



Skilled Nursing Facility Quality Reporting Program Provider Training



**SKILLED
NURSING
FACILITY**

**QUALITY REPORTING
PROGRAM**

**Percent of Residents or
Patients with Pressure
Ulcers That Are New or
Worsened and Associated
MDS 3.0 Items**

Presenter: Ann Spenard

Date: June 21, 2016

Objectives

Upon completion of the training, participants will be able to:

- Define the following associated with the quality measure (QM):
 - Numerator
 - Denominator
 - Complete stay
 - Incomplete stay
 - QM calculation algorithm
 - Risk adjustment



Objectives (continued)

Upon completion of the training, participants will be able to:

- Describe the intent of Section M
- Explain the rationale for, look-back periods of, and correct coding of items M0300 and M0800
- Discuss how to code items G0110A1, H0400, I0900, and I2900
- Accurately code Section M (pressure ulcer) scenarios



Percent of Residents or Patients with Pressure Ulcers That Are New or Worsened

Percent of Residents or Patients with Pressure Ulcers That Are New or Worsened

- This QM is adopted as a cross-setting measure to meet the requirements of the IMPACT Act of 2014 addressing the domain of skin integrity and changes in skin integrity.
- This measure is intended to encourage post-acute care (PAC) providers to prevent pressure ulcer development or worsening, and to closely monitor and appropriately treat existing pressure ulcers.



Scavenger Hunt



Use the ***Skilled Nursing Facility Quality Reporting Program – Specifications for the Quality Measures Adopted through the Fiscal Year 2016 Final Rule*** to fill in the blanks about the QM.

- There are **9** blanks to fill in.
- We will debrief in 10 minutes.

Percent of Residents or Patients with Pressure Ulcers That Are New or Worsened

(continued)

Numerator

The number of _____ residents with an MDS 3.0 Assessment during the selected time window who have one or more Stage 2–4 pressure ulcers that are new or worsened

Denominator

The number of short-stay residents with one or more MDS 3.0 Assessments that are eligible for a look-back scan (except those with exclusions)

Percent of Residents or Patients with Pressure Ulcers That Are New or Worsened

(continued)

- **New or worsened pressure ulcers** are determined based on examination of all assessments in a resident's _____ for reports of Stage 2–4 pressure ulcers that were not present or were at a lesser stage on prior assessment as evidenced by:
 - Stage 2 (M0800A) > 0, OR
 - Stage 3 (M0800B) > 0, OR
 - Stage 4 (M0800C) > 0.

Percent of Residents or Patients with Pressure Ulcers That Are New or Worsened

(continued)

- A _____ is a review of all qualifying assessments within the resident's current episode to determine whether events occurred during the look-back period. All assessments with target dates within the episode are examined to determine whether the event or condition of interest occurred at any time during the episode.
- **Assessment types include:** An Admission, Quarterly, Annual, Significant Change/Correction OBRA Assessment (A0310A = 01, 02, 03, 04, 05, 06); or a PPS 5-, 14-, 30-, 60-, or 90-day, (A0310B = 01, 02, 03, 04, 05) or Discharge with or without return anticipated (A0310F = 10, 11); or SNF PPS Part A Discharge Assessment (A0310H = 1).



Percent of Residents or Patients with Pressure Ulcers That Are New or Worsened

(continued)

SNF Denominator Exclusions

1. Short-stay residents are excluded if _____ of the assessments that are included in the look-back scan has a usable response for items indicating the presence of new or worsened Stage 2, 3, or 4 pressure ulcers since the prior assessment. This situation is identified as follows:
 - If data on new or worsened Stage 2, 3, and 4 pressure ulcers are missing (M0800A= [-] and M0800B = [-] and M0800C = [-]) then the assessment is not usable and is discarded.
 - If all of the assessments that are eligible for the look-back scan are discarded and no usable assessments remain, then the resident is excluded from the numerator and the denominator.



Percent of Residents or Patients with Pressure Ulcers That Are New or Worsened

(continued)

SNF Denominator Exclusions (continued)

2. Short-stay resident is excluded if there is no initial assessment available to derive data for risk adjustment (covariates).
3. Death in facility tracking records (A0310F = [12]) are excluded from measure calculations.



Percent of Residents or Patients with Pressure Ulcers That Are New or Worsened

(continued)

- This measure is risk adjusted based on resident characteristics or covariates.
- Residents with characteristics or conditions that put them at increased risk for skin breakdown or impact their ability to heal are treated differently in the measure's calculation.
- Risk adjustment is used to account for the medical and functional complexity of the residents.



Percent of Residents or Patients with Pressure Ulcers That Are New or Worsened

(continued)

SNF Risk Adjustment Covariates:

1. Indicator of requiring limited or more assistance in _____ self-performance dependence on the initial assessment.
2. Indicator of bowel incontinence at least occasionally on the initial assessment.
3. Have diabetes or _____ on initial assessment.
4. Indicator of Low Body Mass Index (BMI), based on Height (K0200A) and Weight (K0200B) on the initial assessment.



