Track Changes
from Chapter 3, Section M V1.09
to Chapter 3, Section M V1.10

Chapter	Section	Page	Change
3	M0210	M-2	• Check C if the resident's risk for pressure ulcer development is based on clinical assessment. A clinical assessment could include a head-to-toe physical examination of the skin and observation or medical record review of pressure ulcer risk factors. Examples of risk factors include the following: ~~• impaired/decreased mobility and decreased functional ability~~ ~~• co-morbid conditions, such as end stage renal disease, thyroid disease, or diabetes mellitus;~~ ~~• drugs, such as steroids, that may affect wound healing;~~ ~~• impaired diffuse or localized blood flow (e.g., generalized atherosclerosis or lower extremity arterial insufficiency);~~ — impaired/decreased mobility and decreased functional ability — co-morbid conditions, such as end stage renal disease, thyroid disease, or diabetes mellitus; — drugs, such as steroids, that may affect wound healing; — impaired diffuse or localized blood flow (e.g., generalized atherosclerosis or lower extremity arterial insufficiency);
3	M0210	M-3	~~• resident refusal of some aspects of care and treatment;~~ ~~• cognitive impairment;~~ ~~• urinary and fecal incontinence;~~ ~~• under nutrition, malnutrition, and hydration deficits; and~~ ~~• healed pressure ulcers, especially Stage 3 or 4 which are more likely to have recurrent breakdown.~~ — resident refusal of some aspects of care and treatment; — cognitive impairment; — urinary and fecal incontinence; — under nutrition, malnutrition, and hydration deficits; and — healed pressure ulcers, especially Stage 3 or 4 which are more likely to have recurrent breakdown.
3	M0210	M-4	• For MDS assessment, initial numerical staging of pressure ulcers and the initial numerical staging of ulcers after debridement, or sDTI that declares itself, should be coded in terms of what is assessed (seen ~~and~~ or palpated, i.e. visible tissue, palpable bone) during the look-back period. Nursing homes may adopt the NPUAP guidelines in their clinical practice and nursing documentation. However, since CMS has adapted the NPUAP guidelines for MDS purposes, the definitions do not perfectly correlate with each stage as

Track Changes
from Chapter 3, Section M V1.09
to Chapter 3, Section M V1.10

Chapter	Section	Page	Change
			described by NPUAP. Therefore, you cannot use the NPUAP definitions to code the MDS. You must code the MDS according to the instructions in this manual. • Pressure ulcer staging is an assessment system that provides a description and classification based on ~~of~~ anatomic depth of soft ~~the extent of visible~~ tissue damage. This tissue damage can be visible or palpable in the ulcer bed. Pressure ulcer staging~~and~~ also informs expectations for healing times
3	M0210	M-4	3. Examine the resident and determine whether any skin ulcers are present. • Key areas for pressure ulcer development include the sacrum, coccyx, trochanters, ischial tuberosities, and heels. Other areas, such as bony deformities, skin under braces, and skin subjected to excess pressure, shear or friction, are also at risk for pressure ulcers.
3	M0210	M-5	**Coding Tips** • If an ulcer arises from a combination of factors which are primarily caused by pressure, then the ulcer should be included in this section as a pressure ulcer. ~~Each ulcer should be coded only once, either as a pressure ulcer or an ulcer due to another cause.~~ • Oral Mucosal ulcers caused by pressure should not be coded in Section M. These ulcers are captured in item **L0200C, Abnormal mouth tissue**. Mucosal ulcers are not staged using the skin pressure ulcer staging system because anatomical tissue comparisons cannot be made. • If a pressure ulcer is surgically closed~~repaired~~ with a flap or graft, it should be coded as a surgical wound and not as a pressure ulcer. If the flap or graft fails, continue to code it as a surgical wound until healed.
3	M0210	M-5	• If a resident had a pressure ulcer on the last assessment and it is now healed, complete Healed Pressure Ulcers item (M0900). • If a pressure ulcer healed during the look-back period, and was not present on prior assessment, code 0.
3	M0300	M-6	**Step 1…** 1. Observe and palpate the base of any identified pressure ulcers present to determine the anatomic depth of soft tissue damage~~layers~~ involved. 2. Ulcer staging should be based on the ulcer's deepest ~~visible~~ anatomic~~al~~ soft tissue damage that is visible or palpable~~level~~.

Track Changes
from Chapter 3, Section M V1.09
to Chapter 3, Section M V1.10

Chapter	Section	Page	Change
			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 below). Review the history of each pressure ulcer in the medical record. If the pressure ulcer has ever been classified at a higher~~deeper~~ numerical stage than what is observed now, it should continue to be classified at the higher~~deeper~~ numerical stage. Nursing homes that carefully document and track pressure ulcers will be able to more accurately code this item. **Step 2…** 1. Visualization of the wound bed is necessary for accurate staging. ~~However, if the wound bed is partially covered by eschar or slough, but the depth of tissue loss can be measured, do not code as unstageable.~~ 2. Pressure ulcers that have ~~necrotic or~~ eschar (tan, black, or brown) or slough (yellow, tan, gray, green or brown) tissue present such that the anatomic depth of soft tissue damage ~~layers involved with the pressure ulcer~~ cannot be visualized or palpated in the wound bed, ~~determined,~~should be classified as unstageable, as illustrated at ~~http://www.npuap.org/images/NPUAP-Unstage2.jpg~~http://www.npuap.org/wp-content/uploads/2012/03/NPUAP-Unstage2.jpg 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.~~Pressure ulcers in which the base of the ulcer is covered by slough (yellow, tan, gray, green or brown) are unstageable.~~ 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, as illustrated at http://www.npuap.org/images/NPUAP-SuspectDTI.jpg
3	M0300	M-7	**Step 3…** 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. If the pressure ulcer was present on admission/entry or reentry and subsequently increased in numerical ~~worsened to a higher~~ 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."**

