Acronyms in This Presentation

- Ankle Foot Orthosis (AFO)

- Centers for Medicare & Medicaid Services (CMS)

- Deep Tissue Injury (DTI)

- Gastrostomy Tube (G-tube)

- Long-Term Care Hospital (LTCH)

- LTCH Continuity Assessment Record and Evaluation Data Set (LTCH CARE Data Set)

- National Pressure Ulcer Advisory Panel (NPUAP)

- Peripheral Arterial Disease (PAD)

- Peripheral Vascular Disease (PVD)

Overview

- Define Section M: Skin Conditions.

- Explain the intent of Section M.

- Explain new items and/or changes between Long-Term Care Hospital (LTCH) Continuity Assessment Record and Evaluation (CARE) Data Set v3.00 and v4.00.

- Discuss coding instructions and needed information for items.

- Review practice coding scenarios.

Objectives

- State the intent of the changes to Section M.

- Describe the new pressure ulcer/injury Quality Measure.

- Articulate the purpose of the new wording and any implications for coding.

- Apply coding instructions to accurately code practice scenarios.

Intent

- Document the presence, appearance, and change in status of pressure ulcers/injuries based on a complete and ongoing assessment of patient's skin guided by clinical standards.

- Promote effective pressure ulcer/injury prevention and skin management program for all patients.
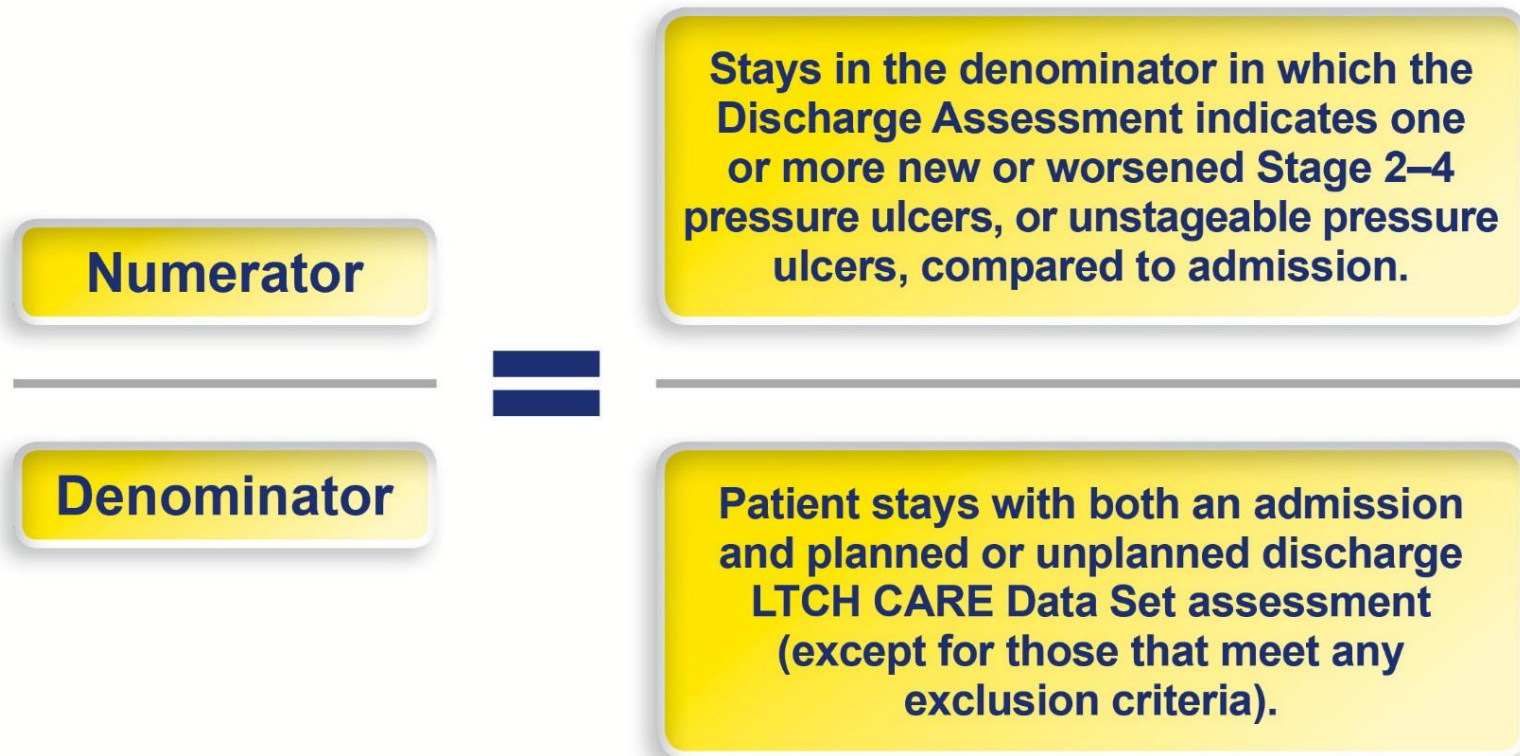
PRESSURE ULCER/INJURY:
Localized injury to the skin and/or underlying tissue, usually over a bony prominence, as a result of pressure, or pressure in combination with shear and/or friction.