Quality Measure Calculation Algorithm

*Calculate the facility observed score
(steps 1 through 3).*

Step 1:

- Calculate the denominator:
 - Count the total number of short-stay residents with a selected target MDS 3.0 Assessment in the measure time window, who do not meet the exclusion criteria.



Quality Measure Calculation Algorithm (continued)

Step 2:

- Calculate the numerator:
 - Count the total number of short-stay residents in the denominator with selected target or look-back assessment that indicates one or more new or worsened pressure ulcers.

Step 3:

- Calculate the facility's _____:
 - Divide the facility's numerator count by its denominator count to obtain the facility's observed score; that is, divide the result of step 2 by the result of step 1.



Quality Measure Calculation Algorithm (continued)

Calculate the expected score for each patient/resident (steps 4 and 5).

Step 4:

- Determine presence or absence of the pressure ulcer covariates for each patient/resident.

Step 5:

- Use resident-level covariates in a logistic regression model to calculate a resident-level expected QM score (the probability that the resident will experience an ulcer, given the presence or absence of risk characteristics measured by the covariates).



Quality Measure Calculation Algorithm (continued)

Calculate the facility expected score (step 6).

Step 6:

- Once an expected QM score has been calculated for each resident, calculate the mean facility-level _____ QM score by averaging all resident/patient-level expected scores.



Quality Measure Calculation Algorithm (continued)

*Calculate national mean QM score
(steps 7 through 9).*

Step 7:

- Calculate the denominator count.
 - Calculate the total number of patient stays/residents retained after exclusions and sum to derive denominator count.

Step 8:

- Calculate the numerator count.
 - Calculate the total number of patient stays/residents that triggered the QM and sum to derive numerator count.



Quality Measure Calculation Algorithm (continued)

Step 9:

- Calculate national mean observed QM score.
 - Divide the numerator count by its denominator count to obtain the national mean observed score; that is, divide the result of step 8 by the result of step 7.

Step 10:

- Calculate the facility-level _____ score.



Meet Mrs. J



We will use Mrs. J's case study throughout the training.

Select Section M Items

Section M – Intent

- The items in this section document the risk, presence, appearance, and change of pressure ulcers.
- This section also notes other skin ulcers, wounds, or lesions, and documents some treatment categories related to skin injury or avoiding injury.
- It is important to recognize and evaluate each resident's risk factors and to identify and evaluate all areas at risk of constant pressure.



Section M – Intent (continued)

- A complete assessment of skin is essential to an effective pressure ulcer prevention and skin treatment program.
- Be certain to include in the assessment process, a holistic approach.
- 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.



M0300: Current Number of Unhealed Pressure Ulcers at Each Stage

Step 1: Determine Deepest Anatomical Stage

For each pressure ulcer, determine the deepest anatomical stage. Do not reverse or back stage. Consider current and historical levels of tissue involvement.

1. Observe and palpate the base of any identified pressure ulcers present to determine the anatomic depth of soft tissue damage involved.

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

Step 1: Determine Deepest Anatomical Stage (continued)

2. Ulcer staging should be based on the ulcer's deepest anatomic soft tissue damage that is visible or palpable. If a pressure ulcer's tissues are obscured such that the depth of soft tissue damage cannot be observed, it is considered to be unstageable (see Step 2). Review the history of each pressure ulcer in the medical record. If the pressure ulcer has ever been classified at a higher numerical stage than what is observed now, it should continue to be classified at the higher numerical stage. Nursing homes that carefully document and track pressure ulcers will be able to more accurately code this item.



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

Step 2: Identify Unstageable Pressure Ulcers

1. Visualization of the wound bed is necessary for accurate staging.
2. 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.
3. 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.



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

Step 2: Identify Unstageable Pressure Ulcers (continued)

4. A pressure ulcer with intact skin that is a suspected deep tissue injury (sDTI) should not be coded as a Stage 1 pressure ulcer. It should be coded as unstageable.
5. Known pressure ulcers covered by a non-removable dressing/device (e.g., primary surgical dressing, cast) should be coded as unstageable.

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

Step 3: Determine “Present on Admission”

*For each pressure ulcer, determine if the pressure ulcer was present at the time of admission/entry or reentry and **not** acquired while the resident was in the care of the nursing home. Consider current and historical levels of tissue involvement.*

1. Review the medical record for the history of the ulcer.
2. Review for location and stage at the time of admission/entry or reentry.



