."
 - This guidance is true even if during the stay the original pressure ulcer healed and reopened at the same stage and remained at that stage at discharge.
3. If the pressure ulcer/injury that is assessed on discharge was present on admission and subsequently increased in numerical stage during the patient's stay, the pressure ulcer/injury

is coded at that higher stage on discharge. That higher stage **should not be coded as “present on admission”** in items M0300B2-G2 on the discharge assessment.

4. If the pressure ulcer/injury was unstageable on admission, but becomes numerically stageable later, it **should be considered as “present on admission” at the stage at which it first becomes numerically stageable, when completing this patient’s discharge assessment.** If it subsequently increases in numerical stage, that higher stage **should not be coded “present on admission” when coding this patient’s discharge assessment.**
5. Clinical assessments performed on patients in the IRF should be completed according to accepted clinical practice and comply with facility policy, State and Federal regulations. The general standard of practice for newly admitted patients is that clinical admission assessments are completed beginning as close to the actual time of admission as possible, and usually within 24 hours. For example, if a facility requires that a full patient assessment be completed within the first 24 hours, then the information required in the IRF-PAI admission assessment would be coded based on that assessment and coincide with the findings that were completed within that same timeframe.
6. The 3-day assessment period used in the IRF-PAI is not intended to replace the timeframe required for clinical admission assessments as established by accepted standards of practice, facility policy, State and Federal regulations. Therefore, the IRF-PAI admission assessment’s sections that include patient assessment should be consistent with the initial clinical assessment (e.g., the assessment of skin conditions that are present **at the time of admission** are based on the first skin assessment that is in conjunction with the admission). So, if a patient that is clinically assessed upon admission has a pressure ulcer/injury identified and staged, that initial clinical assessment is what should be used to assist in coding the IRF-PAI Admission assessment pressure ulcer/injury items. If the pressure ulcer/injury that is identified on admission increases in numerical staging (i.e., worsens) within the 3-day IRF assessment period, the **initial** stage of the pressure ulcer/injury would be documented on the IRF-PAI Admission assessment. This pressure ulcer/injury would be captured on the IRF-PAI Discharge assessment as worsened (unless it heals) and **would not be coded as “present on admission.”**
7. If a patient is discharged to another facility/hospital for longer than 3 calendar days and subsequently returns to the IRF, 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 new admission assessment for the second IRF stay.
8. If a patient is admitted to an IRF with a healed pressure ulcer/injury, and a pressure ulcer/injury occurs in the same anatomical area, and remains at discharge, it would be coded as observed at discharge and **would not be coded as “present on admission”** on the discharge assessment. Therefore, this pressure ulcer/injury would be considered new, or facility acquired.
9. If a pressure ulcer/injury was unstageable on admission and then becomes unstageable for another reason, it **should be considered “present on admission” at the new unstageable status.** For example, if a patient is admitted with a deep tissue injury, but later the injury opens, the wound bed is covered with slough, and the wound is still unstageable, this wound would still be considered “present on admission.”

M0300A. Number of Stage 1 Pressure Injuries

M0300. Current Number of Unhealed Pressure Ulcers/Injuries at Each Stage	
Enter Number <input type="text"/>	<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>

Item Rationale

- Stage 1 pressure injuries may deteriorate to more severe pressure ulcers/injuries without adequate intervention; as such, they are an important risk factor for further tissue damage.
- Development of a Stage 1 pressure injury is one of multiple factors that should lead providers to initiate pressure ulcer/injury prevention interventions.

Steps for Assessment

1. Perform head-to-toe assessment. Conduct a full-body skin assessment focusing on bony prominences and pressure-bearing areas (e.g., sacrum, buttocks, heels, ankles).
2. For the purposes of coding, determine that the lesion being assessed is *primarily* related to pressure and that other conditions have been ruled out. If pressure is *not the primary cause*, **do not code here**.
3. Use multiple descriptors to determine whether a pressure injury is a Stage 1 or a DTI. See Definition of DTI on page M-30. Color changes for a Stage 1 do not include purple or maroon discoloration; these may indicate DTI.
4. Check any reddened areas for ability to blanch by firmly pressing a finger into the reddened tissues and then removing it. In nonblanchable reddened areas, there is no loss of skin color or pressure-induced pallor at the compressed site.
5. Search for other areas of skin that differ from surrounding tissue that may be painful, firm, soft, warmer, or cooler compared with adjacent tissue. Stage 1 pressure injuries may be difficult to detect in individuals with dark skin tones. Visible blanching may not be readily apparent in darker skin tones. Look for temperature or color changes as well as surrounding tissue that may be painful, firm, or soft.

DEFINITIONS

STAGE 1 PRESSURE INJURY

An observable, pressure-related alteration of intact skin whose indicators, as compared with an adjacent or opposite area on the body, may include changes in one or more of the following parameters: skin temperature (warmth or coolness); tissue consistency (firm or boggy); sensation (pain, itching); and/or a defined area of persistent redness in lightly pigmented skin, whereas in darker skin tones, the injury may appear with persistent red, blue, or purple hues.

NONBLANCHABLE

Reddened areas of tissue that do not turn white or pale when pressed firmly with a finger or device.

Coding Instructions

Complete at the time of admission and discharge.

- **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

Admission

Enter Number <input type="text"/>	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
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Discharge

Enter Number <input type="text"/>	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
Enter Number <input type="text"/>	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

Item Rationale

- Stage 2 pressure ulcers may worsen without proper interventions.
- These patients are at risk for further complications or skin injury.
- Most Stage 2 pressure ulcers should heal in a reasonable timeframe (e.g., 60 days).
- Stage 2 pressure ulcers are often related to friction and/or shearing force, and the care plan should incorporate efforts to limit these forces on the skin and tissues.
- Stage 2 pressure ulcers may be more likely to heal with treatment than higher-stage pressure ulcers.
- If a pressure ulcer fails to show some evidence toward healing within 14 days, the pressure ulcer (including potential complications) and the patient's overall clinical condition should be reassessed.
- The care plan should include individualized interventions and evidence that the interventions have been monitored and modified as appropriate.

DEFINITION

STAGE 2 PRESSURE ULCER

Partial thickness loss of dermis presenting as a shallow open ulcer with a red-pink wound bed, **without slough or bruising**. May also present as an intact or open/ruptured serum-filled blister.