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

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

- M0300 will be used to calculate the new quality measure "Changes in Skin Integrity Post-Acute Care: Pressure Ulcer/Injury," with data collection beginning July 1, 2018.

- For this measure, an ulcer is considered new or worsened at discharge if the Discharge Assessment shows a Stage 2- 4 or unstageable pressure ulcer that was not present on admission at that stage (e.g., M0300B1- M0300B2 > 0).

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

Numerator

=

Stays in the denominator in which the Discharge Assessment indicates one or more new or worsened Stage 2–4 pressure ulcers, or unstageable pressure ulcers, compared to admission.

Denominator

Patient stays with both an admission and planned or unplanned discharge LTCH CARE Data Set assessment (except for those that meet any exclusion criteria).

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

Denominator Exclusions:

1. Patient stay is excluded if data on new or worsened Stage 2, 3, 4, and unstageable pressure ulcers, including deep tissue injuries, are missing on the Planned or Unplanned Discharge Assessment.

2. Patient stay is excluded if the patient died during the LTCH stay; i.e., A0250 = [12].

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

Measure Time Window:

- The measure will be calculated quarterly using a rolling 12 months of data. For public reporting, the quality measure score reported for each quarter is calculated using a rolling 12 months of data.

- All LTCH stays during the 12 months, except those that meet the exclusion criteria, are included in the denominator and are eligible for inclusion in the numerator.

- For patients with multiple stays during the 12-month time window, each stay is eligible for inclusion in the measure.

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

Items from the Admission Assessment used to risk-adjust this quality measure:

Functional Mobility Admission Performance.	• GG0170C. Mobility; Lying to Sitting on Side of Bed.
Bowel Continence.	• H0400. Bowel Continence.
Peripheral Vascular Disease/Peripheral Arterial Disease or Diabetes Mellitus.	• I0900. Peripheral Vascular Disease (PVD) or Peripheral Arterial Disease (PAD); or • I2900. Diabetes Mellitus.
Low Body Mass Index, based on Height and Weight.	• K0200A. Height; and • K0200B. Weight.

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Section M: Skin Conditions

Changes Between LTCH CARE

Data Set v3.00 and v4.00

Item Changes

- CMS is aware of the array of terms used to describe alterations in skin integrity due to pressure, including pressure ulcer, pressure injury, pressure sore, decubitus ulcer and bed sore.

- 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.

Item Changes (cont. 1)

- Throughout the LTCH CARE Data Set, LTCH QRP Manual, and this training, CMS adheres to the following guidelines:

    o Stage 1 pressure injuries and deep tissue injuries are termed "pressure injuries" because they are closed wounds.

    o Stage 2, 3, or 4 pressure ulcers, or unstageable ulcers due to slough or eschar, are termed "pressure ulcers" because they are usually open wounds.

    o Unstageable ulcers/injuries due to nonremovable dressing/device are termed "pressure ulcers/injuries" because they may be open or closed wounds.

Item Changes (cont. 2)

New:

- The term **"injuries"** has been added to items: M0210, M0300, M0300A, M0300E–M0300E2, and M0300G–M0300G2 in the Admission, Planned Discharge, and Unplanned Discharge Assessments, effective July 1, 2018.

