

Quality Reporting Program Provider Training



Section M: Skin Conditions (Pressure Ulcer/Injury)

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September 4, 2018

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Today's Presenter



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Acronyms in This Presentation

- Ankle Foot Orthosis (AFO)
- Centers for Medicare & Medicaid Services (CMS)
- Deep Tissue Injury (DTI)
- Inpatient Rehabilitation Facility (IRF)
- Inpatient Rehabilitation Facility Patient Assessment Instrument (IRF-PAI)
- Long-Term Care Hospital (LTCH)
- LTCH Continuity Assessment Record and Evaluation (LTCH CARE) Data Set



Acronyms in This Presentation (cont.)

- National Pressure Ulcer Advisory Panel (NPUAP)
- Peripheral Arterial Disease (PAD)
- Peripheral Vascular Disease (PVD)
- Post-Acute Care (PAC)
- Quality Measure (QM)
- Quality Reporting Program (QRP)
- Skilled Nursing Facility (SNF)



Overview

- Define Section M: Skin Conditions
- Explain the intent of Section M
- Explain new items and/or changes
- Discuss coding instructions for items
- Review practice coding scenarios



Objectives



- 1 State the intent of the changes to Section M
- 2 Describe the new pressure ulcer/injury quality measure (QM)
- 3 Articulate the purpose of the new pressure ulcer terminology and any implications for coding
- 4 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 intense and/or prolonged pressure, or pressure in combination with shear. The pressure ulcer/injury can present as intact skin or an open ulcer and may be painful.

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

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

- M0300 items will be used to calculate the new quality measure “Changes in Skin Integrity Post-Acute Care: Pressure Ulcer/Injury”

July 2018						
SUN	MON	TUE	WED	THU	FRI	SAT
1	2	3	4	5	6	7
8	9	10	11	12	13	14
15	16	17	18	19	20	21
22	23	24	25	26	27	28
29	30	31				

Data collection began
July 1, 2018, for Long Term
Care Hospitals (LTCHs)

October 2018						
SUN	MON	TUE	WED	THU	FRI	SAT
	1	2	3	4	5	6
7	8	9	10	11	12	13
14	15	16	17	18	19	20
21	22	23	24	25	26	27
28	29	30	31			

Data collection begins
October 1, 2018, for Inpatient
Rehabilitation Facilities (IRFs)