Steps for Assessment

1. Perform a head-to-toe assessment. Conduct a full-body skin assessment focusing on bony prominences and pressure-bearing areas (e.g., sacrum, buttocks, heels, ankles).
2. For the purposes of coding, determine that the lesion being assessed is *primarily* related to pressure and that other conditions have been ruled out. If pressure is *not the primary cause*, **do not code here**.
3. Examine the area adjacent to or surrounding an intact blister for evidence of tissue damage. If other conditions are ruled out and the tissue adjacent to or surrounding the blister

demonstrates signs of tissue damage (e.g., color change, tenderness, boggy or firmness, warmth or coolness), these characteristics suggest a DTI rather than a Stage 2 pressure ulcer.

4. Stage 2 pressure ulcers will *generally* lack the surrounding characteristics found with a DTI.
5. When completing the discharge assessment, identify the number of these pressure ulcers that were “present on admission.”

Coding Instructions for M0300B1: Number of Stage 2 pressure ulcers

Complete at the time of admission and discharge.

- **Enter the number** of pressure ulcers that are currently present and whose deepest anatomical stage is Stage 2.
- **Enter 0**, if no Stage 2 pressure ulcers are present.

Coding Instructions for M0300B2: Number of these Stage 2 pressure ulcers that were present upon admission

Complete at the time of discharge.

- **Enter the number** of these Stage 2 pressure ulcers (M0300B1) that were present upon admission (see instructions starting on page M-5 under **Steps for Completing M0300A-G, Step 3: Determine “Present on Admission”**).
- **Enter 0**, if the Stage 2 pressure ulcer(s) present at discharge was/were not noted at the time of admission.

Coding Tips

- A Stage 2 pressure ulcer presents as a shiny or dry shallow ulcer *without slough* or bruising.
- 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.
- Do *not* code skin tears, tape burns, moisture-associated skin damage, or excoriation here.
- When a pressure ulcer/injury presents as an intact serum-filled blister, examine the adjacent and surrounding area for signs of DTI. When a DTI is determined, **do not code as a Stage 2**.

M0300C. Stage 3 Pressure Ulcers

Admission

Enter Number <input type="text"/>	<p>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.</p> <p>1. Number of Stage 3 pressure ulcers</p>
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Discharge

Enter Number <input type="text"/>	<p>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.</p> <p>1. Number of Stage 3 pressure ulcers If 0 → Skip to M0300D, Stage 4</p>
Enter Number <input type="text"/>	<p>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</p>

Item Rationale

- Pressure ulcers affect quality of life for patients because they may limit activity, be painful, and require time-consuming treatments and dressing changes.
- Pressure ulcers at more advanced stages typically require more aggressive interventions, including more frequent repositioning, attention to nutritional status, and care that may be more time or staff intensive.
- An existing pressure ulcer may put patients at risk for further complications or skin injury.
- If a pressure ulcer fails to show some evidence toward healing within 14 days, the pressure ulcer (including potential complications) and the patient's overall clinical condition should be reassessed.

DEFINITION

STAGE 3 PRESSURE ULCER

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 or tunneling (see definition of undermining and tunneling on page M-18).

Steps for Assessment

- Perform head-to-toe assessment. Conduct a full-body skin assessment focusing on bony prominences and pressure-bearing areas (e.g., sacrum, buttocks, heels, ankles).
- For the purposes of coding, determine that the lesion being assessed is *primarily* related to pressure and that other conditions have been ruled out. If pressure is *not the primary cause*, **do not code here**.
- Identify all Stage 3 pressure ulcers currently present.
- When completing the discharge assessment, identify the number of these pressure ulcers that were "present on admission."

Coding Instructions for M0300C1: Number of Stage 3 pressure ulcers

Complete at the time of admission and discharge.

- **Enter the number** of pressure ulcers that are currently present and whose deepest anatomical stage is Stage 3.
- **Enter 0**, if no Stage 3 pressure ulcers are present.

Coding Instructions for M0300C2: Number of these Stage 3 pressure ulcers that were present upon admission

Complete at the time of discharge.

- **Enter the number** of these Stage 3 pressure ulcers (M0300C1) that were present upon admission (see instructions starting on page M-5 under **Steps for Completing M0300A-G, Step 3: Determine “Present on Admission”**).
- **Enter 0**, if the Stage 3 pressure ulcer(s) present at discharge was/were not noted at the time of admission.

Coding Tips

- The depth of a Stage 3 pressure ulcer varies by anatomical location. Stage 3 pressure ulcers can be shallow, particularly on areas that do not have subcutaneous tissue, such as the bridge of the nose, ear, occiput, and malleolus.
- In contrast, areas of significant adiposity can develop extremely deep Stage 3 pressure ulcers. Therefore, observation and assessment of skin folds should be part of overall skin assessment.
- Do **not** code skin tears, tape burns, moisture-associated skin damage, or excoriation here.
- Bone/tendon/muscle is not visible or directly palpable in a Stage 3 pressure ulcer.

Coding Examples

1. A pressure ulcer described as a Stage 2 on the heel was noted and documented in the patient's medical record on admission. On discharge, this wound is noted to be a full thickness ulcer without exposed bone, tendon, or muscle; thus, it is now a Stage 3 pressure ulcer in the same location.

Coding:

Item	Admission Assessment	Discharge Assessment
M0300B1 , Number of Stage 2 pressure ulcers	Code as 1	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	Code as 1
M0300C2 , Number of these Stage 3 pressure ulcers that were present upon admission		Code as 0

Rationale: On the discharge assessment, the designation of “present on admission” requires that the pressure ulcer/injury be at the same location *and* not have increased in numerical stage. This (Stage 2) pressure ulcer increased in numerical stage (to Stage 3) after admission. So, **M0300B1 would be coded as 1 on admission and 0 on discharge. M0300C1 would be coded as 0 on admission and 1 on discharge, and M0300C2 would be coded as 0 on discharge** because it was not a Stage 3 pressure ulcer on admission.

- A patient develops a Stage 2 pressure ulcer on the sacrum *while* at the IRF. The patient is discharged from the IRF to a short-stay acute-care hospital for the treatment of an acute myocardial infarction. The patient returns to the IRF with a Stage 3 pressure ulcer in the same location. Subsequently, the patient is discharged with this ulcer noted to be a full thickness Stage 3 pressure ulcer in the same location.