Track Changes
from Chapter 3, Section M V1.09
to Chapter 3, Section M V1.10

Chapter	Section	Page	Change
			3. 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 ~~worsens to a higher~~increases in numerical stage, that higher stage **should not be considered "present on admission."** 4. If a resident who has a pressure ulcer 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 at the facility prior to the hospitalization. 5. If a current pressure ulcer increases in numerical ~~worsens to a higher~~ stage during a hospitalization, it is coded at the higher stage upon reentry and **should be coded as "present on admission."**
3	M0300	M-7	DEFINITIONS ON ADMISSION ~~On admission is defined as: as~~ As close to the actual time of admission as possible.
3	M0300	M-8	**Steps for Assessment** 2. For the purposes of coding, determine that the lesion being assessed is **primarily** related to pressure and that other conditions have been ruled out. If pressure is ~~**NOT**~~**not** the **primary** cause, do **not**~~NOT~~ code here. 5. Search for other areas of skin that differ from surrounding tissue that may be painful, firm, soft, warmer, or cooler compared to adjacent tissue. Stage 1 may be difficult to detect in individuals with dark skin tones. Visible blanching may not be readily apparent in darker skin tones. Look for temperature or color changes.
3	M0300	M-9	**Planning for Care** • If a pressure ulcer fails to show some evidence toward healing within 14 days, the pressure ulcer (including potential complications) and the patient's overall clinical condition should be reassessed.
3	M0300	M-9	**Steps for Assessment** 2. For the purposes of coding, determine that the lesion being

Chapter	Section	Page	Change
			assessed is primarily related to pressure and that other conditions have been ruled out. If pressure is ~~not~~ **not** the primary cause, do ~~not~~ **not** code here.
3	M0300	M-10	3. **Examine the area adjacent to or surrounding an intact blister for evidence of tissue damage. If other conditions are ruled out and the tissue adjacent to, or surrounding the blister demonstrates signs of tissue damage, (e.g., color change, tenderness, bogginess or firmness, warmth or coolness) these characteristics suggest a suspected deep tissue injury (sDTI) rather than a Stage 2 Pressure Ulcer.**
3	M0300	M-10	**Coding Instructions for M0300B** • Enter the date of the oldest Stage 2 pressure ulcer. The facility should make every effort to determine the actual date that the Stage 2 pressure ulcer was first identified whether or not it was acquired in the facility. If the facility is unable to determine the actual date that the Stage 2 pressure ulcer was first identified (i.e., the date is unknown), enter a dash in every block. Do not leave any boxes blank. If the month or day contains only a single digit, fill the first box in with a "0." For example, January 2, 201~~1~~2, should be entered as 01-02-201~~1~~2.
3	M0300	M-10	**Coding Tips** • Do **not**~~NOT~~ code skin tears, tape burns, ~~perineal~~moisture associated skin damage ~~dermatitis, maceration~~, or excoriation~~, or suspected deep tissue injury~~ here. • When a ~~lesion that is related to~~ pressure ulcer presents as~~with~~ an intact blister, examine the adjacent and surrounding area for signs of deep tissue injury. When a deep tissue injury **is** determined, do **not**~~NOT~~ code as a Stage 2.
3	M0300	M-11	**Steps for Assessment** 2. For the purposes of coding, determine that the lesion being assessed is primarily related to pressure and that other conditions have been ruled out. If pressure is ~~NOT~~ **not** the primary cause, do ~~NOT~~ **not** code here.
3	M0300	M-12	**Examples** 1. A pressure ulcer described as a Stage 2 was noted and documented in the resident's medical record on admission. On a later assessment, the wound is noted to be a full thickness

Chapter	Section	Page	Change
			ulcer without exposed bone, tendon, or muscle, thus it is now a Stage 3 pressure ulcer. Coding: The current Stage 3 pressure ulcer would be coded at M0300C1 as Code 1, and at M0300C2 as 0, not present on admission/entry or reentry. Rationale: The designation of "present on admission" requires that the pressure ulcer be at the same location and not have increased in numerical ~~worsened to a deeper anatomical~~ stage. This pressure ulcer worsened after admission. 2. A resident develops a Stage 2 pressure ulcer while at the nursing facility. The resident is hospitalized due to pneumonia for 8 days and returns with a Stage 3 pressure ulcer in the same location. Coding: The pressure ulcer would be coded at M0300C1 as Code 1, and at M0300C2 as 1, present on admission/entry or reentry. Rationale: Even though the resident had a pressure ulcer in the same anatomical location prior to transfer, because the pressure ulcer increased in numerical stage ~~it worsened~~ to ~~a~~ Stage 3 during hospitalization, it should be coded as a Stage 3, present on admission/entry or reentry.
3	M0300	M-13	3. On admission, the resident has three small Stage 2 pressure ulcers on her coccyx. Two weeks later, the coccyx is assessed. Two of the Stage 2 pressure ulcers have merged and the third has increased in numerical stage ~~worsened~~ to a Stage 3 pressure ulcer. Coding: The two merged pressure ulcers would be coded at M0300B1 as 1, and at M0300B2 as 1, present on admission/entry or reentry. The Stage 3 pressure ulcer would be coded at M0300C1 as 1, and at M0300C2 as 0, not present on admission/entry or reentry. Rationale: Two of the pressure ulcers on the coccyx have merged, but have remained at the same stage as they were at the time of admission; the one that increased in numerical stage to a Stage 3 ~~has increased in stage~~

