

**Track Changes
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to Chapter 3 Section M v1.17.1**

Chapter	Section	Page	Change
3	M0300C	M-14	<p>DEFINITION</p> <p>STAGE 3 PRESSURE ULCER Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle is not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining or tunneling (see definition of undermining and tunneling on page M-17⁹).</p>
3	M1030	M-27	<p>Coding Instructions</p> <p><i>Check all that apply in the last 7 days.</i></p> <p><i>Pressure ulcers coded in M0210 through M0300 should not be coded here.</i></p>
3	—	M-39	<p>Example M0100-M1200</p> <p>1. Mrs. P was admitted to the nursing home on 10/23/2010⁹ for a Medicare stay. In completing the PPS 5-day assessment (ARD of 10/28/2019), it was noted that the resident had a head-to-toe skin assessment and her skin was intact, but upon assessment using the Braden scale, was found to be at risk for skin breakdown. On the 14-day PPS (ARD of 11/5/2010), † The resident was noted to have a Stage 2 pressure ulcer that was identified on her coccyx on 11/1/2010⁹. This Stage 2 pressure ulcer was noted to have pink tissue with some epithelialization present in the wound bed. Dimensions of the ulcer were length 01.1 cm, width 00.5 cm, and no measurable depth. Mrs. P does not have any arterial or venous ulcers, wounds, or skin problems. She is receiving ulcer care with application of a dressing applied to the coccygeal ulcer. Mrs. P. also has pressure reducing devices on both her bed and chair and has been placed on a 1½ hour turning and repositioning schedule per tissue tolerance. In order to stay closer to her family, Mrs. P was discharged to another nursing home on 11/5/2019. This was a planned discharge (A0310G = 2), and her OBRA Discharge assessment was coded at A0310F as 10, Discharge assessment – return not anticipated.</p> <p>5-Day PPS #1:</p>

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3	—	M-40	<p>Deleted following screenshots:</p> <div> <div> <div>M1030. Number of Venous and Arterial Ulcers</div> <div> <div>Enter Number</div> <div>0</div> </div> <div>Enter the total number of venous and arterial ulcers present</div> </div> <div> <div>M1040. Other Ulcers, Wounds and Skin Problems</div> <div> <div>↓ Check all that apply</div> <div> <div>Foot Problems</div> <div> <input type="checkbox"/> A. Infection of the foot (e.g., cellulitis, purulent drainage) <input type="checkbox"/> B. Diabetic foot ulcer(s) <input type="checkbox"/> C. Other open lesion(s) on the foot </div> <div>Other Problems</div> <div> <input type="checkbox"/> D. Open lesion(s) other than ulcers, rashes, cuts (e.g., cancer lesion) <input type="checkbox"/> E. Surgical wound(s) <input type="checkbox"/> F. Burn(s) (second or third degree) <input type="checkbox"/> G. Skin tear(s) <input type="checkbox"/> H. Moisture Associated Skin Damage (MASD) (e.g., incontinence-associated dermatitis [IAD], perspiration, drainage) </div> <div>None of the Above</div> <div> <input checked="" type="checkbox"/> Z. None of the above were present </div> </div> </div> </div> <div> <div>M1200. Skin and Ulcer/Injury Treatments</div> <div> <div>↓ Check all that apply</div> <div> <input type="checkbox"/> A. Pressure reducing device for chair <input type="checkbox"/> B. Pressure reducing device for bed <input type="checkbox"/> C. Turning/repositioning program <input type="checkbox"/> D. Nutrition or hydration intervention to manage skin problems <input type="checkbox"/> E. Pressure ulcer/injury care <input type="checkbox"/> F. Surgical wound care <input type="checkbox"/> G. Application of nonsurgical dressings (with or without topical medications) other than to feet <input type="checkbox"/> H. Applications of ointments/medications other than to feet <input type="checkbox"/> I. Application of dressings to feet (with or without topical medications) <input checked="" type="checkbox"/> Z. None of the above were provided </div> </div> </div> </div>