Coding:

Item	Admission Assessment #1	Discharge Assessment #1	Admission Assessment #2	Discharge Assessment #2
M0300B1 , Number of Stage 2 pressure ulcers	Code as 0	Code as 1	Code as 0	Code as 0
M0300B2 , Number of these Stage 2 pressure ulcers that were present upon admission		Code as 0		Skip
M0300C1 , Number of Stage 3 pressure ulcers	Code as 0	Code as 0	Code as 1	Code as 1
M0300C2 , Number of these Stage 3 pressure ulcers that were present upon admission		Skip		Code as 1

Rationale: Even though the patient had a pressure ulcer/injury in the same anatomical location prior to their transfer to a short-stay acute-care hospital, because the pressure ulcer increased in numerical stage to Stage 3, **M0300C2 is coded as 1** because the Stage 3 pressure ulcer was present on *second* admission to the IRF.

- On admission, the patient has three small Stage 2 pressure ulcers on their coccyx. Three weeks later, upon discharge, the coccyx is assessed. Two of the Stage 2 pressure ulcers have merged, and the third ulcer has increased in numerical staging to a Stage 3 pressure ulcer.

Coding:

Item	Admission Assessment	Discharge Assessment
M0300B1 , Number of Stage 2 pressure ulcers	Code as 3	Code as 1
M0300B2 , Number of these Stage 2 pressure ulcers that were present upon admission		Code as 1
M0300C1 , Number of Stage 3 pressure ulcers	Code as 0	Code as 1
M0300C2 , Number of these Stage 3 pressure ulcers that were present upon admission		Code as 0

Rationale: Two of the pressure ulcers on the coccyx have merged, but have remained at the same stage as they were at the time of admission (therefore, **M0300B1 is coded as 1 at discharge**). The pressure ulcer that increased in numerical staging to a Stage 3 has developed a deeper level of tissue damage in the time since admission; therefore, on the discharge assessment, **M0300C2 is coded as 0**, not present upon admission.

4. A patient developed two Stage 2 pressure ulcers during their stay at the IRF: one on the coccyx and the other on the left lateral malleolus. The patient develops a gastrointestinal bleed and hypotension and is discharged to a short-stay acute-care hospital. When the patient returns to the IRF, they have two pressure ulcers. One is the previous Stage 2 pressure ulcer on the coccyx, which has not changed; the other is a new Stage 3 pressure ulcer on the left trochanter. The Stage 2 pressure ulcer on the left lateral malleolus that was present during the first stay has healed.

Coding:

Item	Admission Assessment #1	Discharge Assessment #1	Admission Assessment #2
M0210 , Unhealed Pressure Ulcers/Injuries	Code as 0	Code as 1	Code as 1
M0300B1 , Number of Stage 2 pressure ulcers	Skip	Code as 2	Code as 1
M0300B2 , Number of these Stage 2 pressure ulcers that were present upon admission		Code as 0	
M0300C1 , Number of Stage 3 pressure ulcers	Skip	Code as 0	Code as 1
M0300C2 , Number of these Stage 3 pressure ulcers that were present upon admission		Skip	

Rationale: On initial admission, this patient had no pressure ulcers/injuries. Two Stage 2 pressure ulcers developed during the first IRF stay and are **coded on discharge in M0300B1 as 2 and in M0300B2 as 0**. On return from the hospital, the Stage 2 pressure ulcer on the coccyx that was present prior to the patient's transfer to a short-stay acute-care hospital is coded as 1 in M0300B1 on the patient's second admission to the IRF. There is a new Stage 3 pressure ulcer that developed during the acute-care hospital stay; therefore, **M0300C1 is coded as 1** on the patient's second admission to the IRF. The Stage 2 pressure ulcer on the left lateral malleolus has healed and is not coded when the patient is admitted to the IRF for the second time.

5. A patient arrives at the IRF with a Stage 2 pressure ulcer. The patient is transferred to a short-stay acute-care hospital, but returns to the IRF less than 3 calendar days after leaving the IRF. When the patient returns, the IRF notes that the Stage 2 pressure ulcer has worsened to a Stage 3 pressure ulcer. The patient is discharged 3 weeks later with a Stage 3 pressure ulcer.

Coding:

Item	Admission Assessment	Discharge Assessment
M0300B1 , Number of Stage 2 pressure ulcers	Code as 1	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	Code as 1
M0300C2 , Number of these Stage 3 pressure ulcers that were present upon admission		Code as 0

Rationale: Because the patient returned to the IRF less than 3 calendar days after being transferred to a short-stay acute-care hospital, the patient's return to the IRF is **not** considered a new admission; therefore, any new pressure ulcer/injury formation or pressure ulcer/injury increase in numerical staging that occurred at the short-stay acute-care hospital should not be coded as "present on admission" on the discharge assessment. The Stage 3 pressure ulcer was not present upon the patient's admission to the IRF; therefore, **M0300C2 should be coded as 0** on the discharge assessment.

- A patient develops a Stage 2 pressure ulcer while at the IRF. The patient is transferred to a short-stay acute-care hospital because of pneumonia. The patient returns to the IRF after 4 days and returns with a Stage 3 pressure ulcer in the same anatomical location.

Coding:

Item	Admission Assessment #1	Discharge Assessment #1	Admission Assessment #2
M0210 , Unhealed Pressure Ulcers/Injuries	Code as 0	Code as 1	Code as 1
M0300B1 , Number of Stage 2 pressure ulcers	Skip	Code as 1	Code as 0
M0300B2 , Number of these Stage 2 pressure ulcers that were present upon admission		Code as 0	
M0300C1 , Number of Stage 3 pressure ulcers	Skip	Code as 0	Code as 1
M0300C2 , Number of these Stage 3 pressure ulcers that were present upon admission		Skip	

Rationale: There were no pressure ulcers identified on admission. Therefore, on the admission assessment, item M0210 is coded as 0 and items **M0300B1** and **M0300C1** are **skipped**. Even though the patient had a pressure ulcer in the same anatomical location prior to transfer to the short-stay acute-care hospital, because it increased in numerical staging to a Stage 3 during hospitalization at another facility that lasted longer than 3 calendar days, **M0300C1 should be coded as 1** on the second admission assessment to indicate that the Stage 3 pressure ulcer was present on the patient's *second admission* to the IRF.