Chapter	Section	Page	Change
			~~sinceadmission and hence~~ cannot be coded in M0300C2 as present on admission/entry or reentry since the Stage 3 ulcer was not present on admission/entry or reentry. 4. A resident developed two Stage 2 pressure ulcers during her stay; one on the coccyx and the other on the left lateral malleolus. At some point she is hospitalized and returns with two pressure ulcers. One is the previous Stage 2 on the coccyx, which has not changed; the other is a new Stage 3 on the left trochanter. The Stage 2 previously on the left lateral malleolus has healed. Coding: The Stage 2 pressure ulcer would be coded at M0300B1 as 1, and at M0300B2 as 0, not present on admission; the Stage 3 would be coded at M0300C1 as 1, and at M0300C2 as 1, present on admission/entry or reentry. Rationale: The Stage 2 pressure ulcer on the coccyx was present prior to hospitalization; the Stage 3 pressure ulcer developed during hospitalization and is coded in M0300C2 as present on admission/entry or reentry. The Stage 2 pressure ulcer on the left lateral malleolus has healed and is therefore no longer coded here but in Item M0900, Healed Pressure Ulcers.
3	M0300	M-14	**Steps for Assessment** 2. For the purposes of coding, determine that the lesion being assessed is primarily related to pressure and that other conditions have been ruled out. If pressure is **not**~~NOT~~ the primary cause, do **not**~~NOT~~ code here.
3	M0300	M-15	**Coding Tips** • Cartilage serves the same anatomical function as bone. Therefore, pressure ulcers that have exposed cartilage should be classified as a Stage 4.
3	M0300	M-16	PAGE LENGTH AND/OR PAGE NUMBER CHANGE
3	M0300	M-17	• Pressure ulcers that present as unstageable require care planning that includes, in the absence of ischemia, debridement of necrotic and dead tissue and restaging once this~~e necrotic~~ tissue is removed.
3	M0300	M-17	**Steps for Assessment** 1. Determine the number of pressure ulcers that are unstageable

Chapter	Section	Page	Change
			due to slough and/or eschar. **Coding Tips** • Pressure ulcers that are covered with slough and/or eschar should be coded as unstageable because the true anatomic depth of soft tissue damage (and therefore stage) cannot be determined. Only until enough slough and/or eschar is removed to expose the anatomic depth of ~~the~~ soft tissue damage~~layers~~ involved, can the stage of the wound be determined. • Once the pressure ulcer is debrided of slough and/or eschar such that the anatomic depth of soft tissue damage ~~tissues~~ involved can be determined, then code the ulcer for the reclassified stage. The pressure ulcer does not have to be completely debrided or free of all slough and/or eschar tissue in order for reclassification of stage to occur.
3	M0300	M-18	**Examples** 1. A resident is admitted with a sacral pressure ulcer that is 100% covered with black eschar. Coding: The pressure ulcer would be coded at M0300F1 as 1, and at M0300F2 as 1, present on admission/entry or reentry. Rationale: The pressure ulcer depth is not observable because the pressure ulcer~~it~~ is covered with eschar. This pressure ulcer ~~so it~~ is unstageable, and ~~. It~~ was present on admission. 2. A pressure ulcer on the sacrum was present on admission, and was 100% covered with black eschar. On the admission assessment, it was coded as unstageable and present on admission. The pressure ulcer is later debrided using conservative methods and after 4 weeks the ulcer has 50% to 75% eschar present. The assessor can now see that the damage extends down to the bone. Coding: The ulcer is reclassified as a Stage 4 pressure ulcer. On the subsequent MDS, it is coded at M0300D1 as 1, and at M0300D2 as 1, present on admission/entry or reentry. Rationale: After debridement, the pressure ulcer is no longer unstageable because bone is visible in the wound bed. Therefore, this ulcer can be classified as ~~it can be~~

Chapter	Section	Page	Change
			~~observed to be~~ a Stage 4 pressure ulcer and should be coded at M0300D. If ~~T~~this pressure ulcer has the largest surface area of all Stage 3 or 4 pressure ulcers for this resident, the pressure ulcer's dimensions would also be entered at M0610, Dimensions of Unhealed Stage 3 or 4 Pressure Ulcers or Unstageable Pressure Ulcer Due to Slough or Eschar ~~if this pressure ulcer has the largest surface area of all Stage 3 or 4 pressure ulcers for this resident~~. 3. Miss J. was admitted with one small Stage 2 pressure ulcer. Despite treatment, it is not improving. In fact, it now appears deeper than originally observed, and the wound bed is covered with slough. Coding: Code at M0300F1 as 1, and at M0300F2 as 0, not present on admission/entry or reentry. Rationale: The pressure ulcer depth is not observable because ~~the pressure ulcer~~it is ~~coded as unstageable due to~~ covered~~age of the wound bed by~~ with slough. This pressure ulcer is unstageable, and is ~~but~~ not coded in M0300F2 as present on admission/entry or reentry because it can no longer be coded as a Stage 2.
3	M0300	M-19	**Health-related Quality of Life** • Quality health care begins with prevention and risk assessment, and care planning begins with prevention. Appropriate care planning is essential in optimizing a resident's ability to avoid, as well as recover from, pressure (as well as all) wounds. Deep tissue injuries may sometimes indicate severe damage. Identification and management of ~~S~~suspected ~~D~~deep ~~T~~tissue ~~I~~injury (sDTI) is imperative.
3	M0300	M-19	**Steps for Assessment** 2. For the purposes of coding, determine that the lesion being assessed is primarily a result of pressure and that other conditions have been ruled out. If pressure is **not**~~NOT~~ the primary cause, do **not**~~NOT~~ code here. 3. Examine the area adjacent to, or surrounding, an intact blister for evidence of tissue damage. If the tissue adjacent to, or surrounding, the blister **does not show** signs of tissue damage (e.g., color change, tenderness, bogginess or firmness, warmth or coolness), do **not**~~NOT~~ code as a suspected ~~D~~deep ~~T~~tissue