Section M	Skin Conditions
Report based on highest stage of existing ulcers/injuries at their worst; do not "reverse" stage.	

M0210. Unhealed Pressure Ulcers/Injuries

Enter Code ☐ — **Does this patient have one or more unhealed pressure ulcers/injuries?**
0. **No** → *Skip to N2001, Drug Regimen Review*
1. **Yes** → *Continue to M0300, Current Number of Unhealed Pressure Ulcers/Injuries at Each Stage*

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

Enter Number ☐ — A. **Stage 1:** Intact skin with non-blanchable redness of a localized area usually over a bony prominence. Darkly pigmented skin may not have a visible blanching; in dark skin tones only it may appear with persistent blue or purple hues
1. **Number of Stage 1 pressure injuries**

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

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Item Changes (cont. 3)

New:

- The term **"device"** was added to items: M0300D1, M0300E–M0300E2, in the Admission, Planned Discharge, and Unplanned Discharge Assessments, effective July 1, 2018.

Enter Number	**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**

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

Item Changes (cont. 4)

New:

- Removed the term "suspected deep tissue injury in evolution" and replaced with **"deep tissue injury"** to items M0300G and M0300G1 in the Admission, Planned Discharge, and Unplanned Discharge Assessments, effective July 1, 2018.

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

Item Changes (cont. 5)

- M0800A–M0800F, Worsening in Pressure Ulcer/Injury Status Since Admission, items have been removed from the Planned Discharge and Unplanned Discharge Assessments.

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Section M: Skin Conditions

Coding Guidance and Coding Scenarios

M0300. Current Number of Unhealed Pressure Ulcers/Injuries

Admission Assessment

- M0300A1–G1
  - Identifies number of unhealed pressure ulcers/injuries at each stage.
  - Establishes the patient's baseline assessment.

Discharge Assessment (Planned or Unplanned)

- M0300A1–G1
  - Identifies number of unhealed pressure ulcers/injuries at each stage.
- M0300A2–G2
  - At the time of discharge, identifies if the unhealed pressure ulcers/injuries in M0300A1–G1 were present on admission or if the pressure ulcers/injuries were acquired or worsened during the stay.

Steps for Completing M0300A–G

1. Determine Deepest Anatomical Stage.

2. Identify Unstageable Pressure Ulcers/Injuries.

3. For the Discharge Assessment, determine the number of ulcers/injuries that were present on admission.

For detailed instructions, refer to Section M of the LTCH QRP Manual.

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

	M0300. Current Number of Unhealed Pressure Ulcers/Injuries at Each Stage
Enter Number ☐	**A. Stage 1:** Intact skin with non-blanchable redness of a localized area usually over a bony prominence. Darkly pigmented skin may not have a visible blanching; in dark skin tones only it may appear with persistent blue or purple hues 1. **Number of Stage 1 pressure injuries**
Enter Number ☐	**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**
Enter Number ☐	**C. Stage 3:** Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle is not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling 1. **Number of Stage 3 pressure ulcers**
Enter Number ☐	**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**
Enter Number ☐	**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**
Enter Number ☐	**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**
Enter Number ☐	**G. Unstageable - Deep tissue injury** 1. **Number of unstageable pressure injuries presenting as deep tissue injury**

M0300A1–G1 Coding Instructions

Completed only if A0250 = 01 Admission, 10 Planned Discharge, or 11 Unplanned Discharge.

- **Enter the number** of pressure injuries/ulcers that are currently present.

- **Enter 0** if no pressure ulcers/injuries are present.

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

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

Enter Number

A. Stage 1: Intact skin with non-blanchable redness of a localized area usually over a bony prominence. Darkly pigmented skin may not have a visible blanching; in dark skin tones only it may appear with persistent blue or purple hues

1. **Number of Stage 1 pressure injuries**

Enter Number

Enter Number

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*

2. **Number of these Stage 2 pressure ulcers that were present upon admission** - enter how many were noted at the time of admission

Enter Number

Enter Number

C. Stage 3: Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle is not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling

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

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

Enter Number

Enter Number

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*

2. **Number of these Stage 4 pressure ulcers that were present upon admission** - enter how many were noted at the time of admission

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M0300. Current Number of Unhealed Pressure Ulcers/Injuries at Each Stage (Discharge) (cont.)