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

Step 3: Determine “Present on Admission” (continued)

3. If the pressure ulcer was present on admission/entry or reentry and subsequently increased in numerical stage during the resident’s stay, the pressure ulcer is coded at that higher stage, and that higher stage **should not be considered as “present on admission.”**
4. If the pressure ulcer was unstageable on admission/entry or reentry, but becomes numerically stageable later, it should be considered as “present on admission” at the stage at which it first becomes numerically stageable. If it subsequently increases in numerical stage, that higher stage **should not be considered “present on admission.”**



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

Step 3: Determine “Present on Admission” (continued)

5. If a resident who has a pressure ulcer that was originally acquired in the facility is hospitalized and returns with that pressure ulcer at the same numerical stage, the pressure ulcer **should not be coded as “present on admission”** because it was present and acquired at the facility prior to the hospitalization.
6. If a resident who has a pressure ulcer that was **“present on admission”** (not acquired in the facility) is hospitalized and returns with that pressure ulcer at the same numerical stage, the pressure ulcer is **still coded as “present on admission”** because it was **originally acquired outside the facility** and has not changed in stage.



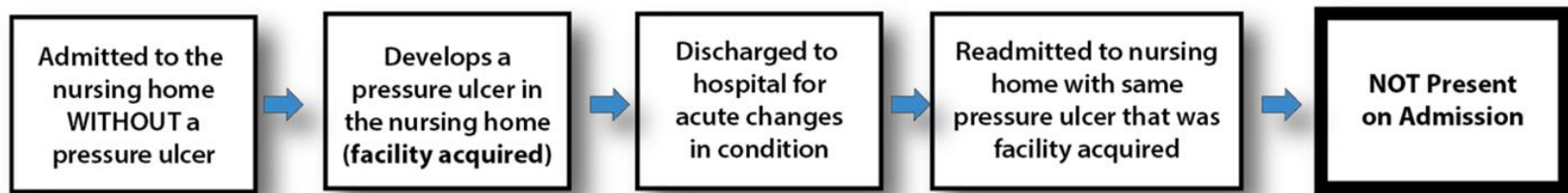
M0300: Current Number of Unhealed Pressure Ulcers at Each Stage (continued)

Step 3: Determine “Present on Admission” (continued)

7. If a resident who has a pressure ulcer is hospitalized and the ulcer increases in numerical stage during the hospitalization, it **should be coded as “present on admission”** at that higher stage upon reentry.

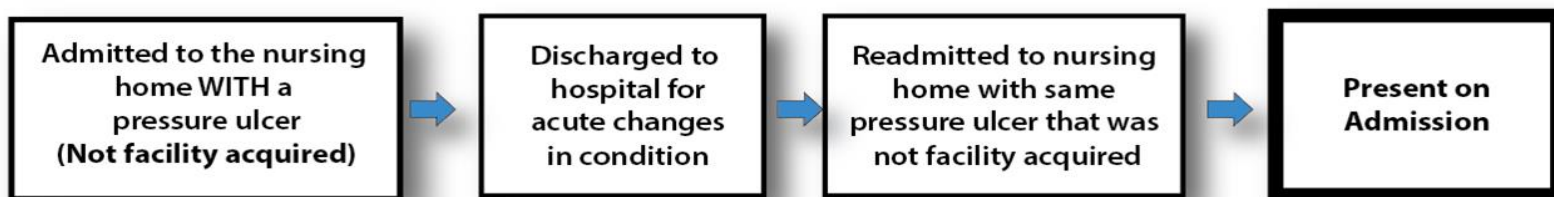


M0300 and Determining Present on Admission



Ms. K is admitted to the facility without a pressure ulcer. During the stay, she develops a Stage 2 pressure ulcer. This is a **facility-acquired** pressure ulcer and was **not “present on admission.”** Ms. K is hospitalized and returns to the facility with the same Stage 2 pressure ulcer. This pressure ulcer was **originally acquired in the nursing home and should not be considered as “present on admission”** when she returns from the hospital.

M0300 and Determining Present on Admission (continued)



Mr. J is a new admission to the facility and is admitted with a Stage 2 pressure ulcer. This pressure ulcer is considered as “**present on admission**” as it was **not acquired in the facility**. Mr. J is hospitalized and returns with the same Stage 2 pressure ulcer, unchanged from the prior admission/entry. This pressure ulcer is **still considered “present on admission”** because it was **originally acquired outside the facility** and has not changed.

M0300A: Stage 1 Pressure Ulcers

A. Number of Stage 1 pressure ulcers

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

M0300. Current Number of Unhealed Pressure Ulcers at Each Stage

Enter Number

A. Number of Stage 1 pressure ulcers

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

M0300A: Stage 1 Pressure Ulcers

(continued)

An observable, pressure-related alteration of intact skin, whose indicators as compared to 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 ulcer may appear with persistent red, blue, or purple hues.



M0300B: Stage 2 Pressure Ulcers

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

M0300. Current Number of Unhealed Pressure Ulcers at Each Stage

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

Enter Number

Enter Number

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/entry or reentry - enter how many were noted at the time of admission/entry or reentry

3. Date of oldest Stage 2 pressure ulcer - Enter dashes if date is unknown:

M0300B: Stage 2 Pressure Ulcers

(continued)

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

M0300C: Stage 3 Pressure Ulcers

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

M0300. Current Number of Unhealed Pressure Ulcers at Each Stage

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

Enter Number

Enter Number

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/entry or reentry - enter how many were noted at the time of admission/entry or reentry

M0300C: Stage 3 Pressure Ulcers

(continued)

- 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.