- A patient enters the IRF with a Stage 2 pressure ulcer. On day 2 of the patient's stay, the wound is reassessed as a Stage 3 pressure ulcer. The wound remains a Stage 3 at the time of discharge, 2 weeks later.

Coding:

Item	Admission Assessment	Discharge Assessment
M0300B1 , Number of Stage 2 pressure ulcers	Code as 1	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	Code as 1
M0300C2 , Number of these Stage 3 pressure ulcers that were present upon admission		Code as 0

Rationale: The Stage 2 pressure ulcer was observed at the time of admission, so **M0300B1 is coded as 1** on the admission assessment. Even though the wound worsened during the 3-day assessment period, the initial stage of the pressure ulcer should be captured because it reflects the patient's condition at the time of admission. On the discharge assessment, **M0300C1 should be coded as 1** and **M0300C2 should be coded as 0** because the Stage 3 pressure ulcer was not present, at that stage, on admission.

8. A patient is admitted to an IRF with one large Stage 3 pressure ulcer on the coccyx. At the time of discharge, there is epithelialization across the pressure ulcer in the center, separating one side of the pressure ulcer from the other.

Coding:

Item	Admission Assessment	Discharge Assessment
M0300B1 , Number of Stage 2 pressure ulcers	Code as 0	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 1	Code as 1
M0300C2 , Number of these Stage 3 pressure ulcers that were present upon admission		Code as 1

Rationale: At the time of discharge, the Stage 3 pressure ulcer on the coccyx that was observed at the time of admission has begun to show some healing at the center. Because this ulcer is healing and has not fully closed, it remains a Stage 3 pressure ulcer on discharge. It will continue to be considered a Stage 3 pressure ulcer until it heals; therefore, **M0300C1 is coded as 1** and **M0300C2 is coded as 1** on the discharge assessment.

9. A patient is admitted to the IRF with nine Stage 2 pressure ulcers. During the patient's stay, they develop two additional Stage 2 pressure ulcers. One of the "new" pressure ulcers heals by the time of discharge, but the patient is discharged with 10 Stage 2 pressure ulcers.

Coding:

Item	Admission Assessment	Discharge Assessment
M0300B1 , Number of Stage 2 pressure ulcers	Code as 9	Code as 9
M0300B2 , Number of these Stage 2 pressure ulcers that were present upon admission		Code as 9
M0300C1 , Number of Stage 3 pressure ulcers	Code as 0	Code as 0

Item	Admission Assessment	Discharge Assessment
M0300C2 , Number of these Stage 3 pressure ulcers that were present upon admission		Code as 0

Rationale: Because there were nine Stage 2 pressure ulcers observed at the time of admission, **M0300B1 is coded as 9** on the Admission assessment. At the time of discharge, the patient had 10 Stage 2 pressure ulcers. However, because there is space to enter only one digit in M0300B1, **M0300B1 would be coded as 9** on the Discharge assessment. **M0300B2 would be coded as 9** on the Discharge assessment because nine of the 10 Stage 2 pressure ulcers that are present on discharge were “present on admission.”

10. A patient is admitted to the IRF with one non-healing Stage 3 pressure ulcer. The patient is transferred to another facility for a flap procedure to close the pressure ulcer and returns to the IRF 2 calendar days following the transfer. The patient is discharged with the flap, which is healing nicely.

Coding:

Item	Admission Assessment	Discharge Assessment
M0210 , Unhealed Pressure Ulcers/Injuries	Code as 1	Code as 0
M0300B1 , Number of Stage 2 pressure ulcers	Code as 0	Skip
M0300B2 , Number of these Stage 2 pressure ulcers that were present upon admission		Skip
M0300C1 , Number of Stage 3 pressure ulcers	Code as 1	Skip
M0300C2 , Number of these Stage 3 pressure ulcers that were present upon admission		Skip

Rationale: The Stage 3 pressure ulcer is observed at the time of admission, so **M0300C1 is coded as 1** on the admission assessment. On the discharge assessment, **M0210 is coded 0 and M0300 items are skipped** because a flap has been used to close the Stage 3 pressure ulcer. A flap used to close a pressure ulcer would essentially render the pressure ulcer as “closed,” and would be considered a surgical wound.

M0300D. Stage 4 Pressure Ulcers

Admission

Enter Number <input type="text"/>	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
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Discharge

Enter Number <input type="text"/>	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
Enter Number <input type="text"/>	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

Item Rationale

- Pressure ulcers affect quality of life for patients because they may limit activity, be painful, and require time-consuming treatments and dressing changes.
- Pressure ulcers at more advanced stages typically require more aggressive interventions, including more frequent repositioning, attention to nutritional status, more frequent dressing changes, and treatment that is more time consuming than with routine preventive care.
- An existing pressure ulcer may put patients at risk for further complications or skin injury.
- If a pressure ulcer fails to show some evidence toward healing within 14 days, the pressure ulcer (including potential complications) and the patient's overall clinical condition should be reassessed.

DEFINITIONS

STAGE 4 PRESSURE ULCER

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.

TUNNELING

A passageway of tissue destruction under the skin surface that has an opening at the skin level from the edge of the wound.

UNDERMINING

The destruction of tissue or ulceration extending under the skin edges (margins) so that the pressure ulcer is larger at its base than at the skin surface.

Steps for Assessment

- Perform head-to-toe assessment. Conduct a full-body skin assessment focusing on bony prominences and pressure-bearing areas (e.g., sacrum, buttocks, heels, ankles).
- For the purposes of coding, determine that the lesion being assessed is *primarily* related to pressure and that other conditions have been ruled out. If pressure is *not the primary cause*, **do not code here**.
- Identify all Stage 4 pressure ulcers currently present.

4. When completing the discharge assessment, identify the number of these pressure ulcers that were “present on admission.”

Coding Instructions for M0300D1: Number of Stage 4 pressure ulcers

Complete at the time of admission and discharge.

- **Enter the number** of pressure ulcers that are currently present and whose deepest anatomical stage is Stage 4.
- **Enter 0**, if no Stage 4 pressure ulcers are present.