Enter Number ☐ Enter Number ☐	**E. Unstageable - Non-removable dressing/device:** Known but not stageable due to non-removable dressing/device 1. **Number of unstageable pressure ulcers/injuries due to non-removable dressing/device** - *If 0* → *Skip to M0300F, Unstageable - Slough and/or eschar* 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
Enter Number ☐ Enter Number ☐	**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** *If 0* → *Skip to M0300G, Unstageable - Deep tissue injury* 2. **Number of <u>these</u> unstageable pressure ulcers that were present upon admission** - enter how many were noted at the time of admission

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

Enter Number ☐ Enter Number ☐	**G. Unstageable - Deep tissue injury** 1. **Number of unstageable pressure injuries presenting as deep tissue injury** - *If 0* → *Skip to N2005, Medication Intervention* 2. **Number of <u>these</u> unstageable pressure injuries that were present upon admission** - enter how many were noted at the time of admission

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M0300B2–G2 Coding Instructions

Complete only if A0250 = 10 Planned Discharge or 11 Unplanned Discharge.

- **Enter the number** of pressure ulcers/injuries 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/injuries were noted at the time of admission.

Present on Admission M0300A2–G2

- The present on admission items (M0300A2–G2) are coded at discharge.

- Address whether the pressure ulcers/injuries observed at discharge were:

> 1. Present on admission

OR

> 2. Acquired or worsened during the stay

Present on Admission M0300A2–G2 (cont.)

- A pressure ulcer/injury reported at discharge and coded as **not Present on Admission** on the Discharge Assessment would be interpreted as new or worsened.

- A pressure ulcer/injury reported at discharge and coded as **Present on Admission** on the Discharge Assessment, would **not** be considered new or worsened.

Coding Scenario 1

- A patient is admitted to an LTCH with a Stage 2 pressure ulcer on the right hip.

- At the time of discharge there is no change to the Stage 2 on the right hip. Additionally, there is a new Stage 2 pressure ulcer on the right heel.

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Coding Scenario 1 (cont. 1)

Item	Admission Assessment	Discharge Assessment
M0300B1. Number of Stage 2 pressure ulcers	**Code as 1**	**Code as 2**
M0300B2. Number of these Stage 2 pressure ulcers that were present upon admission		**Code as 1**

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Coding Scenario 1 (cont. 2)

Rationale:

- Upon admission this patient had one Stage 2 pressure ulcer, located on the right hip. This ulcer is coded on the Admission Assessment in **M0300B1.**

- Upon discharge the Stage 2 pressure ulcer on the right hip was unchanged and a new Stage 2 pressure ulcer is present on the right heel.
  - **M0300B1** is coded as **2** on the Discharge Assessment as there are now two Stage 2 pressure ulcers.
  - **M0300B2** is coded as **1** because, of the two ulcers, only one was present on admission.

Pressure Ulcers:
Program Interruption

- If a patient is transferred from the LTCH and returns within 3 days (including the day of transfer), the transfer is considered a program interruption and is **not** considered a new admission.

- Therefore, any new pressure ulcer/injury formation, or increase in numerical staging that occurs during the program interruption should not be coded as "present on admission."

Coding Scenario 2

- A patient is admitted to the LTCH with a Stage 2 pressure ulcer to the left hip. The patient is transported to an acute care hospital and returns to the LTCH within 2 days.

- Upon return to the LTCH, the left hip pressure ulcer is a full thickness ulcer assessed to be a Stage 3. The patient is discharged to home with this Stage 3 pressure ulcer.

Coding Scenario 2 (cont. 1)

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**

Coding Scenario 2 (cont. 2)

Rationale:

- At admission, the patient has a Stage 2 pressure ulcer at the left hip, therefore:
    - **M0300B1** is coded as **1** on the Admission Assessment.

- The patient transferred to an acute care hospital, but returned within 2 days, therefore:
    - No new Admission Assessment is required and the change in the pressure ulcer status is captured on the Discharge Assessment.