Chapter	Section	Page	Change
			~~I~~injury. 5. Determine the number of pressure ulcers that are unstageable related to suspected ~~D~~deep ~~T~~tissue ~~I~~injury.
3	M0300	M-20	**Coding Instructions for M0300G** • Enter the number of unstageable pressure ulcers related to suspected deep tissue injury. Based on skin tone, the injured tissue area may present as a darker tone than the surrounding intact skin. These areas of discoloration are potentially areas of suspected deep tissue injury. **Coding Tips** • When a lesion due to pressure presents with an intact blister AND the surrounding or adjacent soft tissue does NOT have the characteristics of d~~D~~eep ~~T~~tissue ~~I~~injury, do **not**~~NOT~~ code here.
3	M0610	M-20	M0610: Dimensions of Unhealed Stage 3 or 4 Pressure Ulcers or Unstageable Pressure Ulcer Due to Slough and/or Eschar
3	M0610	M-21	M0610: Dimensions of Unhealed Stage 3 or 4 Pressure Ulcers or Unstageable Pressure Ulcer Due to Slough and/or Eschar (cont.)
3	M0610	M-21	**Steps for Assessment** *If the resident has **one or more** unhealed ~~(non-epithelialized)~~ Stage 3 or 4 pressure ulcers or an unstageable pressure ulcer due to slough and/or eschar, **identify the pressure ulcer with the largest surface area** (length × width) and record in centimeters. **Complete only if a pressure ulcer is coded in M0300C1, M0300D1, or M0300F1.** The Figure (right) illustrates the measurement process.* 1. Measurement is based on observation of the Stage 3, Stage 4, or unstageable pressure ulcer due to slough and/or eschar **after** the dressing and any exudate are removed. 3. Determine longest length (white arrow line) head to toe and greatest width (black arrow line) of each Stage 3, Stage 4, or unstageable pressure ulcer due to slough and/or eschar. 6. Measure every Stage 3, Stage 4, and unstageable pressure ulcer due to slough and/or eschar that is present. **The clinician must be aware of all pressure ulcers present in order to determine which pressure ulcer is the largest.** Use a skin tracking sheet or other worksheet to record the dimensions for

Chapter	Section	Page	Change
			each pressure ulcer. Select the largest one by comparing the surface areas (length x width) of each.
3	M0610	M-22	M0610: Dimensions of Unhealed Stage 3 or 4 Pressure Ulcers or Unstageable Pressure Ulcer Due to Slough and/or Eschar (cont.)
3	M0610	M-22	7. Considering **only** the largest Stage 3 or 4 pressure ulcer due to slough or eschar, determine the deepest area and record the depth in centimeters. To measure wound depth, moisten a sterile, cotton-tipped applicator with 0.9% sodium chloride (NaCl) solution or sterile water. Place the applicator tip in the deepest aspect of the ulcer and measure the distance to the skin level. If the depth is uneven, measure several areas and document the depth of the ulcer that is the deepest. If depth cannot be assessed due to slough and/or eschar, enter dashes in M0610C. 8. If two pressure ulcers occur on the same bony prominence and are separated, at least superficially, by skin, then count them as two separate pressure ulcers. ~~Classify the s~~Stage and measure each pressure ulcer separately.
3	M0610	M-22	**Coding Instructions for M0610 Dimensions of Unhealed Stage 3 or 4 Pressure Ulcers or Unstageable Due to Slough and/or Eschar** • Enter the current longest length of the largest Stage 3, Stage 4, or unstageable pressure ulcer due to slough and/or eschar in centimeters to one decimal point (e.g., 2.3 cm). • Enter the widest width in centimeters of the largest Stage 3, Stage 4, or unstageable pressure ulcer due to slough and/or eschar. Record the width in centimeters to one decimal point. • Enter the depth measured in centimeters of the largest Stage 3 or 4. Record the depth in centimeters to one decimal point. Note that depth cannot be assessed if wound bed is unstageable due to being covered with slough and/or eschar. If a pressure ulcer covered with slough and/or eschar is the largest unhealed pressure ulcer identified for measurement, enter dashes in item M0610C.
3	M0700	M-23	**Coding Instructions for M0700** • Code 1, ~~p~~Epithelial tissue: if the wound is superficial and is re-epithelializing.

Chapter	Section	Page	Change
			• Code 2, ~~g~~Granulation tissue: if the wound is clean (e.g., free of slough and eschar~~necrotic~~ tissue) and contains granulation tissue. • Code 3, ~~s~~Slough: if there is any amount of slough tissue present ~~and necrotic~~eschar tissue is absent. • Code 4, ~~n~~Necrotic tissue (eschar): if there is any ~~necrotic tissue (~~eschar~~)~~ tissue present. • Code 9, None of the above: if none of the above apply.
3	M0700	M-24	**Coding Tips and Special Populations** • ~~Stage 2 pressure ulcers should **not** be coded as having granulation, slough, or necrotic tissue as by definition~~ Stage 2 pressure ulcers~~they~~ by definition have partial-thickness ~~do not have this extent~~ loss of the dermis.~~of tissue damage~~ Granulation tissue, slough or eschar are not present in Stage 2 pressure ulcers. Therefore, Stage 2 pressure ulcers should **not** be coded as having granulation, slough, or eschar tissue and~~All Stage 2 pressure ulcers~~ should be **coded as 1** for this item. • If the wound bed is covered with a mix of different types of tissue, code for the most severe type. For example, if a mixture of necrotic tissue (eschar~~)~~ and slough) is present, code for ~~necrotic tissue (~~eschar~~)~~. • Code this item with **Code 9, None of the above**, in the following situations: ~~• Stage 1 pressure ulcer~~ ~~• Stage 2 pressure ulcer with intact blister~~ ~~• Unstageable pressure ulcer related to non-removable dressing /device~~ ~~• Unstageable pressure ulcer related to suspected deep tissue injury~~ — Stage 1 pressure ulcer — Stage 2 pressure ulcer with intact blister — Unstageable pressure ulcer related to non-removable dressing/device — Unstageable pressure ulcer related to suspected deep tissue injury
3	M0700	M-24	**Examples** 1. A resident has a Stage 2 pressure ulcer on the right ischial tuberosity that is healing and a Stage 3 pressure ulcer on the sacrum that is also healing with red granulation tissue that has