Coding Instructions for M0300D2: Number of these Stage 4 pressure ulcers that were present upon admission

Complete at the time of discharge.

- **Enter the number** of these Stage 4 pressure ulcers (M0300D1) that were present upon admission (see instructions starting on page M-5 under **Steps for Completing M0300A-G, Step 3: Determine “Present on Admission”**).
- **Enter 0**, if the Stage 4 pressure ulcer(s) present at discharge was/were not noted at the time of admission.

Coding Tips

- The depth of a Stage 4 pressure ulcer varies by anatomical location. The bridge of the nose, ear, occiput, and malleolus do not have subcutaneous tissue, and these ulcers can be shallow.
- Stage 4 pressure ulcers can extend into muscle and/or supporting structures (e.g., fascia, tendon, or joint capsule), making osteomyelitis possible.
- In Stage 4 pressure ulcers, exposed bone/tendon/muscle is visible or directly palpable.
- Cartilage serves the same anatomical function as bone. Therefore, pressure ulcers that have exposed cartilage should be classified as Stage 4 pressure ulcers.

M0300E. Unstageable Pressure Ulcers/Injuries Due to Non-removable Dressing/Device

Admission

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
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Discharge

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 <i>If 0 → Skip to M0300F, Unstageable - Slough and/or eschar</i>
Enter Number <input type="text"/>	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

Item Rationale

- Although the wound bed cannot be visualized due to the non-removable dressing/device, and hence the pressure ulcer/injury cannot be staged, the pressure ulcer/injury may affect quality of life for patients because it may limit activity and be painful.
- Although the pressure ulcer/injury itself cannot be observed, the surrounding area is monitored for signs of redness, swelling, increased drainage, or tenderness to the touch, and the patient is monitored for adequate pain control.

DEFINITION

NON-REMOVABLE DRESSING/DEVICE

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

Steps for Assessment

Documentation of an existing pressure ulcer/injury is needed to complete this item.

- 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.
- Determine the number of documented pressure ulcers/injuries covered by a non-removable dressing/device. Examples of non-removable dressings/devices include a dressing or orthopedic device that is not to be removed per physician's order (such as those used in negative-pressure wound therapy [NPWT]), or a cast.
- When completing the discharge assessment, identify the number of these pressure ulcers/injuries that were "present on admission."

Coding Instructions for M0300E1: Number of unstageable pressure ulcers/injuries due to non-removable dressing/device

Complete at the time of admission and discharge.

- **Enter the number** of pressure ulcers/injuries that are unstageable due to non-removable dressing/device.
- **Enter 0**, if no unstageable pressure ulcers/injuries due to non-removable dressing/device are present.

Coding Instructions for M0300E2: Number of these unstageable pressure ulcers/injuries that were present upon admission

Complete at the time of discharge.

- **Enter the number** of these unstageable pressure ulcers/injuries due to a non-removable dressing/device (M0300E1) that were present upon admission (see instructions starting on page M-5 under **Steps for Completing M0300A-G, Step 3: Determine “Present on Admission”**).
- **Enter 0**, if the unstageable pressure ulcer(s)/injury(ies) due to non-removable dressing/device present at discharge was/were not noted at the time of admission.

Coding Tips

- If a pressure ulcer/injury observed on admission does not increase in numerical stage or become unstageable due to slough/eschar during the stay but becomes unstageable due to a non-removable dressing or device at discharge, then it would be coded as unstageable due to non-removable dressing or device at the discharge assessment and *coded as “present on admission” in M0300E2*. This is because even though the stage of the pressure ulcer/injury is unknown at discharge, there is no documentation or indication that it increased in numerical stage during the stay.
- If a pressure ulcer/injury observed on admission increases in numerical stage or becomes unstageable due to slough/eschar during the stay, and then becomes unstageable due to non-removable dressing or device at discharge, code on discharge assessment as unstageable due to non-removable dressing or device *but do not code as “present on admission.”* This is because even though the stage of the pressure ulcer/injury is unknown at discharge, it increased in numerical stage during the stay.
- If a pressure ulcer/injury is observed upon removal of a non-removable dressing/device and there was no available documentation that stated the pressure ulcer/injury existed under the non-removable dressing/device at the time of admission, then the pressure ulcer is coded on the discharge assessment at the observed stage at discharge (M0300x1 = 1) and that this pressure ulcer was not “present on admission” (M0300x2 = 0).

Coding Examples

1. A patient is admitted to an IRF with a short leg cast to the right lower extremity. The patient has no visible wounds on admission but arrives with documentation that a pressure

ulcer/injury exists under the cast. Two weeks after admission to the IRF, the cast is removed by the physician. Following removal of the cast, the right heel is observed and assessed as a Stage 3 pressure ulcer, which remains until discharge.

Coding:

Item	Admission Assessment	Discharge Assessment
M0300B1 , Number of Stage 2 pressure ulcers	Code as 0	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	Code as 1
M0300C2 , Number of these Stage 3 pressure ulcers that were present upon admission		Code as 1
M0300D1 , Number of Stage 4 pressure ulcers	Code as 0	Code as 0
M0300D2 , Number of these Stage 4 pressure ulcers that were present upon admission		Skip
M0300E1 , Number of unstageable pressure ulcers due to non-removable dressing/device	Code as 1	Code as 0
M0300E2 , Number of these unstageable pressure ulcers that were present upon admission		Skip

Rationale: Because the patient came to the IRF with documentation that a pressure ulcer/injury was present under the cast and the cast could not be removed for the first 2 weeks, the admission assessment is coded for the pressure ulcer/injury covered by the cast and would be **coded as 1 for M0300E1** on the admission assessment. On discharge, **M0300C1 is coded as 1** and **M0300C2 is coded as 1** because even though a Stage 3 pressure ulcer was not technically observed at the time of admission, the ulcer/injury was able to be staged only after removal of the cast; therefore, it is coded as “present on admission” at the stage it was first able to be assessed.

- A patient is admitted to an IRF with a known pressure ulcer/injury due to a non-removable dressing/device. Ten days after admission, the surgeon removed the dressing, and a Stage 2 pressure ulcer was identified. Two weeks later the pressure ulcer was determined to be a full thickness ulcer and was at that point a Stage 3. It remained a Stage 3 at the time of discharge.