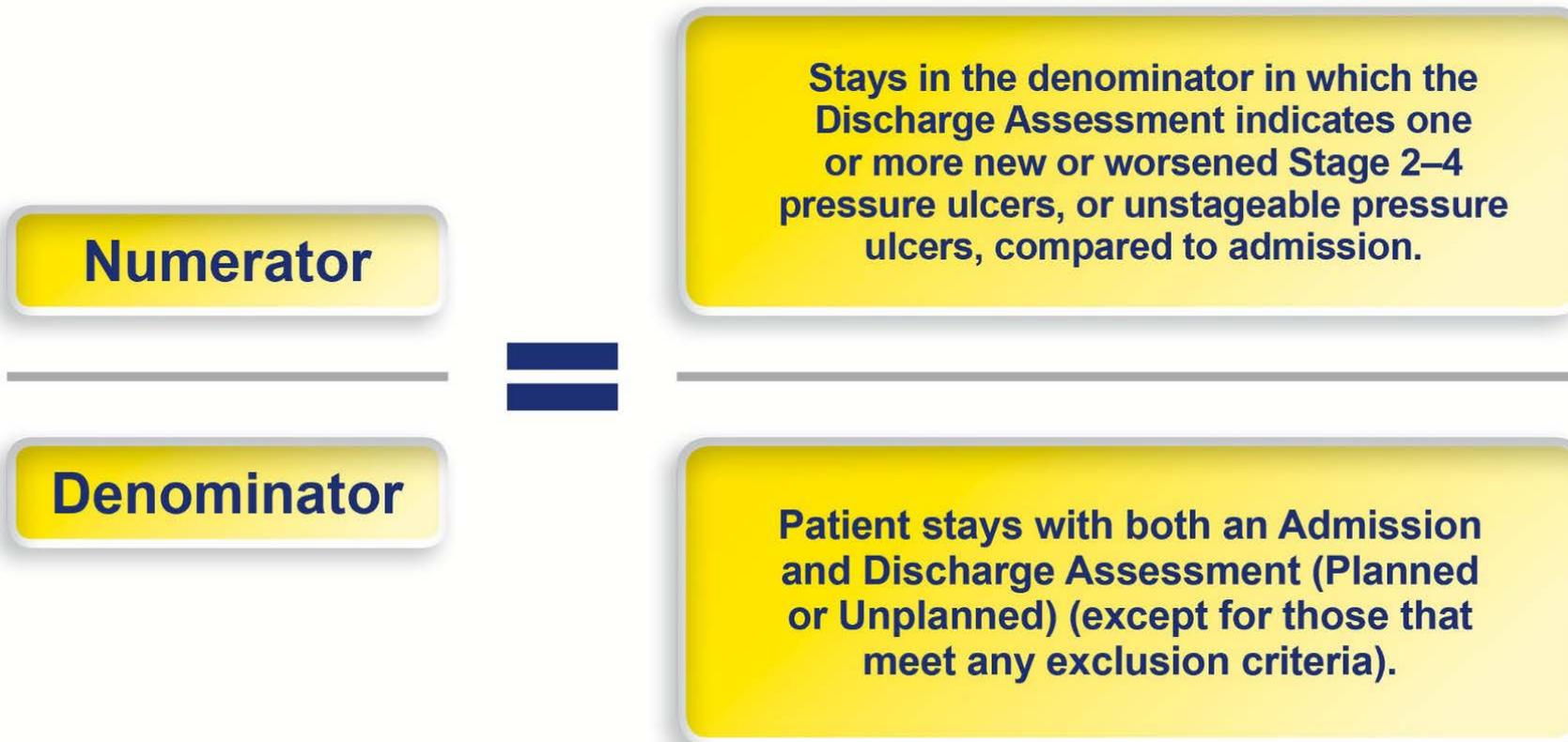


Changes in Skin Integrity Post-Acute Care: Pressure Ulcer/Injury (cont.)



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

Pressure Ulcer/Injury: Numerator/Denominator



Pressure Ulcer/Injury: Denominator Exclusions

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 Discharge Assessment

The patient died during the stay

Pressure Ulcer/Injury: 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 patient 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



Pressure Ulcer/Injury: Risk Adjustment

Admission Assessment items 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)
- I2900. Diabetes Mellitus

Low Body Mass Index,
based on Height and Weight

- K0200A (LTCH) or 25A (IRF). Height
- K0200B (LTCH) or 26A (IRF). Weight

Section M: Skin Conditions

Changes



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

bed sore
decubitus ulcer
pressure
sore
bed sore
pressure injury
pressure ulcer

Item Changes (cont. 1)

CMS adheres to the following guidelines:

Stage 1 pressure injuries and deep tissue injuries are termed “pressure injuries” because they are closed wounds

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

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)

- The term “**injuries**” has been added to items: M0210, M0300, M0300A, M0300E–M0300E2, and M0300G–M0300G2

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	<input type="checkbox"/>	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	<input type="checkbox"/>	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	

Item Changes (cont. 3)

- The term “**device**” was added to items: M0300E–M0300E2

Enter Number <input data-bbox="206 805 277 911" type="text"/>	E. Unstageable - Non-removable dressing/device: Known but not stageable due to non-removable dressing/ device 1. Number of unstageable pressure ulcers/injuries due to non-removable dressing/device
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Item Changes (cont. 4)

- Removed the term “suspected deep tissue injury in evolution” and replaced with “**deep tissue injury**” to items M0300G and M0300G1

Enter Number <input type="text"/>	G. Unstageable - Deep tissue injury 1. Number of unstageable pressure injuries presenting as deep tissue injury
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Item Changes (cont. 5)



- M0800A–M0800F, Worsening in Pressure Ulcer Status Since Admission, items have been removed
- **IRFs Only:** M0900A–M0900D, Healed Pressure Ulcer(s), items have been removed from IRF-PAI

Section M: Skin Conditions

Coding Guidance and Practice Coding Scenarios

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

M0300A1–G1

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

**Admission
Assessment**

M0300A1–G1

- Identifies number of unhealed pressure ulcers/injuries at each stage

M0300B2–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

Discharge Assessment

(For LTCH: Planned or
Unplanned)

Medical Documentation

Use documentation from the previous setting to inform about the original stage of a pressure ulcer/injury



Review the history of each pressure ulcer/injury in the patient's medical record

Steps for Completing M0300A–G

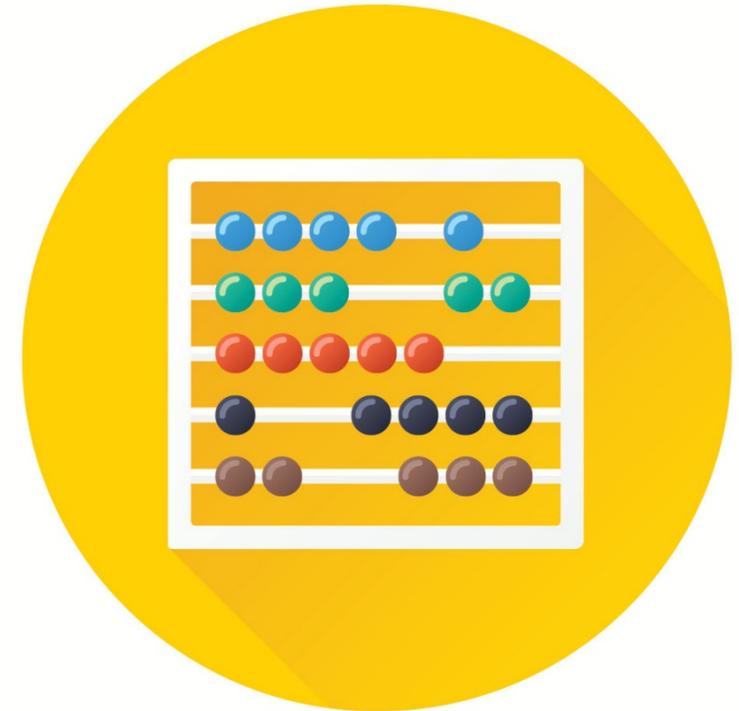


1. Determine Deepest Anatomical Stage
2. Identify Unstageable Pressure Ulcers/Injuries

Steps for Completing M0300A–G (cont.)