Chapter	Section	Page	Change
			filled 75% of the ulcer and epithelial tissue that has resurfaced 25% of the ulcer. Coding: Code M0700 as 2, ~~g~~Granulation tissue. Rationale: Coding for M0700 is based on the sacral ulcer, because it is the pressure ulcer with the most severe tissue type. Code 2, (Granulation tissue), is selected because this is the most severe tissue present in the wound. 2. A resident has a Stage 2 pressure ulcer on the right heel and no other pressure ulcers. Coding: Code M0700 as 1, ~~e~~Epithelial tissue. Rationale: Coding for M0700 is Code 1, (Epithelial tissue) because epithelial tissue is consistent with identification of this pressure ulcer as a Stage 2 pressure ulcer. 3. A resident has a pressure ulcer on the left trochanter that has 25% black eschar~~necrotic~~ tissue present, 75% granulation tissue present, and some epithelialization at the edges of the wound. Coding: Code M0700 as 4, ~~n~~Necrotic tissue (eschar). Rationale: Coding is for the most severe tissue type present, which is not always the majority of type of tissue. Therefore, Coding for M0700 is Code 4, [~~(~~Necrotic tissue (eschar)].
3	M0800	M-25	**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 ~~to a higher (deeper)~~ stage since the last assessment. Such tracking of pressure ulcers is consistent with good clinical care. **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.~~Pressure ulcers that degenerate or worsen to a higher (deeper) stage require a reevaluation of the interdisciplinary care plan.~~

Track Changes
from Chapter 3, Section M V1.09
to Chapter 3, Section M V1.10

Chapter	Section	Page	Change
3	M0800	M-25	**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 ~~higher (deeper)~~ 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.
3	M0800	M-26	2. For each current stage, count the number of current pressure ulcers that are new or have increased in numerical stage~~worsened~~ since the last MDS assessment was completed.
3	M0800	M-26	**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. • Coding worsening of unstageable pressure ulcers: — If a~~n~~ 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. However, if the pressure ulcer subsequently increases in numerical stage ~~it worsens~~after that assessment, it should be considered worsened~~included~~. — If a pressure ulcer was numerically ~~previously~~ staged ~~pressure ulcer~~and becomes unstageable due to slough or eschar, do not consider this pressure ulcer ~~de~~ 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. — If a pressure ulcer was ~~previously~~ numerically staged ~~pressure ulcer~~and becomes unstageable, and ~~then~~ 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~~, code it as such in this item~~.

Chapter	Section	Page	Change
			— 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. — If a pressure ulcer is acquired during a hospital admission, its stage should be coded on admission and ~~is~~ is considered ~~coded~~ as present on admission/entry or reentry. It ~~and~~ is **not** included or coded in ~~a count of~~ this item~~worsening pressure ulcers~~.
3	M0800	M-27	— If a pressure ulcer increases in numerical ~~worsens to a more severe~~ stage during a hospital admission, its stage should be coded on admission and is considered ~~should also be coded~~ as present on admission/entry or reentry. It is ~~and~~ **not** included or coded in ~~counts of worsening pressure ulcers~~ this item. While not included in ~~counts of worsening pressure ulcers~~ 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 ~~(worsens) to a higher (deeper) stage~~ and increases in numerical stage on a subsequent MDS assessment~~s~~, it would be considered as ~~then be included in counts of worsening pressure ulcers~~worsened and would be coded in this item. **Examples** 1. A resident has a pressure ulcer on the right ischial tuberosity that was Stage 2 on the previous MDS assessment and has now increased in numerical stage~~deteriorated (worsened)~~ to a Stage 3 pressure ulcer. Coding: Code M0800A as 0, M0800B as 1, and M0800C as 0. Rationale: The pressure ulcer was at a lesser numerical stage on the prior assessment. 2. A resident is admitted with an unstageable pressure ulcer on the sacrum, which is debrided and reclassified as a Stage 4 pressure ulcer 3 weeks later. The initial MDS assessment listed the pressure ulcer as unstageable. Coding: Code M0800A as 0, M0800B as 0, and M0800C as 0. Rationale: The unstageable pressure ulcer was present

Chapter	Section	Page	Change
			on the initial MDS assessment. After debridement it numerically staged as ~~was~~ a Stage 4 pressure ulcer. This is the first numerical staging since debridement and therefore, should not be considered or coded~~unted~~ as worsening on the MDS assessment. 3. A resident has previous medical record and MDS documentation of a Stage 2 pressure ulcer on the sacrum and a Stage 3 pressure ulcer on the right heel. Current skin care flow sheets indicate a Stage 3 pressure ulcer on the sacrum, a Stage 4 pressure ulcer on the right heel, as well as ~~nd~~ a new Stage 2 pressure ulcer on the left trochanter. Coding: Code M0800A as 1, M0800B as 1, and M0800C as 1. Rationale: M0800A would be coded 1 because the new Stage 2 pressure ulcer on the left trochanter was not present on the prior assessment. M0800B would be coded 1 and M0800C would be coded 1 for the increased numerical staging ~~worsening in pressure ulcer status (i.e. increased severity)~~ of both the sacrum and right heel pressure ulcers.
3	M0800	M-28	4. A resident develops a Stage 3 pressure ulcer while at the nursing home. The wound bed is subsequently covered with slough and is coded on the next assessment as unstageable due to slough. After debridement, the wound bed is clean and the pressure ulcer is reassessed and determined to still be ~~coded as~~a Stage 3 pressure ulcer. Coding: Code M0800A as 0, M0800B as 0, and M0800C as 0. Rationale: M0800B would be coded 0 because the numerical stage of the ~~current Stage 3~~ pressure ulcer is the same numerical stage as it was prior to the period it became unstageable.
3	M0900	M-28	**Health-related Quality of Life** • Pressure ulcers do not heal in a reverse sequence, that is, the body does not replace the types and layers of tissue (e.g., muscle, fat, and dermis) that were lost during ~~the~~ pressure ulcer development before they re-epithelialize. Stage 3 and 4 pressure ulcers fill with granulation tissue ~~(primarily endothelial cells, fibroblasts, collagen and extracellular matrix)~~. This r~~R~~eplacement tissue is never as strong as the tissue that was lost and hence is more prone to future