Coding:

Item	Admission Assessment	Discharge Assessment
M0300C1 , Number of Stage 3 pressure ulcers	Code as 0	Code as 1
M0300C2 , Number of these Stage 3 pressure ulcers that were present upon admission		Code as 0
M0300E1 , Number of unstageable pressure ulcers due to non-removable dressing/device	Code as 1	Code as 0
M0300E2 , Number of these unstageable pressure ulcers present upon admission		Skip

Rationale: This patient was admitted with a documented unstageable pressure ulcer/injury due to non-removable dressing/device, so on the admission assessment this pressure ulcer/injury is **coded as 1 for M0300E1**. The dressing was removed to reveal a

Stage 2 pressure ulcer, and this is the first numerical stage documented in the medical record. Subsequent to this first stage, the ulcer worsened to Stage 3 and remained at Stage 3 at discharge. On discharge, **M0300C1 is coded as 1 and M0300C2 is coded as 0**, because this pressure ulcer was previously staged as a Stage 2 upon initial removal of the dressing, so on the discharge assessment it is not considered “present on admission” as a Stage 3.

M0300F. Unstageable Pressure Ulcers Due to Slough and/or Eschar

Admission

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 1. Number of unstageable pressure ulcers due to coverage of wound bed by slough and/or eschar
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Discharge

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 1. Number of unstageable pressure ulcers due to coverage of wound bed by slough and/or eschar <i>If 0 → Skip to M0300G, Unstageable - Deep tissue injury</i>
Enter Number <input type="text"/>	2. Number of <u>these</u> unstageable pressure ulcers that were present upon admission - enter how many were noted at the time of admission

Item Rationale

- Although the wound bed cannot be visualized, and hence the pressure ulcer cannot be numerically staged, the pressure ulcer may affect quality of life for patients because it may limit activity, be painful, and require time-consuming treatments and dressing changes.
- Visualization of the wound bed is necessary for accurate numerical staging.
- The presence of pressure ulcers and other skin changes should be accounted for in the interdisciplinary care plan.
- Pressure ulcers that present as unstageable require care planning that includes, in the absence of ischemia, debridement of necrotic and dead tissue and restaging once this tissue is removed.

DEFINITIONS

SLOUGH TISSUE

Nonviable yellow, tan, gray, green, or brown tissue; usually moist, can be soft, stringy, and mucinous in texture. Slough may be adherent to the base of the wound or present in clumps throughout the wound bed.

ESCHAR TISSUE

Dead or devitalized tissue that is hard or soft in texture; usually black, brown, or tan in color, and may appear scab-like. Necrotic tissue and eschar are usually firmly adherent to the base of the wound and often the sides/edges of the wound.

Steps for Assessment

- Determine the number of pressure ulcers that are unstageable because of slough and/or eschar.
- When completing the discharge assessment, identify the number of these pressure ulcers that were “present on admission.”

Coding Instructions for M0300F1: Number of unstageable pressure ulcers due to slough and/or eschar

Complete at the time of admission and discharge.

- **Enter the number** of pressure ulcers that are unstageable due to slough and/or eschar.
- **Enter 0**, if no unstageable pressure ulcers due to slough and/or eschar are present.

Coding Instructions for M0300F2: Number of these unstageable pressure ulcers that were present upon admission

Complete at the time of discharge.

- **Enter the number** of these unstageable pressure ulcers due to coverage of wound bed by slough and/or eschar (M0300F1) that were present upon admission (see instructions starting on page M-5 under **Steps for Completing M0300A-G, Step 3: Determine “Present on Admission”**).
- **Enter 0**, if the unstageable pressure ulcer(s) due to slough and/or eschar present at discharge was/were not noted at the time of admission.

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, the numerical stage) cannot be determined. Only when enough slough and/or eschar are removed to expose the anatomic depth of soft tissue damage involved can the numerical stage of the wound be determined.
- Stable eschar (i.e., dry, adherent, intact without erythema or fluctuance) on the heels serves as “the body’s natural (biological) cover” and should be removed only after careful clinical consideration, including ruling out ischemia, and in consultation with the patient’s physician, or nurse practitioner, physician assistant, or clinical nurse specialist if allowable under State licensure laws.
- Even in the presence of slough and/or eschar, if the anatomic depth of soft tissue damage within the wound bed can be identified, the ulcer can then be numerically staged. The pressure ulcer does not have to be completely debrided or free of all slough and/or eschar tissue for classification of the ulcer to occur.
- If a stageable pressure ulcer/injury observed at the time of admission further deteriorates and eventually becomes unstageable due to slough or eschar at discharge, the unstageable pressure ulcer would be coded on the discharge assessment and would not be considered as “present on admission,” so M0300F2 would be coded 0. This is because the pressure ulcer that is assessed on discharge was not “present on admission” at the same stage it is observed at the time of discharge.

DEFINITION

FLUCTUANCE

Used to describe the texture of wound tissue indicative of underlying unexposed fluid.

- If a pressure ulcer becomes unstageable due to slough or eschar and is debrided sufficiently to be numerically staged *by discharge*, review the pressure ulcer history. If the pressure ulcer's stage increased numerically during the stay, it would be coded at that higher stage and **would not be considered nor coded as “present on admission” on the discharge assessment**. In this instance, the discharge “present on admission” item for that higher numerical stage would be coded as 0 (M0300x2 = 0).
- The following guidance is provided regarding pressure ulcers that were observed on admission that were numerically staged, become unstageable, are debrided, and subsequently become numerically stageable:
 - If a numerically staged pressure ulcer that was observed on admission becomes unstageable due to slough or eschar during the stay (i.e., cannot be numerically staged), is debrided, and after debridement is able to be staged numerically, and the reassessed stage is higher than a previous numerical stage, it would be coded at that higher stage and **would not be considered nor coded as “present on admission” on the discharge assessment** (M0300x2 = 0).
 - If a numerically staged pressure ulcer that was observed on admission becomes unstageable due to slough or eschar (i.e., cannot be numerically staged), is debrided, and after debridement is able to be staged numerically, and the reassessed stage at discharge is the same as the stage at admission, it **would be considered and coded as “present on admission” on the discharge assessment at the stage at which it first becomes numerically stageable** (M0300x1 = 1 and M0300x2 = 1).
 - If an unstageable pressure ulcer due to slough or eschar that was observed on admission is debrided and is subsequently able to be numerically staged, and remains at the same stage at discharge, it **would be considered and coded as “present on admission” on the discharge assessment at the stage at which it first becomes numerically stageable** (M0300x1 = 1 and M0300x2 = 1).
 - If an unstageable pressure ulcer due to slough or eschar that was observed on admission is debrided and is able to be numerically staged, and subsequent to this numerical staging the pressure ulcer further deteriorates and is staged at a higher numerical stage and/or is unstageable due to slough or eschar at discharge, the pressure ulcer **would not be considered nor coded as “present on admission” on the discharge assessment** (M0300x2 = 0).