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

For detailed instructions, refer to Section M in the LTCH Quality Reporting Program (QRP) Manual and the Quality Indicator Section of the Inpatient Rehabilitation Facility Patient Assessment Instrument (IRF-PAI) 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 <input type="text"/>	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 <input type="text"/>	B. Stage 2: Partial thickness loss of dermis presenting as a shallow open ulcer with a red or pink wound bed, without slough. May also present as an intact or open/ruptured blister 1. Number of Stage 2 pressure ulcers
Enter Number <input type="text"/>	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 <input type="text"/>	D. Stage 4: Full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present on some parts of the wound bed. Often includes undermining and tunneling 1. Number of Stage 4 pressure ulcers
Enter Number <input type="text"/>	E. Unstageable - Non-removable dressing/device: Known but not stageable due to non-removable dressing/device 1. Number of unstageable pressure ulcers/injuries due to non-removable dressing/device
Enter Number <input type="text"/>	F. Unstageable - Slough and/or eschar: Known but not stageable due to coverage of wound bed by slough and/or eschar 1. Number of unstageable pressure ulcers due to coverage of wound bed by slough and/or eschar
Enter Number <input type="text"/>	G. Unstageable - Deep tissue injury 1. Number of unstageable pressure injuries presenting as deep tissue injury

M0300A1–G1 Coding Instructions

IRF and LTCH: Completed at admission and discharge

(LTCH: A0250 = 01 Admission, 10 Planned Discharge, or 11 Unplanned Discharge)

- **Enter the number** of pressure ulcers/injuries 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 <input type="text"/>	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 <input type="text"/> Enter Number <input type="text"/>	B. Stage 2: Partial thickness loss of dermis presenting as a shallow open ulcer with a red or pink wound bed, without slough. May also present as an intact or open/ruptured blister 1. Number of Stage 2 pressure ulcers - If 0 → Skip to M0300C, Stage 3 2. Number of <u>these</u> Stage 2 pressure ulcers that were present upon admission - enter how many were noted at the time of admission
Enter Number <input type="text"/> Enter Number <input type="text"/>	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 <u>these</u> Stage 3 pressure ulcers that were present upon admission - enter how many were noted at the time of admission
Enter Number <input type="text"/> Enter Number <input type="text"/>	D. Stage 4: Full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present on some parts of the wound bed. Often includes undermining and tunneling 1. Number of Stage 4 pressure ulcers - If 0 → Skip to M0300E, Unstageable - Non-removable dressing/device 2. Number of <u>these</u> Stage 4 pressure ulcers that were present upon admission - enter how many were noted at the time of admission



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

Enter Number <input type="text"/> Enter Number <input type="text"/>	<p>E. Unstageable - Non-removable dressing/device: Known but not stageable due to non-removable dressing/device</p> <p>1. Number of unstageable pressure ulcers/injuries due to non-removable dressing/device - If 0 → Skip to M0300F, Unstageable - Slough and/or eschar</p> <p>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</p>
Enter Number <input type="text"/> Enter Number <input type="text"/>	<p>F. Unstageable - Slough and/or eschar: Known but not stageable due to coverage of wound bed by slough and/or eschar</p> <p>1. Number of unstageable pressure ulcers due to coverage of wound bed by slough and/or eschar If 0 → Skip to M0300G, Unstageable - Deep tissue injury</p> <p>2. Number of <u>these</u> unstageable pressure ulcers that were present upon admission - enter how many were noted at the time of admission</p>
M0300. Current Number of Unhealed Pressure Ulcers/Injuries at Each Stage - Continued	
Enter Number <input type="text"/> Enter Number <input type="text"/>	<p>G. Unstageable - Deep tissue injury</p> <p>1. Number of unstageable pressure injuries presenting as deep tissue injury - If 0 → Skip to N2005, Medication Intervention</p> <p>2. Number of <u>these</u> unstageable pressure injuries that were present upon admission - enter how many were noted at the time of admission</p>



M0300B2–G2 Coding Instructions

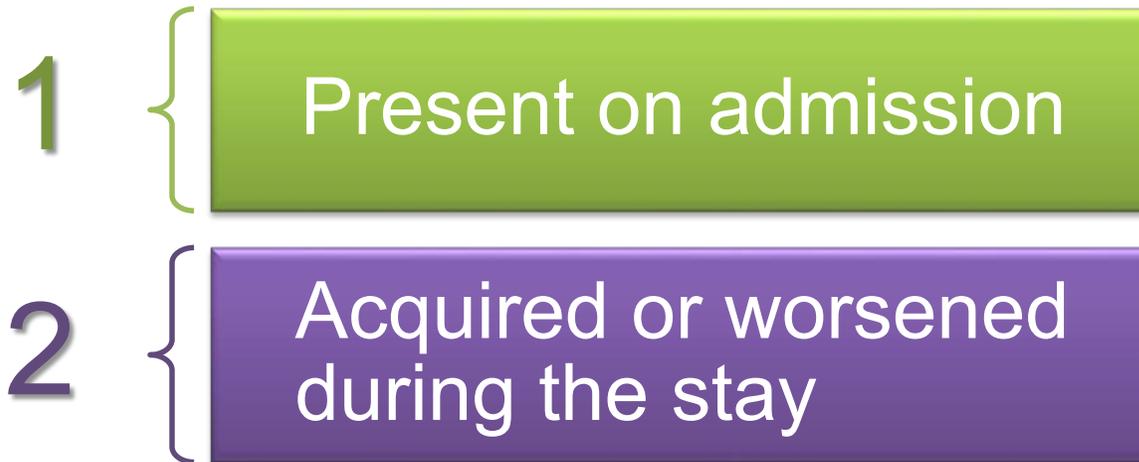
IRF and LTCH: Completed only at discharge
(LTCH: A0250 = 10 Planned Discharge or 11
Unplanned Discharge)