Coding Scenario 2 (cont. 3)

- At discharge, the left hip pressure ulcer is a Stage 3. Therefore:
  - **M0300B1** is coded as **0.**
  - **M0300B2** is skipped.
  - **M0300C1** is coded as **1.**
  - **M0300C2** is coded as **0** because the pressure ulcer was not a Stage 3 at admission.

Unstageable Pressure Ulcers/Injuries

- Visual inspection of the wound bed is necessary for accurate staging.

- Pressure ulcers that have eschar or slough tissue present such that the anatomic depth of soft tissue damage cannot be visually inspected or palpated in the wound bed should be classified as unstageable.

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Unstageable Pressure Ulcers/Injuries (cont.)

- If the wound bed is only **partially** covered by eschar or slough, and the extent of soft tissue damage can be visually inspected or palpated, the ulcer should be numerically staged and should not be coded as unstageable.

Coding Scenario 3

- A patient is admitted to the LTCH with eschar tissue identified on both the right and left heels, as well as a Stage 2 pressure ulcer to the coccyx.

- The patient's pressure ulcers are reassessed before discharge, and the Stage 2 coccyx pressure ulcer has healed. The left heel eschar became fluctuant, showed signs of infection, had to be debrided at the bedside, and was subsequently numerically staged as a Stage 4 pressure ulcer. The right heel eschar remained stable and dry (i.e., remained unstageable).

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Coding Scenario 3 (cont. 1)

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

Coding Scenario 3 (cont. 2)

Item	Admission Assessment	Discharge Assessment
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 due to non-removable dressing 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 due to slough/eschar that were present upon admission		Code as 1

Coding Scenario 3 (cont. 3)

Rationale:

- Both heels cannot be numerically staged at admission because the extent of tissue damage cannot be determined due to the eschar present, so:
  - o **M0300F1 is coded as 2** on the Admission Assessment.

- The Stage 2 pressure ulcer on the coccyx healed, so:
  - o **M0300B1 is coded as 1** on the Admission Assessment.

  - o **M0300B1 is coded as 0** on the Discharge Assessment.

Coding Scenario 3 (cont. 4)

- The left heel eschar that was debrided is coded as a Stage 4 at discharge, so
  - M0300D1 is coded as 1.
  - This ulcer is coded in M0300D2 as 1, "present on admission," on the Discharge Assessment because the first time an unstageable ulcer is able to be numerically staged, it is "present on admission" at the numeric stage it is first assessed.
- The right heel eschar remained stable and intact, so both M0300F1 and M0300F2 are coded as 1 on the Discharge Assessment.

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Non-Removable Dressing/Device

- Known pressure ulcers/injuries covered by a non-removable dressing/device should be coded as unstageable.

  - Examples include a primary surgical dressing that cannot be removed per physician's order, an orthopedic device, or cast.

- "Known" refers to when documentation is available that says a pressure ulcer/injury exists under the non-removable dressing/device.

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 non-removable 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.

Coding Scenario 4 (cont. 1)

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		

Coding Scenario 4 (cont. 1)

Item	Admission Assessment	Discharge Assessment
M0300E1. Number of unstageable pressure ulcers/injuries due to non-removable dressing/device	**Code as 1**	
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		

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Coding Scenario 4 (cont. 1)

Item	Admission Assessment	Discharge Assessment
M0300E1. Number of unstageable pressure ulcers/injuries due to non-removable dressing/device	**Code as 1**	**Code as 0**
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		

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Coding Scenario 4 (cont. 1)

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

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Coding Scenario 4 (cont. 1)

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

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Coding Scenario 4 (cont. 1)

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

Coding Scenario 4 (cont. 1)

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

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Coding Scenario 4 (cont. 2)

Rationale:

The documentation that accompanied the patient on admission identified a pressure ulcer/injury that was located beneath a non-removable dressing.

- This "known" ulcer/injury is coded as **1** on the Admission Assessment, item **M0300E1** Unstageable Pressure Ulcers/Injuries due to Non-Removable Dressing/Device.

Coding Scenario 4 (cont. 3)

The dressing is subsequently removed by the physician and a Stage 3 pressure ulcer is identified. The pressure ulcer at the time of discharge is covered with eschar and cannot be staged.