Coding Examples

1. A patient is admitted to an IRF with two Stage 2 pressure ulcers, one on the left heel and one on the right heel. The patient also is admitted with a Stage 4 pressure ulcer to the sacral area. The patient develops a new Stage 4 pressure ulcer on the right greater trochanter area while at the IRF. At the time of discharge, the Stage 2 pressure ulcers have healed on both heels and the patient continues to have the Stage 4 sacral ulcer and the Stage 4 pressure ulcer on the right greater trochanter area.

Coding:

Item	Admission Assessment	Discharge Assessment
M0300B1 , Number of Stage 2 pressure ulcers	Code as 2	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	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	Code as 2
M0300D2 , Number of these Stage 4 pressure ulcers that were present upon admission		Code as 1

Rationale: The two Stage 2 pressure ulcers on the heels that were observed at the time of admission have resolved, so **M0300B1 is coded as 2** at the time of admission and **M0300B1 is coded as 0** at discharge. **M0300D1 is coded as 1** at the time of admission and **M0300D1 is coded as 2** on discharge because the patient has a new Stage 4 pressure ulcer in addition to the Stage 4 pressure ulcer that was “present on admission.” **M0300D2 is coded as 1** on discharge because only one of the two Stage 4 pressure ulcers was “present on admission” to the IRF.

- A patient is admitted to an IRF with one Stage 2 pressure ulcer on the left heel and a Stage 3 pressure ulcer on the coccyx. The patient is reassessed before discharge to a nursing home, and the Stage 2 pressure ulcer on the left heel is now a Stage 4, the coccyx ulcer has increased in numerical staging to a Stage 4, and there is a new Stage 3 on the left buttock area.

Coding:

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

Rationale: The Stage 2 pressure ulcer on the heel and the Stage 3 pressure ulcer on the coccyx that were identified on admission (**M0300B1** and **M0300C1** were coded as 1 on the admission assessment) have both increased in numerical staging to Stage 4; therefore, on the discharge assessment, **M0300D1 is coded as 2** and **M0300D2 is coded as 0**. The new Stage 3 pressure ulcer identified on the left buttock area is coded in **M0300C1 as 1** and in **M0300C2 as 0** at discharge because it is a new Stage 3 pressure ulcer that was not “present on admission.”

3. A patient is admitted to the IRF with eschar tissue covering pressure ulcers on both the right and left heels, as well as a Stage 2 pressure ulcer to the coccyx. The patient is reassessed before discharge, and the Stage 2 coccyx pressure ulcer has healed. The left heel eschar became fluctuant, showed signs of infection, and had to be debrided at the bedside. The left heel wound was subsequently numerically staged as a Stage 4 pressure ulcer. The right heel eschar remained stable and dry (i.e., remained unstageable).

Coding:

Item	Admission Assessment	Discharge Assessment
M0300B1 , Number of Stage 2 pressure ulcers	Code as 1	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	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	Code as 1
M0300D2 , Number of these Stage 4 pressure ulcers that were present upon admission		Code as 1
M0300E1 , Number of unstageable pressure ulcers due to non-removable dressing/device	Code as 0	Code as 0
M0300E2 , Number of these unstageable pressure ulcers that were present upon admission		Skip
M0300F1 , Number of unstageable pressure ulcers due to slough/eschar	Code as 2	Code as 1
M0300F2 , Number of these unstageable pressure ulcers that were present upon admission		Code as 1

Rationale: Both heels cannot be numerically staged at admission because the level of tissue damage cannot be determined due to the eschar present, so they are coded on the admission assessment as unstageable due to slough/eschar (**M0300F1 is coded as 2**). The Stage 2 pressure ulcer on the coccyx healed, so **M0300B1 is coded as 1** at admission and **M0300B1 is coded as 0** at discharge. The left heel eschar that was debrided is coded as a Stage 4 at discharge, so **M0300D1 is coded as 1**. Since the left heel eschar was debrided, and the first time an unstageable ulcer/injury is staged, it is considered as “present on admission” at the stage it is initially assessed. Therefore, **M0300D2 is coded as 1** on the discharge assessment. The right heel eschar remains unstageable. Therefore, on the discharge assessment, **M0300F1 is coded as 1** and **M0300F2 is coded as 1**.

4. A patient is admitted to the IRF with an eschar-covered sacral pressure ulcer. After 20 days, the patient’s nutritional status improves, and the surgery department is consulted for debridement of the sacral pressure ulcer. The patient is transferred to the short-stay, acute-care hospital, undergoes surgical debridement of the sacral wound, and transfers back to the IRF the same day. Upon return to the IRF, the wound-care nurse assesses the wound and numerically stages it as a Stage 4 pressure ulcer. The wound remains a Stage 4 pressure ulcer when the patient eventually gets discharged to a nursing home for extended wound care.

Coding:

Item	Admission Assessment	Discharge Assessment
M0300B1 , Number of Stage 2 pressure ulcers	Code as 0	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	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	Code as 1
M0300D2 , Number of these Stage 4 pressure ulcers that were present upon admission		Code as 1
M0300E1 , Number of unstageable pressure ulcers due to non-removable dressing/device	Code as 0	Code as 0
M0300E2 , Number of these unstageable pressure ulcers that were present upon admission		Skip
M0300F1 , Number of unstageable pressure ulcers due to slough/eschar	Code as 1	Code as 0
M0300F2 , Number of these unstageable pressure ulcers that were present upon admission		Skip

Rationale: The patient presented with an unstageable pressure ulcer on admission. After surgical debridement, the wound is numerically staged as a Stage 4. On discharge, **M0300D1** and **M0300D2** are coded as 1. **M0300D2** is coded as 1 because the pressure ulcer that was unstageable on admission was debrided and can then be numerically staged; therefore, it is considered as “present on admission” at the stage it is first assessed.