- **Enter the number** of these pressure ulcers/injuries that were present on admission
 - See instructions 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 M0300B2–G2

- The present on admission items (M0300B2–G2) are coded at discharge
- Address whether the pressure ulcers/injuries observed at discharge were:



Present on Admission M0300B2–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

Pressure Ulcers: Program Interruption

- If a patient is transferred from the post-acute care (PAC) setting to an acute care hospital 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”



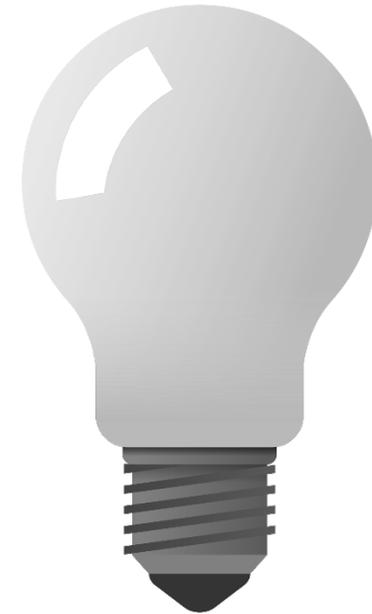
Practice Coding Scenario 1

- A patient is admitted to the PAC setting with a Stage 2 pressure ulcer to the left hip. The patient is transported to an acute care hospital and returns to the PAC setting within 2 days
- Upon return to the PAC setting, the left hip pressure ulcer is assessed to be a full thickness ulcer assessed to be a Stage 3. The patient is discharged to home with this Stage 3 pressure ulcer



How would you code M0300 on the Admission Assessment?

- A. M0300B1. Stage 2 = 1
- B. M0300C1. Stage 3 = 1
- C. M0300D1. Stage 4 = 2
- D. M0300G1. Unstageable –
Deep tissue injury (DTI) = 1



How would you code M0300 on the Admission Assessment? (cont.)

- ✓ A. M0300B1. Stage 2 = 1
- B. M0300C1. Stage 3 = 1
- C. M0300D1. Stage 4 = 2
- D. M0300G1. Unstageable –
Deep tissue injury (DTI) = 1



How would you code M0300 on the Discharge Assessment?

- A. M0300B1. Stage 2 = 1
- B. M0300C1. Stage 3 = 1
- C. M0300D1. Stage 4 = 2
- D. M0300G1. Unstageable – DTI = 1



How would you code M0300 on the Discharge Assessment? (cont.)

- A. M0300B1. Stage 2 = 1
- ✓ B. M0300C1. Stage 3 = 1
- C. M0300D1. Stage 4 = 2
- D. M0300G1. Unstageable – DTI = 1



Practice Coding Scenario 1 (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



Practice Coding Scenario 1 (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



Practice Coding Scenario 1 (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

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

Practice Coding Scenario 2

- A patient is admitted to the PAC setting with a Stage 4 pressure ulcer on her left hip
- When the pressure ulcer is reassessed at discharge, it is entirely covered with eschar and the wound bed cannot be assessed. The patient is discharged with an unstageable pressure ulcer due to slough/eschar



How would you code M0300 on the Admission Assessment?

- A. M0300C1. Stage 3 = 1
- B. M0300D1. Stage 4 = 1
- C. M0300F1. Unstageable – slough and/or eschar = 1
- D. M0300G1. Unstageable – DTI = 1



How would you code M0300 on the Admission Assessment? (cont.)

- A. M0300C1. Stage 3 = 1
- ✓ B. M0300D1. Stage 4 = 1
- C. M0300F1. Unstageable – slough and/or eschar = 1
- D. M0300G1. Unstageable – DTI = 1



How would you code M0300 on the Discharge Assessment?

- A. M0300C1. Stage 3 = 1
- B. M0300D1. Stage 4 = 1
- C. M0300F1. Unstageable – slough and/or eschar = 1
- D. M0300G1. Unstageable – DTI = 1



How would you code M0300 on the Discharge Assessment? (cont.)

- A. M0300C1. Stage 3 = 1
- B. M0300D1. Stage 4 = 1
- ✓ C. M0300F1. Unstageable – slough and/or eschar = 1
- D. M0300G1. Unstageable – DTI = 1



Was this unstageable pressure ulcer due to slough and/or eschar present on admission?

- A. Yes, code M0300F2 = 1
- B. No, code M0300F2 = 0
- C. Skip M0300F2



Was this unstageable pressure ulcer due to slough and/or eschar present on admission? (cont.)