M0300D: Stage 4 Pressure Ulcers

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

M0300. Current Number of Unhealed Pressure Ulcers at Each Stage

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

Enter Number

Enter Number

1. Number of Stage 4 pressure ulcers - If 0 → Skip to M0300E, Unstageable: Non-removable dressing

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

M0300D: Stage 4 Pressure Ulcers

(continued)

- 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.



M0300E: Unstageable Pressure Ulcers Related to Non-Removable Dressing/Device

E. Unstageable - Non-removable dressing: Known but not stageable due to non-removable dressing/device

M0300. Current Number of Unhealed Pressure Ulcers at Each Stage - Continued	
	E. Unstageable - Non-removable dressing: Known but not stageable due to non-removable dressing/device
Enter Number <input type="text"/>	1. Number of unstageable pressure ulcers due to non-removable dressing/device - If 0 → Skip to M0300F, Unstageable: Slough and/or eschar
Enter Number <input type="text"/>	2. Number of <u>these</u> unstageable pressure ulcers that were present upon admission/entry or reentry - enter how many were noted at the time of admission/entry or reentry



M0300E: Unstageable Pressure Ulcers Related to Non-Removable Dressing/Device (continued)

- Non-removable dressing/device includes, for example, a primary surgical dressing that cannot be removed, an orthopedic device, or cast.



M0300F: Unstageable Pressure Ulcers Related to Slough and/or Eschar

F. Unstageable - Slough and/or eschar: Known but not stageable due to coverage of wound bed by slough and/or eschar

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

F. Unstageable - Slough and/or eschar: Known but not stageable due to coverage of wound bed by slough and/or eschar

Enter Number

Enter Number

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
2. **Number of these unstageable pressure ulcers that were present upon admission/entry or reentry** - enter how many were noted at the time of admission/entry or reentry

M0300F: Unstageable Pressure Ulcers Related to Slough and/or Eschar (continued)

- **Slough:** Non-viable 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:** 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.

M0300G: Unstageable Pressure Ulcers Related to Suspected Deep Tissue Injury

G. Unstageable - Deep tissue: Suspected deep tissue injury in evolution

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

G. Unstageable - Deep tissue: Suspected deep tissue injury in evolution

Enter Number

Enter Number

- 1. Number of unstageable pressure ulcers with suspected deep tissue injury in evolution** - If 0 → Skip to M0610, Dimension of Unhealed Stage 3 or 4 Pressure Ulcers or Eschar
- 2. Number of these unstageable pressure ulcers that were present upon admission/entry or reentry** - enter how many were noted at the time of admission/entry or reentry

M0300G: Unstageable Pressure Ulcers Related to Suspected Deep Tissue Injury

(continued)

- **Suspected Deep Tissue Injury:** Purple or maroon area of discolored intact skin due to damage of underlying soft tissue. The area may be preceded by tissue that is painful, firm, mushy, boggy, warmer or cooler as compared to adjacent tissue.

M0300

Polling Scenario

Miss N was admitted with a pressure ulcer on her right ischium on March 3, 2016. The ulcer was obscured with slough on admission. The physician debrided the ulcer on March 14; a full-thickness ulcer without exposed bone, tendon, or muscle was revealed.

Polling Question: M0300 (1)

How will the pressure ulcer stage be reflected in M0300 on the combined Admission/5-day PPS Assessment with an assessment reference date (ARD) of March 10?

- A. Unstageable
Related to
Suspected Deep
Tissue Injury
- B. Stage 3
- C. Unstageable
Related to Slough
and/or Eschar
- D. Stage 4



Polling Question: M0300 (2)

Following debridement, how will the pressure ulcer stage be reflected in M0300?

- A. Unstageable
Related to
Suspected Deep
Tissue Injury
- B. Stage 3
- C. Unstageable
Related to Slough
and/or Eschar
- D. Stage 4



Polling Question: M0300 (3)

Following debridement, will the pressure ulcer be considered “present on admission” in M0300?

A. Yes

B. No



M0800: Worsening in Pressure Ulcer Status Since Prior Assessment (OBRA or Scheduled PPS) or Last Admission/Entry or Reentry

M0800. Worsening in Pressure Ulcer Status Since Prior Assessment (OBRA or Scheduled PPS) or Last Admission/Entry or Reentry	
Complete only if A0310E = 0	
Indicate the number of current pressure ulcers that were not present or were at a lesser stage on prior assessment (OBRA or scheduled PPS) or last entry. 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



M0800: Worsening in Pressure Ulcer Status Since Prior Assessment (OBRA or Scheduled PPS) or Last Admission/Entry or Reentry (continued)

Item Rationale: Health-Related Quality of Life

- This item documents whether skin status, overall, has worsened since the last assessment.
- To track increasing skin damage, this item documents the number of new pressure ulcers and whether any pressure ulcers have “worsened” or increased in numerical stage since the last assessment.
- Such tracking of pressure ulcers is consistent with good clinical care.



