



Long-Term Care Hospital (LTCH) Quality Reporting Program (QRP) Provider Training



Section M: Skin Conditions

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Section M: Objectives

- Define Section M: Skin Conditions.
- Explain new items and/or changes between LTCH CARE Data Set v2.01 and v3.00.
- Explain the intent of Section M.
- Discuss coding instructions and needed information for items.
- Accurately code scenario(s).

Section M: New Items and Changes

CHANGES:

- “Present on Admission” (POA) items M0300B2 – M0300G2 have been removed from the Admission Assessment.

NEW:

- New items added to M0800 on the Planned and Unplanned Discharge Assessments:
 - M0800D. Unstageable – Non-removable dressing.
 - M0800E. Unstageable – Slough and/or eschar.
 - M0800F. Unstageable – Suspected deep tissue injury.

Section M: Intent

Document the presence, appearance, and change of pressure ulcers.

Section M: Overarching Principles

- Staging definitions are adapted from 2007 NPUAP staging definitions.
- LTCH CARE Data Set does not preclude LTCH from providing complete and ongoing skin assessment using accepted clinical practice and guidelines.
- Identify and evaluate risk, and determine the etiology of all skin ulcers, wounds, and lesions to ensure appropriate treatment.

M0300: Current Number of Unhealed Pressure Ulcers at Each Stage (Admission)

M0300. Current Number of Unhealed Pressure Ulcers 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>Number of Stage 1 pressure ulcers</p>
Enter Number <input type="text"/>	<p>B. Stage 2: Partial thickness loss of dermis presenting as a shallow open ulcer with a red or pink wound bed, without slough. May also present as an intact or open/ruptured blister</p> <p>1. Number of Stage 2 pressure ulcers</p>
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>
Enter Number <input type="text"/>	<p>D. Stage 4: Full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present on some parts of the wound bed. Often includes undermining and tunneling</p> <p>1. Number of Stage 4 pressure ulcers</p>
Enter Number <input type="text"/>	<p>E. Unstageable - Non-removable dressing: Known but not stageable due to non-removable dressing/device</p> <p>1. Number of unstageable pressure ulcers due to non-removable dressing/device</p>
Enter Number <input type="text"/>	<p>F. Unstageable - Slough and/or eschar: Known but not stageable due to coverage of wound bed by slough and/or eschar</p> <p>1. Number of unstageable pressure ulcers due to coverage of wound bed by slough and/or eschar</p>
Enter Number <input type="text"/>	<p>G. Unstageable - Deep tissue injury: Suspected deep tissue injury in evolution</p> <p>1. Number of unstageable pressure ulcers with suspected deep tissue injury in evolution</p>

Note: The graphic above reflects items contained in the Admission LTCH CARE Data Set.

Section M: M0300A1-G1

CODING INSTRUCTIONS:

- Completed only if A0250 = 01 Admission; 10 Planned Discharge; or 11 Unplanned Discharge.
- **Enter the number** of pressure ulcers that are currently present.
- **Enter 0**, if no pressure ulcers are present.

M0300: Current Number of Unhealed Pressure Ulcers at Each Stage (Discharge)

M0300. Current Number of Unhealed Pressure Ulcers at Each Stage	
<input type="text"/> <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>Number of Stage 1 pressure ulcers</p>
<input type="text"/> <input type="text"/>	<p>B. Stage 2: Partial thickness loss of dermis presenting as a shallow open ulcer with a red or pink wound bed, without slough. May also present as an intact or open/ruptured blister</p> <p>1. Number of Stage 2 pressure ulcers - If 0 → Skip to M0300C, Stage 3</p> <p>2. Number of these Stage 2 pressure ulcers that were present upon admission - enter how many were noted at the time of admission</p>
<input type="text"/> <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> <p>2. Number of these Stage 3 pressure ulcers that were present upon admission - enter how many were noted at the time of admission</p>
<input type="text"/> <input type="text"/>	<p>D. Stage 4: Full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present on some parts of the wound bed. Often includes undermining and tunneling</p> <p>1. Number of Stage 4 pressure ulcers - If 0 → Skip to M0300E, Unstageable - Non-removable dressing</p> <p>2. Number of these Stage 4 pressure ulcers that were present upon admission - enter how many were noted at the time of admission</p>
<input type="text"/> <input type="text"/>	<p>E. Unstageable - Non-removable dressing: Known but not stageable due to non-removable dressing/device</p> <p>1. Number of unstageable pressure ulcers due to non-removable dressing/device - If 0 → Skip to M0300F, Unstageable - Slough and/or eschar</p> <p>2. Number of these unstageable pressure ulcers that were present upon admission - enter how many were noted at the time of admission</p>
<input type="text"/> <input type="text"/>	<p>F. Unstageable - Slough and/or eschar: Known but not stageable due to coverage of wound bed by slough and/or eschar</p> <p>1. Number of unstageable pressure ulcers due to coverage of wound bed by slough and/or eschar - If 0 → Skip to M0300G, Unstageable - Deep tissue injury</p> <p>2. Number of these unstageable pressure ulcers that were present upon admission - enter how many were noted at the time of admission</p>

Note: The graphic above reflects some of the M0300 items contained in the Discharge LTCH CARE Data Set.