- A. Yes, code M0300F2 = 1
- ✓ B. No, code M0300F2 = 0
- C. Skip M0300F2



Practice Coding Scenario 2 (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 0
M0300C2. Number of these Stage 3 pressure ulcers that were present upon admission		Skip
M0300D1. Number of Stage 4 pressure ulcers	Code as 1	Code as 0
M0300D2. Number of these Stage 4 pressure ulcers that were present upon admission		Skip

Practice Coding Scenario 2 (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 0	Code as 1
M0300F2. Number of these unstageable pressure ulcers due to slough/eschar that were present upon admission		Code as 0



Practice Coding Scenario 2 (cont. 3)

Rationale:

- At admission, the patient had a Stage 4 pressure ulcer on the left hip, so:
 - **M0300D1 is coded as 1** on the Admission Assessment
- The Stage 4 pressure ulcer on the left hip developed eschar and is unable to be assessed and numerically staged on discharge, so:
 - **M0300D1 is coded as 0** on the Discharge Assessment
 - **M0300D2 is coded as Skip** on the Discharge Assessment

Practice Coding Scenario 2 (cont. 4)

Rationale:

- The Stage 4 pressure ulcer on the left hip is entirely covered with eschar and the wound bed cannot be assessed. The patient is discharged with an unstageable pressure ulcer due to slough/eschar, so:
 - **M0300F1 is coded as 1** on the Discharge Assessment
 - **M0300F2 is coded as 0** on the Discharge Assessment

Non-Removable Dressing/Device

- Non-removable dressing/device refers to a dressing or device that may not be removed from the patient **per physician's order**



Non-Removable Dressing/Device (cont. 1)

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

These pressure ulcers/injuries are considered unstageable due to the inability to further assess the documented pressure ulcer/injury that is covered by the non-removable dressing/device

Non-Removable Dressing/Device (cont. 2)

- “Known” refers to when documentation is available indicating that a pressure ulcer/injury exists under the non-removable dressing/device
- Presence of the pressure ulcer/injury should have been previously documented in the patient medical record



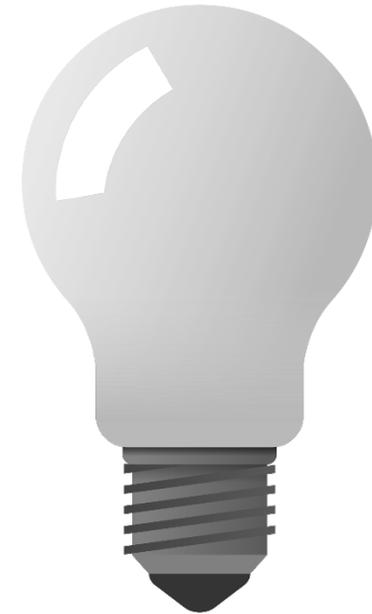
Practice Coding Scenario 3

- A patient is admitted to the PAC setting 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 4 of the stay, the dressing is removed by the physician and assessment reveals a Stage 3 pressure ulcer
- On Day 9 of the stay, the pressure ulcer is covered with eschar and is assessed as unstageable. The eschar-covered ulcer is unchanged at the time of discharge



How would you code M0300 on the Admission Assessment?

- A. M0300C1. Stage 3 = 1
- B. M0300E1. Unstageable – Non-removable dressing/device = 1
- C. M0300F1. Unstageable – Slough and/or eschar = 1
- D. M0300G1. Unstageable – DTI = 1



How would you code M0300 on the Admission Assessment? (cont.)

- A. M0300C1. Stage 3 = 1
- ✓ B. M0300E1. Unstageable – Non-removable dressing/device = 1
- C. M0300F1. Unstageable – Slough and/or eschar = 1
- D. M0300G1. Unstageable – DTI = 1



How would you code M0300 on the Discharge Assessment?

- A. M0300C1. Stage 3 = 1
- B. M0300E1. Unstageable – Non-removable dressing/device = 1
- C. M0300F1. Unstageable – Slough and/or eschar = 1
- D. M0300G1. Unstageable – DTI = 1



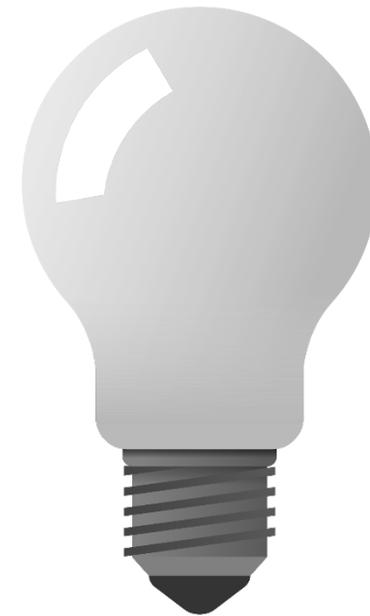
How would you code M0300 on the Discharge Assessment? (cont.)

- A. M0300C1. Stage 3 = 1
- B. M0300E1. Unstageable – Non-removable dressing/device = 1
- ✓ C. M0300F1. Unstageable – Slough and/or eschar = 1
- D. M0300G1. Unstageable – DTI = 1



Was this unstageable pressure ulcer due to slough and/or eschar present on admission?

- A. Yes, code M0300F2 = 1
- B. No, code M0300F2 = 0
- C. Skip M0300F2



Was this unstageable pressure ulcer due to slough and/or eschar present on admission? (cont.)