M0800: Worsening in Pressure Ulcer Status Since Prior Assessment (OBRA or Scheduled PPS) or Last Admission/Entry or Reentry (continued)

Item Rationale: Planning for Care

- The interdisciplinary care plan should be reevaluated to ensure that appropriate preventative measures and pressure ulcer management principles are being adhered to when new pressure ulcers develop or when pressure ulcers worsen.



M0800: Worsening in Pressure Ulcer Status Since Prior Assessment (OBRA or Scheduled PPS) or Last Admission/Entry or Reentry (continued)

- Pressure ulcer “**worsening**” is defined as a pressure ulcer that has progressed to a deeper level of tissue damage and is therefore staged at a higher number using a numerical scale of 1–4 (using the staging assessment system classifications assigned to each stage; starting at Stage 1, and increasing in severity to Stage 4) on an assessment as compared to the previous assessment.
- For the purposes of identifying the absence of a pressure ulcer, zero pressure ulcers is used when there is no skin breakdown or evidence of damage.



M0800: Worsening in Pressure Ulcer Status Since Prior Assessment (OBRA or Scheduled PPS) or Last Admission/Entry or Reentry (continued)

- The **look-back period** for this item is back to the ARD of the prior assessment.
- If there was no prior assessment (i.e., if this is the first OBRA or scheduled PPS assessment), do not complete this item. Skip to M1030, Number of Venous and Arterial Ulcers.



M0800: Worsening in Pressure Ulcer Status Since Prior Assessment (OBRA or Scheduled PPS) or Last Admission/Entry or Reentry (continued)

Steps for Assessment

1. Review the history of each current pressure ulcer. Specifically, compare the current stage to past stages to determine whether any pressure ulcer on the current assessment is new or at an increased numerical stage when compared to the last MDS Assessment. This allows a more accurate assessment than simply comparing total counts on the current and prior MDS Assessment.
2. For each current stage, count the number of current pressure ulcers that are new or have increased in numerical stage since the last MDS Assessment was completed.



M0800: Worsening in Pressure Ulcer Status Since Prior Assessment (OBRA or Scheduled PPS) or Last Admission/Entry or Reentry (continued)

Coding Instructions

- **Enter the number** of pressure ulcers that were not present OR were at a lesser numerical stage on prior assessment.
- **Code 0:** if no pressure ulcers have increased in numerical stage OR there are no new pressure ulcers.



M0800: Worsening in Pressure Ulcer Status Since Prior Assessment (OBRA or Scheduled PPS) or Last Admission/Entry or Reentry (continued)

Coding Tips

- Coding this item will be easier for nursing homes that document and follow pressure ulcer status on a routine basis.
- If a numerically staged pressure ulcer increases in numerical staging it is considered worsened.



M0800: Worsening in Pressure Ulcer Status Since Prior Assessment (OBRA or Scheduled PPS) or Last Admission/Entry or Reentry (continued)

Coding Worsening of Unstageable Pressure Ulcers

- If a pressure ulcer was unstageable on admission/entry or reentry, do not consider it to be worsened on the first assessment that it is able to be numerically staged.
- If a pressure ulcer was numerically staged and becomes unstageable due to slough or eschar, do not consider this pressure ulcer as worsened. The only way to determine if this pressure ulcer has worsened is to remove enough slough or eschar so that the wound bed becomes visible. Once enough of the wound bed can be visualized and/or palpated such that the tissues can be identified and the wound restaged, the determination of worsening can be made.



M0800: Worsening in Pressure Ulcer Status Since Prior Assessment (OBRA or Scheduled PPS) or Last Admission/Entry or Reentry (continued)

Coding Worsening of Unstageable Pressure Ulcers (continued)

- If a pressure ulcer was numerically staged and becomes unstageable, and is subsequently debrided sufficiently to be numerically staged, compare its numerical stage before and after it was unstageable. If the pressure ulcer's current numerical stage has increased, consider this pressure ulcer as worsened.
- If two pressure ulcers merge, do not code as worsened. Although two merged pressure ulcers might increase the overall surface area of the ulcer, there would need to be an increase in numerical stage in order for it to be considered as worsened.



M0800: Worsening in Pressure Ulcer Status Since Prior Assessment (OBRA or Scheduled PPS) or Last Admission/Entry or Reentry (continued)

Coding Worsening of Unstageable Pressure Ulcers (continued)

- If a pressure ulcer is acquired during a hospital admission, its stage should be coded on admission and is considered as present on admission/entry or reentry. It is not included or coded in this item.
- If a pressure ulcer increases in numerical stage during a hospital admission, its stage should be coded on admission and is considered as present on admission/entry or reentry. It is not included or coded in this item. While not included in this item, it is important to recognize clinically on reentry that the resident's overall skin status deteriorated while in the hospital. In either case, if the pressure ulcer deteriorates further and increases in numerical stage on a subsequent MDS Assessment, it would be considered as worsened and would be coded in this item.