Therefore, the Discharge Assessment item:

- **M0300F1.** Unstageable Pressure Ulcers due to Slough and/or Eschar is coded **1.**

- **M0300F2** is coded as **0** because this pressure ulcer was not unstageable due to slough/eschar on admission.

Healed Pressure Ulcers/Injuries

- Terminology referring to "healed" vs. "unhealed" ulcers/injuries refers to whether the ulcer/injury is "closed" vs. "open."

- Stage 1 pressure injuries, deep tissue injuries (DTIs), and unstageable pressure ulcers, although covered with tissue, eschar, or slough, would not be considered healed.

Coding Scenario 5

- Patient is admitted to 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.

Coding Scenario 5 (cont. 1)

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		

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Coding Scenario 5 (cont. 1)

Item	Admission Assessment	Discharge Assessment
M0300B1. Number of Stage 2 pressure ulcers	**Code as 0**	
M0300B2. Number of these Stage 2 pressure ulcers that were present upon admission		
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		

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Coding Scenario 5 (cont. 1)

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		
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		

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Coding Scenario 5 (cont. 1)

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		
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		

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Coding Scenario 5 (cont. 1)

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**	
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		

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Coding Scenario 5 (cont. 1)

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		
M0300D1. Number of Stage 4 pressure ulcers		
M0300D2. Number of these Stage 4 pressure ulcers that were present upon admission		

Coding Scenario 5 (cont. 1)

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		
M0300D2. Number of these Stage 4 pressure ulcers that were present upon admission		

Coding Scenario 5 (cont. 1)

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	
M0300D2. Number of these Stage 4 pressure ulcers that were present upon admission		

Coding Scenario 5 (cont. 1)

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		

Coding Scenario 5 (cont. 1)

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

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Coding Scenario 5 (cont. 2)

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	███	

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Coding Scenario 5 (cont. 2)

Item	Admission Assessment	Discharge Assessment
M0300E1. Number of unstageable pressure ulcers/injuries due to non-removable dressing/device	**Code as 0**	
M0300E2. Number of these unstageable pressure ulcers/injuries due to non-removable dressing/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		

Coding Scenario 5 (cont. 2)

Item	Admission Assessment	Discharge Assessment
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 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		

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Coding Scenario 5 (cont. 2)

Item	Admission Assessment	Discharge Assessment
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 due to non-removable dressing/device that were present upon admission		**Skip**
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		

Coding Scenario 5 (cont. 2)

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

Coding Scenario 5 (cont. 2)

Item	Admission Assessment	Discharge Assessment
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 due to non-removable dressing/device 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 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		

Coding Scenario 5 (cont. 2)

Item	Admission Assessment	Discharge Assessment
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 due to non-removable dressing/device 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 due to slough/eschar that were present upon admission		**Skip**
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		

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Coding Scenario 5 (cont. 2)

Item	Admission Assessment	Discharge Assessment
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 due to non-removable dressing/device 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 due to slough/eschar that were present upon admission		Skip
M0300G1. Number of unstageable pressure injuries with deep tissue injury	Code as 2	
M0300G2. Number of these unstageable pressure injuries with deep tissue injury that were present upon admission		

Coding Scenario 5 (cont. 2)

Item	Admission Assessment	Discharge Assessment
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 due to non-removable dressing/device 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 due to slough/eschar that were present upon admission		Skip
M0300G1. Number of unstageable pressure injuries with deep tissue injury	Code as 2	Code as 1
M0300G2. Number of these unstageable pressure injuries with deep tissue injury that were present upon admission		

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Coding Scenario 5 (cont. 2)

Item	Admission Assessment	Discharge Assessment
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 due to non-removable dressing/device 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 due to slough/eschar that were present upon admission		Skip
M0300G1. Number of unstageable pressure injuries with deep tissue injury	Code as 2	Code as 1
M0300G2. Number of these unstageable pressure injuries with deep tissue injury that were present upon admission		Code as 1

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Coding Scenario 5 (cont. 3)

Rationale:

- After a thorough clinical and skin examination, as well as an assessment of the lesions and surrounding tissues, the sacral and the heel areas were determined to be consistent with what constitutes a DTI.