Section M: M0300B2-G2

CODING INSTRUCTIONS:

- Completed only if A0250 = 10 Planned discharge or 11 Unplanned discharge.
- **Enter the number** of pressure ulcers that were present on admission (see instructions starting on M-4 under **Steps for Completing M0300A-G, Step 3: Determine “Present on Admission”**).
- **Enter 0**, if no pressure ulcers were noted at the time of admission.

Section M: M0300 Coding Scenario (1)

A patient arrives at the LTCH on Day 1, a clinical skin assessment is completed on admission, with no pressure ulcers identified. On Day 3, while bathing the patient, a Stage 2 pressure ulcer was noted on the patient's sacrum and documented in the patient's medical record. The patient was discharged with a Stage 2 pressure ulcer 8 days later.

How would you code M0300 on the Admission and Discharge Assessments?

What is your rationale?

Section M: M0300 Coding Scenario (1)

CODING:

Item	Admission Assessment	Discharge Assessment
M0300B1, Number of Stage 2 pressure ulcers	Code as 0	Code as 1
M0300B2, Number of these Stage 2 pressure ulcers present on admission		Code as 0

Section M: M0300 Coding Scenario (1)

CODING:

- **M0300B1 is coded as 0** on the Admission Assessment.
- **M0300B1 is coded as 1** on the Discharge Assessment.
- **M0300B2 is coded as 0** on the Discharge Assessment.

RATIONALE: Even though the patient had a Stage 2 pressure ulcer identified on Day 3 of the LTCH stay, only those pressure ulcers that were present as close to the time of admission are coded on the Admission Assessment.

Section M: M0300 Coding Scenario (2)

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

How would you code M0300 on the Admission and Discharge Assessments?

What is your rationale?

Section M: M0300 Coding Scenario (2)

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 present on admission		Code as 1
M0300C1, Number of Stage 3 pressure ulcers		Code as 1
M0300C2, Number of these Stage 3 pressure ulcers present on admission		Code as 0

Section M: M0300 Coding Scenario (2)

CODING:

- **M0300B1 is coded as 3** on the Admission Assessment.
- **M0300B1 is coded as 1** on the Discharge Assessment.
- **M0300C1 is coded as 1** on the Discharge Assessment.
- **M0300C2 is coded as 0** on the Discharge Assessment.

RATIONALE: There were three Stage 2 pressure ulcers present on admission to the LTCH but prior to discharge two of the three Stage 2 pressure ulcers merged to create one Stage 2 pressure ulcer, and the third Stage 2 developed a deeper level of tissue damage to a Stage 3 pressure ulcer.

Section M: M0300 Coding Scenario (3)

A patient enters the LTCH 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 does not heal by the time of discharge, 2 weeks later.

How would you code M0300 on the Admission and Discharge Assessments?

What is your rationale?

Section M: M0300 Coding Scenario (3)

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 present on admission		Code as 0
M0300C1, Number of Stage 3 pressure ulcers		Code as 1
M0300C2, Number of these Stage 3 pressure ulcers present on admission		Code as 0

Section M: M0300 Coding Scenario (3)

CODING:

- **M0300B1 is coded as 1** on the Admission Assessment.
- **M0300B1 and M0300B2 are coded as 0** on the Discharge Assessment.
- **M0300C1 is coded as 1** on the Discharge Assessment.
- **M0300C1 is coded as 0** on the Discharge Assessment.

RATIONALE: The Stage 2 pressure ulcer was present on admission, and even though the wound developed a deeper level of tissue damage during the 3-day assessment period, the initial stage of the pressure ulcer is captured because it reflects the patient's skin assessment at the time of admission.

Section M: M0800. Worsening in Pressure Ulcer Status Since Admission

M0800. Worsening in Pressure Ulcer Status Since Admission	
Indicate the number of current pressure ulcers that were not present or were at a lesser stage on admission. If no current pressure ulcer at a given stage, enter 0	
Enter Number <input type="text"/>	A. Stage 2
Enter Number <input type="text"/>	B. Stage 3
Enter Number <input type="text"/>	C. Stage 4
Enter Number <input type="text"/>	D. Unstageable - Non-removable dressing
Enter Number <input type="text"/>	E. Unstageable - Slough and/or eschar
Enter Number <input type="text"/>	F. Unstageable - Deep tissue injury

Applies to the Admission, Planned Discharge, and Unplanned Discharge Assessment.

Section M: M0800

CODING INSTRUCTIONS:

- **Enter the number** of Stage 2–4 or unstageable pressure ulcers that were not present (i.e., are new) or were at a lesser stage on admission (as documented on the Admission Assessment) compared with the number of Stage 2–4 or unstageable pressure ulcers that are present on discharge.
- **Enter 0**, if there are no current Stage 2–4 or unstageable pressure ulcers on discharge.