Coding Scenario



- Please work in groups at your table to code M0300 and M0800 for Mrs. J's Discharge Assessment.
- We will debrief in 10 minutes.

Coding Scenario: M0300

Answers and Discussion

- How would you code **M0300: Current Number of Unhealed Pressure Ulcers at Each Stage** on Mrs. J's Discharge Assessment?
 - A. Number of Stage 1 pressure ulcers –
 - B. Number of Stage 2 pressure ulcers –
 - C. Number of Stage 3 pressure ulcers –
 - D. Number of Stage 4 pressure ulcers –
 - E. Number of unstageable pressure ulcers (non-removable dressing) –
 - F. Number of unstageable pressure ulcers (slough and/or eschar) –
 - G. Number of unstageable pressure ulcers (deep tissue) –

Coding Scenario: M0300

Answers and Discussion (continued)

- Is/are the ulcer(s) considered **present on admission** on Mrs. J's Discharge Assessment?



Coding Scenario: M0800

Answers and Discussion

- How will **M0800: Worsening in Pressure Ulcer Status Since Prior Assessment (OBRA or Scheduled PPS) or Last Admission/Entry or Reentry** be coded on Mrs. J's Discharge Assessment?
 - Stage 2 –
 - Stage 3 –
 - Stage 4 –

Covariate Items

G0110A: Bed Mobility

A. Bed mobility - how resident moves to and from lying position, turns side to side, and positions body while in bed or alternate sleep furniture

G0110. Activities of Daily Living

Refer to the ADL flow chart in the RAI manual to facilitate accurate coding

Instructions for Rule of 3

■ When an activity occurs three times at any one given level, code that level.

A. Bed mobility - how resident moves to and from lying position, turns side to side, and positions body while in bed or alternate sleep furniture

B. Transfer - how resident moves between surfaces including to or from: bed, chair, wheelchair, standing position (**excludes** to/from bath/toilet)

C. Walk in room - how resident walks between locations in his/her room

D. Walk in corridor - how resident walks in corridor on unit

E. Locomotion on unit - how resident moves between locations in his/her room and adjacent corridor on same floor. If in wheelchair, self-sufficiency once in chair

☐
☐
☐
☐
☐
☐
☐
☐
☐
☐

G0110A: Bed Mobility (continued)

- **Bed mobility:** how resident moves to and from lying position, turns side to side, and positions body while in bed or alternate sleep furniture.



Coding Instructions for G0110, Column 1, ADL Self-Performance

- **Code 0, Independent:** if resident completed activity with no help or oversight **every time** during the 7-day look-back period and the activity occurred at least three times.
- **Code 1, Supervision:** if oversight, encouragement, or cueing was provided **three or more times** during the last 7 days.
- **Code 2, Limited assistance:** if resident was highly involved in activity and received physical help in guided maneuvering of limb(s) or other non-weight-bearing assistance on **three or more times** during the last 7 days.



Coding Instructions for G0110, Column 1, ADL Self-Performance (continued)

- **Code 3, Extensive assistance:** if resident performed part of the activity over the last 7 days and help of the following type(s) was provided **three or more times**:
 - Weight-bearing support provided **three or more times, OR**
 - Full staff performance of activity **three or more times** during part but not all of the last 7 days.



Coding Instructions for G0110, Column 1, ADL Self-Performance (continued)

- **Code 4, Total dependence:** if there was **full staff performance** of an activity with no participation by resident for any aspect of the ADL activity and the activity occurred three or more times. The resident must be unwilling or unable to perform any part of the activity over the entire 7-day look-back period.
- **Code 7, Activity occurred only once or twice:** if the activity occurred **fewer than three times**.
- **Code 8, Activity did not occur:** if the activity did not occur or family and/or non-facility staff provided care 100% of the time for that activity over the entire 7-day look-back period.



The Rule of 3

- The “Rule of 3” is a method that was developed to help determine the appropriate code to document ADL Self-Performance on the MDS.
- It is very important that staff who complete this section fully understand the components of each ADL, the ADL Self-Performance coding level definitions, and the Rule of 3.
- In order to properly apply the Rule of 3, the facility must first note which ADL activities occurred, how many times each ADL activity occurred, what type and what level of support was required for each ADL activity over the entire 7-day look-back period.