M0300G. Unstageable Pressure Injuries Presenting as Deep Tissue Injury

Admission

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

Enter Number <input type="text"/>	G. Unstageable - Deep tissue injury 1. Number of unstageable pressure injuries presenting as deep tissue injury <i>If 0 → Skip to N0415, High-Risk Drug Classes: Use and Indication</i>
Enter Number <input type="text"/>	2. Number of <u>these</u> unstageable pressure injuries that were present upon admission - enter how many were noted at the time of admission

Item Rationale

- A DTI may precede the development of a Stage 3 or 4 pressure ulcer, even with optimal treatment.
- Quality healthcare begins with prevention and risk assessment, and care planning begins with prevention. Appropriate care planning is essential in optimizing a patient's ability to avoid, as well as recover from, pressure (as well as all) wounds. DTIs may sometimes indicate severe tissue damage. Identification and management of a DTI is imperative.
- A DTI requires vigilant monitoring because of the potential for rapid deterioration. Such monitoring should be reflected in the plan of care.

DEFINITION

DEEP TISSUE INJURY (DTI)

Purple or maroon area of discolored intact skin or partial-thickness tissue loss due to pressure damage of underlying soft tissue. The area may be preceded by tissue that is painful, firm, mushy, boggy, warmer, or cooler than adjacent tissue.

Steps for Assessment

- Perform head-to-toe assessment. Conduct a full-body skin assessment focusing on bony prominences and pressure-bearing areas (e.g., sacrum, buttocks, heels, ankles).
- For the purposes of coding, determine that the lesion being assessed is *primarily* a result of pressure and that other conditions have been ruled out. If pressure is *not* the primary cause, **do not code as a DTI**.
- Examine the area adjacent to or surrounding an intact blister for evidence of tissue damage. If the tissue adjacent to or surrounding the blister *does not show* signs of tissue damage (e.g., color change, tenderness, boggiess or firmness, warmth, or coolness), **do not code as a DTI**.
- In dark-skinned individuals, the area of injury is probably not purple/maroon, but rather darker than the surrounding tissue.

5. Determine the number of pressure injuries that are unstageable presenting as DTIs.
6. Clearly document assessment findings in the patient's medical record, monitor the injury, and document appropriate wound-care planning and management.
7. When completing the discharge assessment, identify the number of these pressure injuries that were "present on admission."

Coding Instructions for M0300G1: Number of unstageable pressure injuries presenting as deep tissue injury

Complete at the time of admission and discharge.

- **Enter the number** of unstageable pressure injuries presenting as DTIs. Based on skin tone, the injured tissue area may present as a darker tone than the surrounding intact skin. These areas of discoloration are potentially areas of DTIs.
- **Enter 0**, if no unstageable pressure injuries presenting as DTIs are present.

Coding Instructions for M0300G2: Number of these unstageable pressure injuries that were present upon admission

Complete at the time of discharge.

- **Enter the number** of these unstageable pressure injuries presenting as DTIs (M0300G1) that were "present on admission" (see instructions starting on page M-5 under **Steps for Completing M0300A-G, Step 3: Determine "Present on Admission"**).
- **Enter 0**, if the unstageable pressure injury/(ies) presenting as a DTI at discharge was/were not noted at the time of admission.

Coding Tips

- A pressure ulcer/injury presenting with characteristics of a DTI is reported as a DTI unless full thickness tissue loss is present. For example, a DTI presenting as purple localized discoloration with tenderness caused by pressure, but without full thickness tissue loss would be coded as a DTI, even if the wound is not completely intact.
- Once a DTI has fully opened, exposing the level of tissue damage, reassess the wound via observation and/or palpation and code based on clinical assessment and staging criteria.
- If a DTI that was observed on admission evolves and is subsequently able to be numerically staged, and remains at the same stage at discharge, it would be considered and coded as "present on admission" on the discharge assessment at the stage at which it first becomes numerically stageable (M0300x1 = 1 and M0300x2 = 1).
- If a DTI that was observed on admission does not evolve to be numerically staged, but is subsequently classified as another type of unstageable pressure ulcer/injury, it would be considered and coded as "present on admission" on the discharge assessment in that unstageable pressure ulcer/injury category (M0300x1 = 1 and M0300x2 = 1).
- DTIs may be difficult to detect in individuals with dark skin tones.

- Evolution of DTIs may be rapid, exposing additional layers of tissue even with optimal treatment.
- When a lesion due to pressure presents with an intact serum-filled blister *and* the surrounding or adjacent soft tissue does *not* have the characteristics of a DTI, **do not code here** (see definition of Stage 2 pressure ulcer on page M-9).

Coding Example

1. Patient is admitted to the IRF 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. 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. On discharge, the right heel remains at Stage 3.

Coding:

Item	Admission Assessment	Discharge Assessment
M0300B1 , Number of Stage 2 pressure ulcers	Code as 0	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	Code as 1
M0300C2 , Number of these Stage 3 pressure ulcers that were present upon admission		Code as 1
M0300D1 , Number of Stage 4 pressure ulcers	Code as 0	Code as 0
M0300D2 , Number of these Stage 4 pressure ulcers that were present upon admission		Skip
M0300E1 , Number of unstageable pressure ulcers/injuries due to non-removable dressing/device	Code as 0	Code as 0
M0300E2 , Number of these unstageable pressure ulcers/injuries that were present upon admission		Skip
M0300F1 , Number of unstageable pressure ulcers due to slough/eschar	Code as 0	Code as 0
M0300F2 , Number of these unstageable pressure ulcers that were present upon admission		Skip
M0300G1 , Number of unstageable pressure injuries presenting as deep tissue injury	Code as 1	Code as 0
M0300G2 , Number of these unstageable pressure injuries that were present upon admission		Skip

Rationale: After a thorough clinical and skin examination, an assessment of the right heel and surrounding tissues revealed skin injury consistent with what constitutes a DTI. For the admission assessment, **M0300G1 is coded with a 1** because a DTI was observed at the time of admission. 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**.