Section M: M0800 Coding Scenario (1)

A patient is admitted to the LTCH with a Stage 2 pressure ulcer. The ulcer develops a deeper level of tissue damage, exposing muscle, and is staged as a Stage 3 pressure ulcer during the stay. The wound bed subsequently covers with slough, and is identified as an unstageable pressure ulcer. The patient discussed his discharge plan with the LTCH and decided to go home with home health services and receive wound treatment at a local wound care clinic. On discharge, the patient record notes that wound debridement was not performed on the Stage 3 pressure ulcer at the LTCH and would be performed at the wound clinic.

How would you code M0800 on the Admission and Discharge Assessments?

What is your rationale?

Section M: M0800 Coding Scenario (1)

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		Code as 0
M0300F1 , Number of unstageable pressure ulcers due to coverage of wound bed by slough and/or eschar		Code as 1
M0300F2 , Number of these unstageable pressure ulcers that were present upon admission		Code as 0
M0800A , Worsening in Pressure Ulcer Status Since Admission – Stage 2		Code as 0
M0800B , Worsening in Pressure Ulcer Status Since Admission – Stage 3		Code as 0
M0800C , Worsening in Pressure Ulcer Status Since Admission – Stage 4		Code as 0
M0800D , Worsening in Pressure Ulcer Status Since Admission – Unstageable - Non-removable dressing		Code as 0
M0800E , Worsening in Pressure Ulcer Status Since Admission – Unstageable - Slough and/or Eschar		Code as 1
M0800F , Worsening in Pressure Ulcer Status Since Admission – Unstageable - Deep tissue injury		Code as 0

Section M: M0800 Coding Scenario (1)

CODING:

- **M0300B1 is coded as 1** on the Admission Assessment.
- **M0300B1 and M0300B2 are coded as 0** on the Discharge Assessment.
- **M0300F1 is coded as 1** on the Discharge Assessment.
- **M0300F2 is coded as 0** on the Discharge Assessment.
- **M0800E is coded as 1** on the Discharge Assessment.

RATIONALE: The Stage 2 pressure ulcer that was present on admission further evolved to a Stage 3 pressure ulcer during the LTCH stay and covered over with slough prior to discharge. The ulcer was not debrided prior to the patient's discharge.

Section M: M0800 Coding Scenario (2)

A patient was admitted to the LTCH from the acute-care hospital with a Stage 2 pressure ulcer blister on the left heel which ruptured and presented as a shallow ulcer with a pink wound bed. On the fourth day, the right heel was noted to have a blood-filled blister, with the area surrounding the blister being boggy, painful, and warm by Day 6. After discussion with the family, and approval by the patient, they decided to care for the patient at home with home care services and asked to be discharged from the LTCH against medical advice.

How would you code M0800 on the Admission and Discharge Assessments?

What is your rationale?

Section M: M0800 Coding Scenario (2)

CODING:

Item	Admission Assessment	Discharge Assessment
M0300B1 , Number of Stage 2 pressure ulcers	Code as 1	Code as 1
M0300B2 , Number of these Stage 2 pressure ulcers present upon admission		Code as 1
M0300G1 , Number of pressure ulcers with suspected deep tissue injury in evolution		Code as 1
M0300G2 , Number of pressure ulcers with suspected deep tissue injury in evolution that were present upon admission		Code as 0
M0800A , Worsening in Pressure Ulcer Status Since Admission – Stage 2		Code as 0
M0800B , Worsening in Pressure Ulcer Status Since Admission – Stage 3		Code as 0
M0800C , Worsening in Pressure Ulcer Status Since Admission – Stage 4		Code as 0
M0800D , Worsening in Pressure Ulcer Status Since Admission – Unstageable - Non-removable dressing		Code as 0
M0800E , Worsening in Pressure Ulcer Status Since Admission – Unstageable - Slough and/or Eschar		Code as 0
M0800F , Worsening in Pressure Ulcer Status Since Admission – Unstageable - Deep tissue injury		Code as 1

Section M: M0800 Coding Scenario (2)

CODING:

- **M0300B1 is coded as 1** on the Admission Assessment.
- **M0300B1 and M0300B2 are coded as 1** on the Discharge Assessment.
- **M0300G1 is coded as 1 and M0300G2 is coded as 0** on the Discharge Assessment.
- **M0800F is coded as 1** on the Discharge Assessment.

RATIONALE: The initial assessment identified one Stage 2 pressure ulcer on the left heel which was present on admission. This ulcer remained a Stage 2 until discharge. The patient developed a suspected deep tissue injury on the right heel prior to discharge.

Section M: Summary

- Section M documents the presence, appearance, and change of pressure ulcers.
- Keep the overarching principles in mind when completing Section M.
- M0300B2 – M0300G2 items removed from Admission Assessment.
- New items were added to M0800 on the Planned and Unplanned Discharge Assessments.

Section M: Action Plan

- Revise processes to ensure tracking of all pressure ulcers and changes in pressure ulcer status in the patient record.
- Review current way you are capturing “Present on Admission” pressure ulcers and compare it to how these ulcers are captured on the new LTCH CARE Data Set v3.00.
- Be sure to add unstageable pressure ulcers to your tracking of new and/or worsened pressure ulcers.
- Practice coding a variety of scenarios with staff.