Chapter	Section	Page	Change
			breakdown.
3	M0900	M-29	**Planning for Care** • Pressure ulcers that heal require continued prevention interventions as the site is always at risk for future damage. • **Most Stage 2** pressure ulcers should heal within a reasonable timeframe (e.g. 60 days). Full thickness Stage 3 and 4 pressure ulcers may require longer healing times. • ~~Current c~~Clinical standards do not support reverse staging or backstaging as a way to document healing as it does not accurately characterize what is physiologically occurring as the ulcer heals. For example, over time, even though a Stage 4 pressure ulcer has been healing and contracting such that it is less deep, wide, and long, the tissues that were lost (muscle, fat, dermis) will never be replaced with the same type of tissue. Previous standards using reverse or backstaging would have permitted identification of th~~e~~is pressure ulcer as a Stage 3, then a Stage 2, and so on, ~~2 pressure ulcer~~ when it reached a depth consistent with these stages~~Stage 2 pressure ulcers~~. Clinical ~~urrent~~ standards now would require that this ~~it~~ ulcer continue to be documented as a Stage 4 pressure ulcer until it has completely healed. Nursing homes can document the healing of pressure ulcers using descriptive characteristics of the wound (i.e. depth, width, presence or absence of granulation tissue, etc.) or by using a validated pressure ulcer healing tool. Once a pressure ulcer has healed, it is documented as a healed pressure ulcer at its highest numerical stage – in this example, a healed Stage 4 pressure ulcer. For care planning purposes, this~~a~~ healed Stage 4 pressure ulcer w~~ill~~ould remain at increased risk for future breakdown or injury and would~~ill~~ require continued monitoring and preventative care. **Steps for Assessment** *Complete on all residents, including those without a current pressure ulcer. Look-back period for this item is the ARD of the prior assessment.* ***If no prior assessment (i.e., if this is the first OBRA or scheduled PPS assessment), do not complete this item. Skip to M1030.*** 1. Review medical records to identify whether any pressure ulcers that were noted on the prior MDS assessment have ~~completely closed~~ healed by the ARD (A2300) of the current assessment.

Track Changes
from Chapter 3, Section M V1.09
to Chapter 3, Section M V1.10

Chapter	Section	Page	Change
			2. Identify the deepest anatomical stage (see definition on page M-5) of each ~~resurfaced (or~~healed~~)~~ pressure ulcer.
3	M0900	M-30	~~*Complete on all residents (even if M0210 = 0)*~~ *Complete on **all** residents (**even if M0210 = 0**)*
3	M0900	M-30	**Coding Instructions for M0900B, C, and D.** • Enter the number of pressure ulcers that have healed since the last assessment for each Stage, 2 through 4.
3	M0900	M-30	**Coding Tips** • If the prior assessment documents that a pressure ulcer healed between MDS assessments, but another pressure ulcer occurred at the same anatomical location, do **not** consider this pressure ulcer as healed. The re-opened pressure ulcer should be staged at its highest numerical stage until fully healed.
3	M10300	M-31	**Coding Instructions** ***Check all that apply** in the last 7 days.* *Pressure ulcers coded in M0210 through M0900 should **not**~~*NOT*~~ be coded here.*
3	M1030 & M1040	M-32	PAGE LENGTH AND/OR PAGE NUMBER CHANGE
3	M1040	M-33	**Coding Instructions** ***Check all that apply** in the last 7 days. If there is no evidence of such problems in the last 7 days, check none of the above.* *Pressure ulcers coded in M0200 through M0900 should **not**~~*NOT*~~ be coded here.* • M1040A, ~~i~~Infection of the foot (e.g., cellulitis, purulent drainage) • M1040B, ~~d~~Diabetic foot ulcer(s) • M1040C, ~~o~~Other open lesion(s) on the foot (e.g., cuts, fissures)
3	M10400	M-34	• M1040D, ~~o~~Open lesion(s) other than ulcers, rashes, cuts (e.g., cancer lesion) • M1040E, ~~s~~Surgical wound(s) • M1040F, ~~b~~Burn(s)(second or third degree) • M1040G, ~~s~~Skin tear(s)

Chapter	Section	Page	Change
			• M1040H, Moisture Associated Skin Damage (MASD) (i.e., incontinence (IAD), perspiration, drainage) • M1040Z, ~~n~~None of the above were present
3	M1040	M-34	**Coding Tips** **M1040B Diabetic Foot Ulcers** • Do ~~NOT~~ **not** include pressure ulcers that occur on residents with diabetes mellitus here. For example, an ulcer caused by pressure on the heel of a diabetic resident is a pressure ulcer and not a diabetic foot ulcer. **M1040D Open Lesion Other than Ulcers, Rashes, Cuts** • Do ~~NOT~~ **not** code rashes, skin tears, cuts/lacerations here. Although not recorded on the MDS assessment, these skin conditions should be considered in the plan of care. **M1040E Surgical Wounds** • ~~Do not code pressure ulcers that have been surgically debrided as surgical wounds. They continue to be coded as pressure ulcers.~~Surgical debridement of a pressure ulcer does not create a surgical wound. Surgical debridement is used to remove necrotic or infected tissue from the pressure ulcer in order to facilitate healing. A pressure ulcer that has been surgically debrided should continue to be coded as a pressure ulcer.
3	M1040	M-35	M1040: Other Ulcers, Wounds and Skin Problems (cont.) • ~~This c~~Code~~ing is appropriate for~~ pressure ulcers that require ~~are~~ surgical~~ly~~ intervention for ~~repaired~~ closure with graft~~s~~ and/or flap procedures in this item (e.g. excision of pressure ulcer with myocutaneous flap). Once a pressure ulcer is excised and a graft and/or flap is applied, it is no longer considered a pressure ulcer, but a surgical wound. **M1040F Burns (Second or Third Degree)** • Do ~~NOT~~ **not** include first degree burns (changes in skin