For the Admission Assessment:

- **M0300G1 is coded as 2** because there were two DTIs, both present on admission.

Coding Scenario 5 (cont. 4)

Rationale:

Once the heel DTI is drained, debrided, and numerically staged,

- **M0300C1 and M0300C2 are coded as 1** on the Discharge Assessment.
  - **M0300C1 is coded as 1** on the Discharge Assessment, because the heel DTI was debrided and was able to be numerically staged. Because this was the first time the ulcer was able to be assessed and numerically staged, it is considered to be present on admission.
- **M0300G1 is coded as 1** on the Discharge Assessment, because the sacral DTI cannot be numerically staged.
- **M0300G2 is coded as 1** on the Discharge Assessment, because of the two DTIs that were present on admission, only one remains an DTI on discharge.

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.

Coding Scenario 6 (cont. 1)

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

Coding Scenario 6 (cont. 1)

Item	Admission Assessment	Discharge Assessment
M0210. Unhealed Pressure Ulcers/Injuries	**Code as 0**	

Coding Scenario 6 (cont. 1)

Item	Admission Assessment	Discharge Assessment
M0210. Unhealed Pressure Ulcers/Injuries	**Code as 0**	**Code as 0**

Coding Scenario 6 (cont. 2)

Rationale:

- This patient had no pressure ulcers/injuries on admission. Although the patient developed a Stage 2 pressure ulcer noted on Day 5, the pressure ulcer healed (area closed) at discharge. Therefore:
  - **M0210** would be coded as **0** and all **M0300** pressure ulcer/injury items would be skipped.

Medical Device Related Pressure Ulcers

- When an ulcer/injury is caused due to the use of a medical device, assess the area to determine if pressure is the primary cause. These ulcers/injuries generally conform to the pattern or shape of the device.

- If pressure is determined to be the primary cause, use the staging system to stage the ulcer/injury and code in Section M of the LTCH CARE Data Set. If the ulcer/injury is not due to pressure, do not code it in Section M.

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.

Coding Scenario 7 (cont. 1)

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		

Coding Scenario 7 (cont. 1)

Item	Admission Assessment	Discharge Assessment
M0210. Unhealed Pressure Ulcers/Injuries	**Code as 1**	
M0300B1. Number of Stage 2 pressure ulcers		
M0300B2. Number of these Stage 2 pressure ulcers that were present upon admission		

Coding Scenario 7 (cont. 1)

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

Coding Scenario 7 (cont. 1)

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 1**	
M0300B2. Number of these Stage 2 pressure ulcers that were present upon admission		

Coding Scenario 7 (cont. 1)

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 1**	**Skip**
M0300B2. Number of these Stage 2 pressure ulcers that were present upon admission		

Coding Scenario 7 (cont. 1)

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 1**	**Skip**
M0300B2. Number of these Stage 2 pressure ulcers that were present upon admission		**Skip**

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Coding Scenario 7 (cont. 2)

Rationale:

- The area that was identified on the calf beneath the AFO was determined to be caused by the pressure of the device against the skin surface.

  - *"Medical device related pressure injuries result from the use of devices designed and applied for diagnostic or therapeutic purposes. The resultant pressure injury generally conforms to the pattern or shape of the device. The injury should be staged using the staging system." ***

- Following the instructions for the purposes of coding, a determination was made that the lesion being assessed is *primarily* related to pressure and that other conditions (skin tears, tape burns, moisture-associated skin damage, or excoriation) have been ruled out.

*From The National Pressure Ulcer Advisory Panel (NPUAP) » Resources » Educational and Clinical Resources » NPUAP Pressure Injury Stages

Coding Scenario 7 (cont. 3)

- **M0300B1.** Number of Stage 2 pressure ulcers is coded as **1** on the Admission Assessment.

- The Stage 2 pressure ulcer is healed at the time of discharge and there are no other pressure ulcers/ injuries, therefore:
  - o **M0210.** Unhealed Pressure Ulcers/Injuries is coded as **0.**
  - o **M0300** items would be skipped.