The Rule of 3 (continued)

- The following ADL Self-Performance coding levels are exceptions to the Rule of 3:
 - **Code 0, Independent:** Coded only if the resident completed the ADL activity with no help or oversight **every time** the ADL activity occurred during the 7-day look-back period and the activity occurred at least three times.
 - **Code 4, Total dependence:** Coded only if the resident required **full staff performance** of the ADL activity **every time** the ADL activity occurred during the 7-day look-back period and the activity occurred three or more times.
 - **Code 7, Activity occurred only once or twice:** Coded if the ADL activity occurred **fewer than three times** in the 7-day look back period.
 - **Code 8, Activity did not occur:** Coded only if the ADL activity **did not occur** or **family and/or non-facility staff provided care 100% of the time** for that activity over the entire 7-day look-back period.



Instructions for the Rule of 3

- When an ADL activity has occurred three or more times, apply the steps of the Rule of 3 below **(keeping the ADL coding level definitions and the above exceptions in mind)** to determine the code to enter in Column 1, ADL Self-Performance.
- These steps must be used in sequence.
- Use the first instruction encountered that meets the coding scenario (e.g., if #1 applies, stop and code that level).

Instructions for the Rule of 3 (continued)

1. When an activity occurs **three or more times at any one level**, code that level.
2. When an activity occurs **three or more times at multiple levels**, code the most dependent level that occurred three or more times.



Instructions for the Rule of 3 (continued)

3. When an activity occurs **three or more times and at multiple levels, but not three times at any one level**, apply the following:
 - a) Convert episodes of full staff performance to weight-bearing assistance when applying the third Rule of 3, as long as the full staff performance episodes did not occur every time the ADL was performed in the 7-day look-back period. It is only when every episode is full staff performance that **Total dependence (4)** can be coded. Remember, that weight-bearing episodes that occur three or more times or full staff performance that is provided three or more times during part but not all of the last 7 days are included in the ADL Self-Performance coding level definition for **Extensive assistance (3)**.



Instructions for the Rule of 3 (continued)

- b) When there is a combination of full staff performance and weight-bearing assistance that total three or more times—code **Extensive assistance (3)**.
- c) When there is a combination of full staff performance/weight-bearing assistance, and/or non-weight-bearing assistance that total three or more times—code **Limited assistance (2)**.

**If none of the above are met,
code Supervision.**



Polling Question: G0100, Column 1 (1)

Choose the correct code for G0110, Column 1:

Resident's ADL documentation demonstrates:

- Supervision was provided nine times
- Limited assistance was provided twice
- Extensive assistance was provided once
- Total assistance was provided twice

- A. Code 1, Supervision
- B. Code 2, Limited assistance
- C. Code 3, Extensive assistance
- D. Code 4, Total dependence



Polling Question: G0100, Column 1 (2)

Choose the correct code for G0110, Column 1:

Resident's ADL documentation demonstrates:

- Supervision was provided nine times
- Limited assistance was provided three times
- Extensive assistance was provided once
- Total assistance was provided twice

- A. Code 1, Supervision
- B. Code 2, Limited assistance
- C. Code 3, Extensive assistance
- D. Code 4, Total dependence



Polling Question: G0100, Column 1 (3)

Choose the correct code for G0110, Column 1:

Resident's ADL documentation demonstrates:

- Supervision was provided one time
- Limited assistance was provided two times
- Extensive assistance was provided once
- Total assistance was provided twice

- A. Code 1, Supervision
- B. Code 2, Limited assistance
- C. Code 3, Extensive assistance
- D. Code 4, Total dependence



Polling Question: G0100, Column 1 (4)

Choose the correct code for G0110, Column 1:

Resident's ADL documentation demonstrates:

- Supervision was provided two times
- Limited assistance was provided two times
- Extensive assistance was provided one time
- Total assistance was provided one time

- A. Code 1, Supervision
- B. Code 2, Limited assistance
- C. Code 3, Extensive assistance
- D. Code 4, Total dependence



H0400: Bowel Continence

H0400. Bowel Continence

Enter Code

Bowel continence - Select the one category that best describes the resident

- 0. **Always continent**
- 1. **Occasionally incontinent** (one episode of bowel incontinence)
- 2. **Frequently incontinent** (2 or more episodes of bowel incontinence, but at least one continent bowel movement)
- 3. **Always incontinent** (no episodes of continent bowel movements)
- 9. **Not rated**, resident had an ostomy or did not have a bowel movement for the entire 7 days



H0400: Bowel Continence (continued)

Coding Instructions

- **Code 0, Always continent:** if during the 7-day look-back period the resident has been continent of bowel on all occasions of bowel movements, without any episodes of incontinence.
- **Code 1, Occasionally incontinent:** if during the 7-day look-back period the resident was incontinent of stool once. This includes incontinence of any amount of stool day or night.



H0400: Bowel Continence (continued)

Coding Instructions (continued)

- **Code 2, Frequently incontinent:** if during the 7-day look-back period, the resident was incontinent of bowel more than once, but had at least one continent bowel movement. This includes incontinence of any amount of stool day or night.
- **Code 3, Always incontinent:** if during the 7-day look-back period, the resident was incontinent of bowel for all bowel movements and had no continent bowel movements.