Chapter	Section	Page	Change
			color only). ## M1040H Moisture Associated Skin Damage (MASD) • Moisture associated skin damage (MASD) is a result of skin damage caused by moisture rather than pressure. It is caused by sustained exposure to moisture which can be caused, for example, by incontinence, wound exudate and perspiration. It is characterized by inflammation of the skin, and occurs with or without skin erosion and/or infection. MASD is also referred to as incontinence-associated dermatitis and can cause other conditions such as intertriginous dermatitis, periwound moisture-associated dermatitis, and peristomal moisture-associated dematitis. Provision of optimal skin care and early identification and treatment of minor cases of MASD can help avoid progression and skin breakdown. ## Examples 1. A resident with diabetes mellitus presents with an ulcer on the heel that is due to pressure. Coding: This ulcer is not checked at M1040B. **This ulcer should be coded where appropriate under the Pressure Ulcers items (M0210-M0900).** Rationale: Persons with diabetes can still develop pressure ulcers. 2. A resident is readmitted from the hospital after myocutaneous flap surgery to ~~repair~~ excise and close his~~a~~ sacral pressure ulcer. Coding: Check M1040E, ~~(~~Surgical Wound~~(s))~~. Rationale: A surgical flap procedure was used to ~~repair~~close the resident's pressure ulcer. The pressure ulcer is now considered ~~s changes the coding to~~ a surgical wound. 3. Mrs. J. was reaching over to get a magazine off of her bedside table and sustained a skin tear on her wrist from the edge of the table when she pulled the magazine back towards her. Coding: Check M1040G, Skin Tear(s). Rationale: The resident sustained a skin tear while

Chapter	Section	Page	Change
			reaching for a magazine.
3	M1040	M-36	4. Mr. S. who is incontinent, is noted to have a large, red and excoriated area on his buttocks and interior thighs with serous exudate which is starting to cause skin glistening. Coding: Check M1040H, Moisture Associated Skin Damage (MASD). Rationale: Mr. S. skin assessment reveals characteristics of incontinence-associated dermatitis. 5. Mrs. F. complained of discomfort of her right great toe and when her stocking and shoe was removed, it was noted that her toe was red, inflamed and had pus draining from the edge of her nail bed. The podiatrist determined that Mrs. F. has an infected ingrown toenail. Coding: Check M1040A, Infection of the foot. Rationale: Mrs. F. has an infected right great toe due to an ingrown toenail. 6. Mr. G. has bullous pemphigoid and requires the application of sterile dressings to the open and weeping blistered areas. Coding: Check M1040D, Open lesion other than ulcers, rashes, cuts. Rationale: Mr. G. has open bullous pemphigoid blisters. 7. Mrs. A. was just admitted to the nursing home from the hospital burn unit after sustaining second and third degree burns in a house fire. She is here for continued treatment of her burns and for rehabilitative therapy. Coding: Check M1040F, Burns (second or third degree). Rationale: Mrs. A. has second and third degree burns, therefore, burns (second or third degree) should be checked.
3	M1200	M-37	**Coding Instructions** • M1200A, ~~p~~Pressure reducing device for chair • M1200B, ~~p~~Pressure reducing device for bed • M1200C, ~~t~~Turning/repositioning program • M1200D, ~~n~~Nutrition or hydration intervention to manage

Chapter	Section	Page	Change
			skin problems • M1200E, ~~p~~Pressure ulcer care • M1200F, ~~s~~Surgical wound care
3	M1200	M-38	• M1200G, ~~a~~Application of non-surgical dressings (with or without topical medications) other than to feet. Non-surgical dressings do not include Band-Aids. • M1200H, ~~a~~Application of ointments/medications other than to feet • M1200I, ~~a~~Application of dressings to feet (with or without topical medications) • M1200Z, ~~n~~None of the above were provided **Coding Tips** **M1200A/M1200B Pressure Reducing Devices** • Pressure reducing devices redistribute pressure so that there is some relief on or near the area of the ulcer. The appropriate reducing (redistribution) device should be selected based on the individualized needs of the resident. • Do **not** include egg crate cushions of any type in this category. • Do **not**~~NOT~~ include doughnut or ring devices in chairs.
3	M1200	M-39	**M1200E Pressure Ulcer Care** • Pressure ulcer care includes **any** intervention for treating pressure ulcers coded in **Current Number of Unhealed Pressure Ulcers at Each Stage** ~~item~~ **(M0300A-G)**. Examples may include the use of topical dressings, enzymatic, mechan~~em~~ical or surgical debridement, wound irrigations, negative pressure wound therapy (NPWT), and/or hydrotherapy. **M1200F Surgical Wound Care** • Does not include post-operative care following eye or oral surgery. • Surgical debridement of a pressure ulcer does not create a surgical wound. Surgical debridement is used to remove necrotic or infected tissue from the pressure ulcer in order to facilitate healing, and thus, any wound care associated with pressure ulcer debridement would be coded in