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3	—	M-40	<p>14-Day PPS Discharge Assessment:</p> <p>Coding:</p> <ul style="list-style-type: none"> • M0100A (Resident has a pressure ulcer/injury, a scar over bony prominence, or a non-removable dressing/device), Check box. • M0100B (Formal assessment instrument), Check box. • M0100C (Clinical assessment), Check box. • M0150 (Risk of Pressure Ulcers/Injuries), Code 1. • M0210 (One or more Unhealed Pressure Ulcers/Injuries), Code 1. • M0300A (Number of Stage 1 pressure ulcers), Code 0. • M0300B1 (Number of Stage 2 pressure ulcers), Code 1. • M0300B2 (Number of these Stage 2 pressure ulcers present on admission/entry or reentry), Code 0. • M0300C1 (Number of Stage 3 pressure ulcers), Code 0 and skip to M0300D (Stage 4). • M0300D1 (Number of Stage 4 pressure ulcers), Code 0 and skip to M0300E (Unstageable – Non-removable dressing/device). • M0300E1 (Unstageable – Non-removable dressing/device), Code 0 and skip to M0300F (Unstageable – Slough and/or eschar). • M0300F1 (Unstageable – Slough and/or eschar), Code 0 and skip to M0300G (Unstageable – Deep tissue injury). • M0300G1 (Unstageable – Deep tissue injury), Code 0 and skip to M1030 (Number of Venous and Arterial Ulcers). • M1030 (Number of Venous and Arterial Ulcers), Code 0. • M1040 (Other Ulcers, Wounds and Skin Problems), Check Z (None of the above). • M1200A (Pressure reducing device for chair), M1200B (Pressure reducing device for bed), M1200C (Turning/repositioning program), and M1200E (Pressure ulcer/injury care) are all checked.

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3	—	M-40	<p>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. has a pressure ulcer. On the 5-day PPS assessment, the resident's skin was noted to be intact; however, on the 14-day PPS PPS Discharge assessment, it was noted that the resident had a new Stage 2 pressure ulcer. Since the resident has had both a 5-day PPS and 14-day PPS PPS Discharge assessment completed, the 14-day PPS PPS Discharge assessment would be coded 0 at A0310E. This is because the 14-day PPS PPS Discharge assessment is not the first assessment since the most recent admission/entry or reentry. 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, had preventative measures put in place, with pressure reducing devices for her chair and bed. She was also placed on a turning and repositioning program based on tissue tolerance. Therefore, items 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 be coded here because any intervention for treating pressure ulcers is coded in M1200E (Pressure ulcer/injury care).</p>

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3	—	M-40	<p>Deleted following screenshot:</p> <p>The screenshot shows a series of assessment forms for pressure ulcers. M0100. Determination of Pressure Ulcer/Injury Risk: A form with checkboxes for 'A. Resident has a pressure ulcer/injury, a scar over bony prominence, or a non-removable dressing/device', 'B. Formal assessment instrument/tool (e.g., Braden, Norton, or other)', 'C. Clinical assessment', and 'Z. None of the above'. M0150. Risk of Pressure Ulcers/Injuries: A form with an 'Enter Code' field containing '1' and a question 'Is this resident at risk of developing pressure ulcers/injuries?' with options '0. No' and '1. Yes'. M0210. Unhealed Pressure Ulcers/Injuries: A form with an 'Enter Code' field containing '1' and a question 'Does this resident have one or more unhealed pressure ulcers/injuries?' with options '0. No' and '1. Yes'. M0300. Current Number of Unhealed Pressure Ulcers/Injuries at Each Stage: A form with multiple sections for different stages of ulcers. Each section has an 'Enter Number' field and a description of the stage. 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'. The 'Enter Number' field contains '0'. 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'. The 'Enter Number' field contains '1'. 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'. The 'Enter Number' field contains '0'. 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'. The 'Enter Number' field contains '0'. Unstageable - Non-removable dressing/device: 'Known but not stageable due to non-removable dressing/device'. The 'Enter Number' field contains '0'. Unstageable - Slough and/or eschar: 'Known but not stageable due to coverage of wound bed by slough and/or eschar'. The 'Enter Number' field contains '0'. Unstageable - Deep tissue injury: 'Known but not stageable due to coverage of wound bed by slough and/or eschar'. The 'Enter Number' field contains '0'. M0300 continued on next page: A note at the bottom of the form.</p>
3	—	M-40	<p>Deleted following screenshot:</p> <p>The screenshot shows the continuation of the M0300 form. M0300. Current Number of Unhealed Pressure Ulcers/Injuries at Each Stage - Continued: Unstageable - Non-removable dressing/device: 'Known but not stageable due to non-removable dressing/device'. The 'Enter Number' field contains '0'. Unstageable - Slough and/or eschar: 'Known but not stageable due to coverage of wound bed by slough and/or eschar'. The 'Enter Number' field contains '0'. Unstageable - Deep tissue injury: 'Known but not stageable due to coverage of wound bed by slough and/or eschar'. The 'Enter Number' field contains '0'. M0300 continued on next page: A note at the bottom of the form.</p>

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M1200. Skin and Ulcer/Injury Treatments

↓ Check all that apply

☒ A. Pressure reducing device for chair
☒ B. Pressure reducing device for bed
☒ C. Turning/repositioning program
☐ D. Nutrition or hydration intervention to manage skin problems
☒ E. Pressure ulcer/injury care
☐ F. Surgical wound care
☐ G. Application of nonsurgical dressings (with or without topical medications) other than to feet
☐ H. Applications of ointments/medications other than to feet
☐ I. Application of dressings to feet (with or without topical medications)
☐ Z. None of the above were provided