H0400: Bowel Continence (continued)

Coding Instructions (continued)

- **Code 9, Not rated:** if during the 7-day look-back period the resident had an ostomy or did not have a bowel movement for the entire 7 days. (Note that these residents should be checked for fecal impaction and evaluated for constipation.)

Polling Question: H0400

Mr. J had loose stools one day and was incontinent three times that day. He was continent of stool all other days during the look-back period. How should H0400 be coded for Mr. J?

- A. 0, Always continent
- B. 1, Occasionally incontinent
- C. 2, Frequently incontinent
- D. 3, Always incontinent



Section I: Active Diagnoses

Section I	
Active Diagnoses	
Heart/Circulation	
<input type="checkbox"/>	I0200. Anemia (e.g., aplastic, iron deficiency, pernicious, and sickle cell)
<input type="checkbox"/>	I0300. Atrial Fibrillation or Other Dysrhythmias (e.g., bradycardias and tachycardias)
<input type="checkbox"/>	I0400. Coronary Artery Disease (CAD) (e.g., angina, myocardial infarction, and atherosclerotic heart disease (ASHD))
<input type="checkbox"/>	I0500. Deep Venous Thrombosis (DVT), Pulmonary Embolus (PE), or Pulmonary Thrombo-Embolism (PTE)
<input type="checkbox"/>	I0600. Heart Failure (e.g., congestive heart failure (CHF) and pulmonary edema)
<input type="checkbox"/>	I0700. Hypertension
<input type="checkbox"/>	I0800. Orthostatic Hypotension
<input type="checkbox"/>	I0900. Peripheral Vascular Disease (PVD) or Peripheral Arterial Disease (PAD)
Gastrointestinal	
<input type="checkbox"/>	I1100. Cirrhosis

I2900. Diabetes Mellitus (DM) (e.g., diabetic retinopathy, nephropathy, and neuropathy)

Metabolic	
<input type="checkbox"/>	I2900. Diabetes Mellitus (DM) (e.g., diabetic retinopathy, nephropathy, and neuropathy)
<input type="checkbox"/>	I3100. Hyponatremia
<input type="checkbox"/>	I3200. Hyperkalemia
<input type="checkbox"/>	I3300. Hyperlipidemia (e.g., hypercholesterolemia)
<input type="checkbox"/>	I3400. Thrombotic Disorder (e.g., stroke, myocardial infarction, and pulmonary embolism)

Section I: Active Diagnoses (continued)

Two diagnoses are covariate items:

- I0900: Peripheral Vascular Disease (PVD) or Peripheral Arterial Disease (PAD).
- I2900: Diabetes Mellitus (DM) (e.g., diabetic retinopathy, nephropathy, and neuropathy).



Section I: Active Diagnoses (continued)

There are two look-back periods for this section:

- Diagnosis identification (Step 1) is a 60-day look-back period.
- Diagnosis status: Active or Inactive (Step 2) is a 7-day look-back period (except for Item I2300 UTI, which does not use the active 7-day look-back period).



Section I: Active Diagnoses (continued)

*Code diseases that have a **documented diagnosis in the last 60 days** and have a **direct relationship to the resident's current functional status, cognitive status, mood or behavior status, medical treatments, nursing monitoring, or risk of death during the 7-day look-back period.***



K0200: Height and Weight

K0200. Height and Weight - While measuring, if the number is X.1 - X.4 round down; X.5 or greater round up							
<table><tr><td><input type="text"/></td><td><input type="text"/></td></tr><tr><td colspan="2">inches</td></tr></table>	<input type="text"/>	<input type="text"/>	inches		A. Height (in inches). Record most recent height measure since the most recent admission/entry or reentry		
<input type="text"/>	<input type="text"/>						
inches							
<table><tr><td><input type="text"/></td><td><input type="text"/></td><td><input type="text"/></td></tr><tr><td colspan="3">pounds</td></tr></table>	<input type="text"/>	<input type="text"/>	<input type="text"/>	pounds			B. Weight (in pounds). Base weight on most recent measure in last 30 days; measure weight consistently, according to standard facility practice (e.g., in a.m. after voiding, before meal, with shoes off, etc.)
<input type="text"/>	<input type="text"/>	<input type="text"/>					
pounds							

K0200A: Height

Coding Instructions

- Record height to the nearest whole inch.
- Use mathematical rounding (i.e., if height measurement is X.5 inches or greater, round height upward to the nearest whole inch. If height measurement number is X.1 to X.4 inches, round down to the nearest whole inch).

K0200B: Weight

- Use mathematical rounding (i.e., If weight is X.5 pounds [lbs] or more, round weight upward to the nearest whole pound. If weight is X.1 to X.4 lbs, round down to the nearest whole pound).
- If a resident cannot be weighed, for example because of extreme pain, immobility, or risk of pathological fractures, use the standard no-information code (-) and document rationale on the resident's medical record.

Questions and Answers

