

Long-Term Care Hospital Quality Reporting Program Section M

CODING SCENARIO SHEETS



December 6–7, 2017
InterContinental Dallas Hotel
Addison, TX

Coding Scenario 4

- A patient is admitted with documentation in the medical record of a sacral pressure ulcer/injury. This ulcer/injury is covered with a nonremovable dressing; therefore, this pressure ulcer/injury is unstageable.
- On Day 5 of the stay, the dressing is removed by the physician and assessment reveals a Stage 3 pressure ulcer.
- On Day 10 of the stay, the pressure ulcer is covered with eschar and is assessed as unstageable. The eschar-covered ulcer is unchanged at the time of discharge.

How would you code M0300?

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

Refer to Presentation Slides 45–54.



Coding Scenario 5

- Patient is admitted to the LTCH with a bruised, butterfly-shaped area on the sacrum and a blood-filled blister to the right heel.
- The sacral area, based on assessment of the surrounding tissues, is determined to be a DTI.
- The heel blister is also assessed, and based on the assessment of the surrounding tissues, it is determined that the heel blister is also 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 and the sacral area continues to be assessed as a DTI at discharge.

How would you code M0300?

Item	Admission Assessment	Discharge Assessment
M0300B1. Number of Stage 2 pressure ulcers		
M0300B2. Number of these Stage 2 pressure ulcers that were present upon admission		
M0300C1. Number of Stage 3 pressure ulcers		
M0300C2. Number of these Stage 3 pressure ulcers that were present upon admission		
M0300D1. Number of Stage 4 pressure ulcers		
M0300D2. Number of these Stage 4 pressure ulcers that were present upon admission		

Coding Scenario 5 continued

How would you code M0300?

Item	Admission Assessment	Discharge Assessment
M0300E1. Number of unstageable pressure ulcers/injuries due to non-removable dressing/device		
M0300E2. Number of these unstageable pressure ulcers/injuries due to non-removable dressing/device that were present upon admission		
M0300F1. Number of unstageable pressure ulcers due to slough/eschar		
M0300F2. Number of these unstageable pressure ulcers due to slough/eschar that were present upon admission		
M0300G1. Number of unstageable pressure injuries with deep tissue injury		
M0300G2. Number of these unstageable pressure injuries with deep tissue injury that were present upon admission		

Refer to Presentation Slides 56–78.

Coding Scenario 6

- The patient’s skin assessment on admission reveals no pressure ulcers or injuries.
- On Day 5, the patient record identifies a Stage 2 pressure ulcer on the right elbow.
- On discharge, the patient’s skin assessment reveals a healed Stage 2 pressure ulcer on the right elbow.

How would you code M0210?

Item	Admission Assessment	Discharge Assessment
M0210. Unhealed Pressure Ulcers/Injuries		

Refer to Presentation Slides 79–83.

Coding Scenario 7

- A patient is admitted with a right ankle foot orthosis (AFO) to compensate for weakness and foot drop.
- On the initial skin assessment, the clinician notes a Stage 2 pressure ulcer at the right calf that conforms to the shape of the AFO. The orthotist is consulted and the AFO is adjusted.
- The ulcer heals before discharge and no other pressure ulcers/injuries are present.

How would you code M0210 and M0300?

Item	Admission Assessment	Discharge Assessment
M0210. Unhealed Pressure Ulcers/Injuries		
M0300B1. Number of Stage 2 pressure ulcers		
M0300B2. Number of these Stage 2 pressure ulcers that were present upon admission		

Refer to Presentation Slides 85–93.

Coding Scenario 8

- A patient with a gastrostomy tube (G-tube) is admitted. The G-tube insertion site is covered with a dressing. The admitting clinician removes the dressing to complete an admission skin assessment and identifies a lesion present on the stoma.
- There are no other lesions identified at admission and throughout the stay.

How would you code M0210?

Item	Admission Assessment	Discharge Assessment
M0210: Unhealed Pressure Ulcers/Injuries		

Refer to Presentation Slides 95–99.