Chapter	Section	Page	Change
			M1200E, Pressure Ulcer Care. The only time a surgical wound would be created is if the pressure ulcer itself was excised and a flap and/or graft used to close the pressure ulcer. ~~continues to be coded as a pressure ulcer.~~ • Surgical wou~~l~~nd care may include any intervention for treating or protecting any type of surgical wound. Examples may include topical cleansing, wound irrigation, application of antimicrobial ointments, application of dressings of any type, suture/staple removal, and warm soaks or heat application. • Surgical wound care for pressure ulcers that require surgical intervention for closure (e.g., excision of pressure ulcer with flap and/or graft coverage) can be coded in this item, as once a pressure ulcer is excised and flap and/or graft applied, it is no longer considered a pressure ulcer, but a surgical wound.
3	M1200	M-40	**M1200G Application of Non-surgical Dressings (with or without Topical Medications) Other than to Feet** • Do **not** ~~NOT~~ code application of non-surgical dressings for pressure ulcer(s) other than to feet in this item; use **M1200E, Pressure Ulcer Care** ~~item (M1200E)~~. • Dressings do not have to be applied daily in order to be coded on the MDS assessment. If any dressing meeting the MDS definitions was applied even once during the 7-day look-back period, the assessor should check that MDS item. • This category may include but is not limited to: dry gauze dressings, dressings moistened with saline or other solutions, transparent dressings, hydrogel dressings, and dressings with hydrocolloid or hydroactive particles used to treat a skin condition, compression bandages, etc. Non-surgical dressings do **not** include adhesive bandages (e.g., BAND~~and~~ AID® bandages)~~ids~~. **M1200H Application of Ointments/Medications Other than to Feet** • Do **not**~~NOT~~ code application of ointments/medications (e.g. chemical or enzymatic debridement) for pressure ulcers here; use **M1200E, Pressure Ulcer Care**~~, item (M1200E)~~. • This category may include ointments or medications used

Chapter	Section	Page	Change
			to treat a skin condition (e.g., cortisone, antifungal preparations, chemotherapeutic agents). • Ointments/medications may include topical creams, powders, and liquid sealants used to treat or prevent skin conditions. • This category~~definition~~ does not include ointments used to treat non-skin conditions (e.g., nitropaste for chest pain, testosterone cream). **M1200I Application of Dressings to the Feet (with or without Topical Medications)** • Includes interventions to treat any foot wound or ulcer **other than a pressure ulcer**. • Do **not**~~NOT~~ code application of dressings to pressure ulcers on the foot, use **M1200E, Pressure Ulcer Care** ~~item (M1200E)~~. • Do not code application of dressings to the ankle. The ankle ~~is made up of two joints (ankle joint proper and subtalar joint) and~~ is not considered part of the foot.
3	M1200	M-41	PAGE LENGTH AND/OR PAGE NUMBER CHANGE
3	M1200	M-42	4. Mr. J. has a diagnosis of Advanced Alzheimer's and is totally dependent on staff for all of his care. His care plan states that he is to be turned and repositioned, per facility policy, every 2 hours. Coding: Do~~O~~ **not**~~NOT~~ check item M1200C.
3	M1200	M-42	PAGE LENGTH AND/OR PAGE NUMBER CHANGE
3	M1200	M-43	PAGE LENGTH AND/OR PAGE NUMBER CHANGE
3	M1200	M-44	PAGE LENGTH AND/OR PAGE NUMBER CHANGE
3	M1200	M-45	PAGE LENGTH AND/OR PAGE NUMBER CHANGE
3	M1200	M-46	PAGE LENGTH AND/OR PAGE NUMBER CHANGE
3	M1200	M-47	PAGE LENGTH AND/OR PAGE NUMBER CHANGE
3	M1200	M-48	• M0610 (Dimension of Unhealed Stage 3 or 4 Pressure Ulcers or Eschar), is **not**~~NOT~~ completed, as the resident has a Stage 2 pressure ulcer. • M0700 (Most severe tissue type for any pressure ulcer), Code 1 (Epithelial tissue). • M0800 (Worsening in pressure ulcer status since prior assessment (OBRA or scheduled PPS or Last Admission/Entry or Reentry)), M0800A, Code 1; M0800B, Code 0; M0800C, Code 0. This item is completed because

Chapter	Section	Page	Change
			the 14-Day PPS is **not**~~NOT~~ the first assessment since the most recent admission/entry or reentry. Therefore, A0310E=0. M0800A is coded 1 because the resident has a new Stage 2 pressure ulcer that was not present on the prior assessment. • M0900A (Healed pressure ulcers), Code 0. This is completed because the 14-Day PPS is **not**~~NOT~~ the first assessment since the most recent admission/entry or reentry. Therefore A0310E=0. Since there were no pressure ulcers noted on the 5-Day PPS assessment, this is coded 0, and skip to M1030.
3	M1200	M-49	Rationale: The resident had a formal assessment using the Braden scale and also had a head-to-toe skin assessment completed. Pressure ulcer risk was identified via formal assessment. On the 5-Day PPS assessment the resident's skin was noted to be intact, however, on the 14-Day PPS assessment, it was noted that the resident had a new Stage 2 pressure ulcer. Since the resident has had both a 5-day and 14-Day PPS completed, the 14-Day PPS would be coded 0 at A0310E. This is because the 14-Day PPS is **not**~~NOT~~ the first assessment since the most recent admission/entry or reentry. Since A0310E=0, items M0800 (Worsening in pressure ulcer status) and M0900 (Healed pressure ulcers) would be completed. Since the resident did not have a pressure ulcer on the 5-Day PPS and did have one on the 14-Day PPS, the new Stage 2 pressure ulcer is documented under M0800 (Worsening in pressure ulcer status). M0900 (Healed pressure ulcers) is coded as 0 because there were no pressure ulcers noted on the prior assessment (5-Day PPS). There were no other skin problems noted. However the resident, since she is at an even higher risk of breakdown since the development of a new ulcer, has preventative measures put in place with pressure redistribution devices for her chair and bed. She was also placed on a turning and repositioning program based on tissue tolerance. Therefore M1200A, M1200B, and M1200C were all checked. She also now requires ulcer care and application of a dressing to the coccygeal ulcer, so M1200E is also checked. M1200G (Application of nonsurgical dressings – with or without topical medications) would **not**~~**NOT**~~ be coded here because **any** intervention for treating pressure ulcers is coded in M1200E (Pressure ulcer care).
3	M1200	M-50	PAGE LENGTH AND/OR PAGE NUMBER CHANGE

Track Changes
from Chapter 3, Section M V1.09
to Chapter 3, Section M V1.10

Chapter	Section	Page	Change
3	M1200	M-51	PAGE LENGTH AND/OR PAGE NUMBER CHANGE
3	M1200	M-52	PAGE LENGTH AND/OR PAGE NUMBER CHANGE