- A. Yes, code M0300F2 = 1
- ✓ B. No, code M0300F2 = 0
- C. Skip M0300F2



Practice Coding Scenario 3 (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 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 0
M0300D2. Number of these Stage 4 pressure ulcers that were present upon admission		Skip



Practice 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 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

Practice Coding Scenario 3 (cont. 3)

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

Practice Coding Scenario 3 (cont. 4)

- 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 numerically 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

Practice Coding Scenario 4

- A patient is admitted to the PAC setting with a Stage 3 pressure ulcer on her coccyx
- On Day 5 of her PAC stay the ulcer is assessed as a Stage 4 pressure ulcer. She is seen at the wound clinic and returns to the PAC setting with a dressing and orders that the dressing is to remain intact until the next clinic visit
- The patient is discharged to a Skilled Nursing Facility (SNF) prior to the follow-up wound clinic visit. At the time of discharge, this ulcer is covered with a non-removable dressing



How would you code M0300 on the Admission Assessment?

- A. M0300C1. Stage 3 = 1
- B. M0300D1. Stage 4 = 1
- C. M0300E1. Unstageable – Non-removable dressing/device = 1
- D. M0300F1. Unstageable – Slough and/or eschar = 1



How would you code M0300 on the Admission Assessment? (cont.)

- ✓ A. M0300C1. Stage 3 = 1
- B. M0300D1. Stage 4 = 1
- C. M0300E1. Unstageable – Non-removable dressing/device = 1
- D. M0300F1. Unstageable – Slough and/or eschar = 1



How would you code M0300 on the Discharge Assessment?

- A. M0300C1. Stage 3 = 1
- B. M0300D1. Stage 4 = 1
- C. M0300E1. Unstageable – Non-removable dressing/device = 1
- D. M0300F1. Unstageable – Slough and/or eschar = 1



How would you code M0300 on the Discharge Assessment? (cont.)

- A. M0300C1. Stage 3 = 1
- B. M0300D1. Stage 4 = 1
- ✓ C. M0300E1. Unstageable – Non-removable dressing/device = 1
- D. M0300F1. Unstageable – Slough and/or eschar = 1



Was this unstageable pressure ulcer/injury due to Non-removable dressing/device present on admission?

- A. Yes, code M0300E2 = 1
- B. No, code M0300E2 = 0
- C. Skip M0300E2



Was this unstageable pressure ulcer/injury due to Non-removable dressing/device present on admission? (cont.)

- A. Yes, code M0300E2 = 1
- ✓ B. No, code M0300E2 = 0
- C. Skip M0300E2



Practice Coding Scenario 4 (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 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 0
M0300D2. Number of these Stage 4 pressure ulcers that were present upon admission		Skip



Practice Coding Scenario 4 (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 1
M0300E2. Number of these unstageable pressure ulcers/injuries due to non-removable dressing that were present upon admission		Code as 0
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



Practice Coding Scenario 4 (cont. 3)

Rationale:

- At admission, the patient had a Stage 3 pressure ulcer on the coccyx, so:
 - **M0300C1 is coded as 1** on the Admission Assessment
- The pressure ulcer increases in numerical stage to a Stage 4 during her stay. A dressing is applied to cover the wound and at discharge the pressure ulcer remains covered by a non-removable dressing/device, so:
 - **M0300C1 is coded as 0** on the Discharge Assessment
 - **M0300D1 is coded as 0 and M0300D2 is coded as 0** on the Discharge Assessment
 - **M0300E1 is coded as 1 and M0300E2 is coded as 0** on the Discharge Assessment