Mucosal Ulcers

- Mucosal pressure ulcers are not staged using the skin pressure ulcer/injury staging system because anatomical tissue comparisons cannot be made.

- Therefore, mucosal ulcers (e.g., those related to nasogastric tubes, oxygen tubing, endotracheal tubes, urinary catheters, mucosal ulcers in the oral cavity) should not be coded on the LTCH CARE Data Set.

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.

Coding Scenario 8 (cont. 1)

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

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Coding Scenario 8 (cont. 1)

Item	Admission Assessment	Discharge Assessment
M0210. Unhealed Pressure Ulcers/Injuries	**Code as 0**	

Coding Scenario 8 (cont. 1)

Item	Admission Assessment	Discharge Assessment
M0210. Unhealed Pressure Ulcers/Injuries	**Code as 0**	**Code as 0**

Coding Scenario 8 (cont. 2)

Rationale:

- The lesion is present on the gastrostomy stoma. Stoma mucosa is not staged using the pressure ulcer staging system.

- 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, oxygen tubing, endotracheal tubes, urinary catheters, mucosal ulcers in the oral cavity, etc.) should ***not*** be coded on the LTCH CARE Data Set.

Kennedy Ulcers

- Skin ulcers that occur at the end of life are known as Kennedy or terminal ulcers.
  - Kennedy (terminal) skin ulcers are not captured in Section M of the LTCH CARE Data Set.
  - However, they should be assessed and staged using the pressure ulcer/injury staging system, documented in the clinical record, and addressed in care planning.
  - Etiology is believed to be related to tissue perfusion issues due to organ and skin failure.
- Evolution and appearance differ from a typical pressure ulcer/injury.

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Section M: Skin Conditions

Additional Coding Scenarios

Coding Scenario 9

- A patient is admitted to an LTCH with one large Stage 3 pressure ulcer on the coccyx.

- At the time of discharge, there is some epithelialization in the center of the pressure ulcer.

Coding Scenario 9 (cont. 1)

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

Coding Scenario 9 (cont. 2)

Rationale:

- At the time of discharge, the Stage 3 pressure ulcer on the coccyx that was present on 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.**
  - **M0300C2 is coded as 1** on the Discharge Assessment.

Coding Scenario 10

- 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; thus, it is now a Stage 3 pressure ulcer in the same location.

Coding Scenario 10 (cont. 1)

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

Coding Scenario 10 (cont. 2)

Rationale:

- On the Admission Assessment, the Stage 2 pressure ulcer was present and is therefore:
  - **M0300B1 is coded as 1 on the Admission Assessment.**

- On the Discharge Assessment, the designation of "present on admission" in M0300B2 requires that the pressure ulcer be at the same location *and* not have increased in numerical stage. The (Stage 2) pressure ulcer increased in numerical stage (to Stage 3) after admission. So:
  - **M0300B1** would be coded as **0** on the Discharge Assessment.
  - **M0300B2** would be skipped because there is no Stage 2 pressure ulcer on discharge.

Coding Scenario 10 (cont. 3)

Rationale:
- **M0300C1** would be coded as **0** on the Admission Assessment because there were no Stage 3 pressure ulcers that were present on admission.

- **However, on the Discharge Assessment,**
  - **M0300C1** would be coded as **1.**
  - **M0300C2** would be coded as **0** because the Stage 3 pressure ulcer that is present on discharge was not a Stage 3 pressure ulcer on admission.

Summary

- To be inclusive of updated terminology supported by NPUAP, the term **"injuries"** has been added in the Section M heading of the following items:
    - M0210.
    - M0300 and M0300A.
    - M0300E, M0300E1, and M0300E2.
    - M0300G, M0300G1, and M0300G2.

Summary (cont. 1)

- Removed the term "suspected deep tissue injury in evolution" and replaced with **"deep tissue injury"** to items:
  - M0300G and M0300G1.

- To improve clarity, the term "device" was added to items:
  - M0300A.
  - M0300E, M0300E1, and M0300E2.

Summary (cont. 2)

- M0800A–M0800F have been removed to reduce provider burden.

Action Plan

- Review Section M intent, rationale, and steps for assessment.

- Review the changes in the language to Section M.

- Practice coding a variety of scenarios with staff.

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