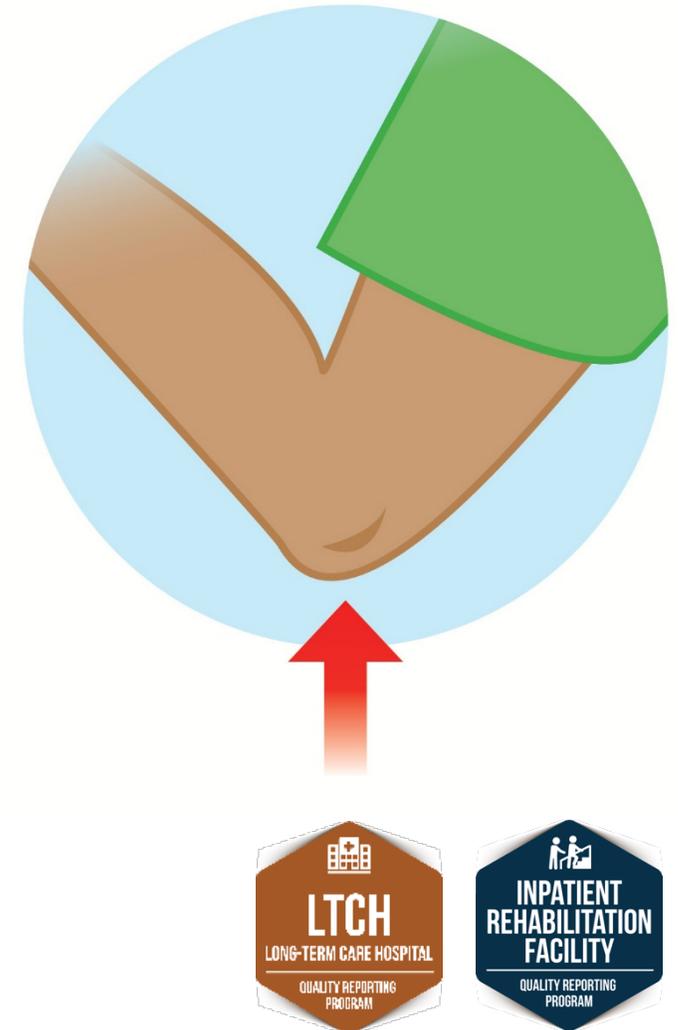
Healed Pressure Ulcers/Injuries

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

Practice Coding Scenario 5

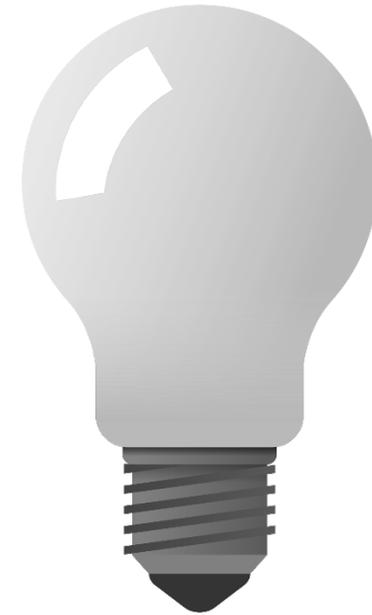
- The patient's skin assessment on admission to PAC reveals no pressure ulcers or injuries
- On Day 5, while conducting a skin assessment, a Stage 2 pressure ulcer is identified on the right elbow
- On discharge, the patient's skin assessment reveals a healed Stage 2 pressure ulcer on the right elbow



How would you code M0210 on the Admission Assessment?

Does this patient have one or more
unhealed pressure ulcers/injuries?

- A. **0, No**
- B. **1, Yes**



How would you code M0210 on the Admission Assessment? (cont.)

Does this patient have one or more unhealed pressure ulcers/injuries?

- ✓ A. **0, No** → *Skip to N2001. Drug Regimen Review*
- B. **1, Yes**



How would you code M0210 on the Discharge Assessment?

Does this patient have one or more unhealed pressure ulcers/injuries?

- A. 0, No
- B. 1, Yes



How would you code M0210 on the Discharge Assessment? (cont.)

Does this patient have one or more unhealed pressure ulcers/injuries?

- ✓ A. **0, No** → *Skip to N2001. Drug Regimen Review*
- B. **1, Yes**



Practice Coding Scenario 5 (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

Practice Coding Scenario 6

- A patient is admitted to the PAC setting with a Stage 1 pressure injury on the coccyx
- The skin assessment of the tissues surrounding this injury on Day 6 is consistent with a DTI
- This DTI remains intact at the time of discharge to home 3 days later



How would you code M0300 on the Admission Assessment?

- A. M0300A1. Stage 1 = 1
- B. M0300B1. Stage 2 = 1
- C. M0300F1. Unstageable – Slough and/or eschar = 1
- D. M0300G1. Unstageable – DTI = 1



How would you code M0300 on the Admission Assessment? (cont.)

- ✓ A. M0300A1. Stage 1 = 1
- B. M0300B1. Stage 2 = 1
- C. M0300F1. Unstageable – Slough and/or eschar = 1
- D. M0300G1. Unstageable – DTI = 1



How would you code M0300 on the Discharge Assessment?

- A. M0300A1. Stage 1 = 1
- B. M0300B1. Stage 2 = 1
- C. M0300F1. Unstageable – Slough and/or eschar = 1
- D. M0300G1. Unstageable – DTI = 1



How would you code M0300 on the Discharge Assessment? (cont.)

- A. M0300A1. Stage 1 = 1
- B. M0300B1. Stage 2 = 1
- C. M0300F1. Unstageable – Slough and/or eschar = 1
- ✓ D. M0300G1. Unstageable – DTI = 1



Was this unstageable pressure injury present on admission?

- A. Yes, code M0300G2 = 1
- B. No, code M0300G2 = 0
- C. Skip M0300G2



Was this unstageable pressure injury present on admission? (cont.)

A. Yes, code M0300G2 = 1

✓ B. No, code M0300G2 = 0

C. Skip M0300G2



Practice Coding Scenario 6 (cont. 1)

Item	Admission Assessment	Discharge Assessment
M0300A1. Number of Stage 1 pressure ulcers	Code as 1	Code as 0
M0300B1. Number of Stage 2 pressure ulcers	Code as 0	Code as 0
M0300B2. Number of these Stage 2 pressure ulcers that were present upon admission		Skip
M0300C1. Number of Stage 3 pressure ulcers	Code as 0	Code as 0
M0300C2. Number of these Stage 3 pressure ulcers that were present upon admission		Skip
M0300D1. Number of Stage 4 pressure ulcers	Code as 0	Code as 0
M0300D2. Number of these Stage 4 pressure ulcers that were present upon admission		Skip



Practice Coding Scenario 6 (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 0	Code as 1
M0300G2. Number of these unstageable pressure injuries with deep tissue injury that were present upon admission		Code as 0

Practice Coding Scenario 6 (cont. 3)

Rationale:

- At admission, the patient had a Stage 1 pressure injury on the coccyx
- The subsequent skin assessment determines this injury to be a DTI, which remains until discharge, so:
 - **M0300G1 is coded as 1 and M0300G2 is coded as 0** on the Discharge Assessment

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 or IRF-PAI. If the ulcer/injury is not due to pressure, do not code it in Section M

Practice Coding Scenario 7

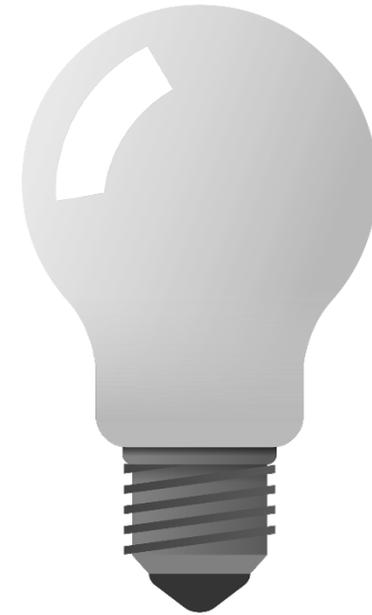
- A patient is admitted to PAC with a right ankle foot orthosis (AFO) to compensate for weakness and foot drop
- On the initial skin assessment, the clinician notes a Stage 2 pressure ulcer at the right calf, that conforms to the shape of the AFO. The orthotist is consulted and the AFO is adjusted
-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



How would you code M0210 on the Admission Assessment?

Does this patient have one or more
unhealed pressure ulcers/injuries?

- A. 0, No
- B. 1, Yes



How would you code M0210 on the Admission Assessment? (cont.)

Does this patient have one or more unhealed pressure ulcers/injuries?

A. **0, No**

✓ B. **1, Yes** → *Continue to M0300. Current Number of Unhealed Pressure Ulcers/Injuries at Each Stage*



How would you code M0300 on the Admission Assessment?

- A. M0300A1. Stage 1 = 1
- B. M0300B1. Stage 2 = 1
- C. M0300E1. Unstageable – Non-removable dressing/device = 1
- D. M0300G1. Unstageable – DTI = 1



How would you code M0300 on the Admission Assessment? (cont.)

- A. M0300A1. Stage 1 = 1
- ✓ B. M0300B1. Stage 2 = 1
- C. M0300E1. Unstageable – Non-removable dressing/device = 1
- D. M0300G1. Unstageable – DTI = 1



How would you code M0210 on the Discharge Assessment?

Does this patient have one or more unhealed pressure ulcers/injuries?

- A. 0, No
- B. 1, Yes



How would you code M0210 on the Discharge Assessment? (cont.)

Does this patient have one or more unhealed pressure ulcers/injuries?

- ✓ A. **0, No** → *Skip to N2001. Drug Regimen Review*
- B. **1, Yes**



Practice 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

Practice 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.” **

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

Practice Coding Scenario 7 (cont. 3)

Rationale:

- 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

Practice Coding Scenario 7 (cont. 4)

- **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:
 - **M0210.** Unhealed Pressure Ulcers/Injuries is coded as **0**
 - **M0300** items would be skipped

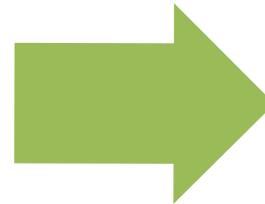
Mucosal Ulcers

- 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 or IRF-PAI



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

Evolution and appearance differ from a typical pressure ulcer/injury

- Related to tissue perfusion issues due to organ and skin failure

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.)

- 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:
 - M0300E, M0300E1, and M0300E2
- Removed items M0800A–M0800F
- Removed items M0900A–M0900D from IRF-PAI



FY 2019 IRF and LTCH Rule Updates

- The final rules removed the following measures from the IRF QRP and LTCH QRP:
 - IRF and LTCH
 - National Healthcare Safety Network (NHSN) Facility-wide Inpatient Hospital-onset Methicillin-resistant Staphylococcus aureus (MRSA) Bacteremia Outcome Measure (NQF #1716) beginning with the FY 2020 IRF and LTCH QRPs.
 - Beginning October 1, 2018, IRFs and LTCHs will no longer be required to submit data on this measure for the purposes of the IRF and LTCH QRPs.
 - Percent of Residents or Patients Who Were Assessed and Appropriately Given the Seasonal Influenza Vaccine (Short Stay) (NQF #0680) beginning with the FY 2021 IRF and LTCH QRPs.
 - Beginning October 1, 2018, IRFs/LTCHs should enter any of the valid codes or a dash (–) for O0250A, O0250B, and O0250C until the next IRF-PAI and LTCH CARE Data Set is released.
 - LTCH-only
 - National Healthcare Safety Network (NHSN) Ventilator-Associated Event (VAE) Outcome Measure beginning with the FY 2020 LTCH QRP.
 - Beginning October 1, 2018, LTCHs will no longer be required to submit data on this measure for the purposes of the LTCH QRP.



FY 2019 IRF and LTCH Rule Updates (cont.)

- Further, CMS finalized the following:
 - An update to expand the methods by which IRFs and LTCHs are notified of noncompliance with the requirements of the IRF and LTCH QRPs for a program year and how CMS will notify IRFs and LTCHs of a reconsideration decision.
 - IRF-only: To display data on the four assessment-based functional outcome measures in CY 2020.
- For more information, refer to the final rules:
 - FY 2019 IRF PPS final rule: <https://www.gpo.gov/fdsys/pkg/FR-2018-08-06/pdf/2018-16517.pdf>
 - FY 2019 IPPS/LTCH PPS final rule: <https://www.gpo.gov/fdsys/pkg/FR-2018-08-17/pdf/2018-16766.pdf>



