Objectives

- Review key components of pressure ulcer risk assessment.
- Discuss the new pressure ulcer staging.
- Describe how to measure pressure ulcers.
- Discuss importance of interdisciplinary collaboration for wound differentiation.
- Code Section M correctly and accurately.

Major Changes to Section M1

- Risk assessment
- Staging
  - No more “reverse” staging
  - Deepest pressure ulcer
  - Worsening pressure ulcer(s)
  - Separate items for unstageable and suspected Deep Tissue Injury (sDTI) pressure ulcers

Major Changes to Section M2

- Pressure ulcer present on admission/reentry
- Date of oldest Stage 2 pressure ulcer
- Dimensions in centimeters as actually measured
- Type of tissue in the wound bed

Clinical/ Administrative Interface

- Look at your systems
  - Clinical/administrative intersection
  - Who does the data collection and how does it flow?
  - How is documentation done? Who is responsible?
- Review your current:
  - Pressure ulcer policies and guidelines
  - Process for pressure ulcer risk
  - Process for developing and implementing a care plan for at risk residents
Clinician Skills Needed

- Risk assessment
- New pressure ulcer staging
- Ulcer measurement
  - Using instrument according to CMS guidelines.
- Wound identification
  - Etiology of the wound is paramount.
  - Requires interdisciplinary collaboration.
  - Consider the whole person and underlying etiology.

NPUAP Pressure Ulcer Definition

- CMS has adapted the NPUAP 2007 definition of a pressure ulcer as well as categories/staging.
- A pressure ulcer is a localized injury to the skin and/or underlying tissue usually over a bony prominence, as a result of pressure or pressure in combination with shear and/or friction.

Items M0100 & M0150

Determination of Pressure Ulcer Risk

Risk of Pressure Ulcers

Pressure Ulcer Risk Factors

- Immobility and decreased functional ability
- Co-morbid conditions (ESRD, thyroid, diabetes)
- Drugs such as steroids
- Impaired diffuse or localized blood flow
- Resident refusal of care and treatment

Pressure Ulcer Risk Factors2

- Cognitive impairment
- Exposure of skin to urinary and fecal incontinence
- Undernutrition, malnutrition, and hydration deficits
- Healed pressure ulcer that has closed
  - Higher risk of opening up due to damage, injury, or pressure
  - Due to loss of tensile strength of the overlying tissue
  - Tensile strength of skin overlaying a closed pressure ulcer only 80% of normal skin

Is This Evidence of a Risk Factor?
Healed PU = Risk of PU

Ulcer healed in 3 months
Presented with Stage 4 ulcer

M0100 Determination of Pressure Ulcer Risk

- Reflects multiple approaches for determining a resident’s risk for developing a pressure ulcer.
  - Presence or indicators of pressure ulcers
  - Assessment using a formal tool
  - Physical examination of skin and/or medical record

M0100A Risk Factors

- Non-Removable Device
- Healed (Closed) Pressure Ulcer
- Non-Removable Dressing

M0100B Formal Assessment/ Tools

- Braden Scale:
  - www.bradenscale.org
  - www.hartfordign.org

- Norton Scale

M0100C Clinical Assessment

- Observe the resident’s skin.
- Review the medical record.
- Imperative to determine etiology of all wounds and lesions.
- Consider using mnemonics that capture key risk factors.
  - HALT© is one example.

HALT©

- H – History of pressure ulcer/ patient events
  - Immobility
  - Decreased functional ability
  - Undernutrition, malnutrition hydration deficits
- A – Associated diagnoses/ co-morbidities
  - Advancing age
  - Medications (e.g. steroids)
  - Hemodynamic instability, blood flow impairment
  - ESRD, thyroid disease
  - Diastolic pressure below 60
**HALT®<sup>2</sup>**

- **L** – Look at the skin
- **T** – Touch the skin
  - Temperature changes of the skin
  - Exposure to incontinence

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**M0150 Risk of Pressure Ulcers**

- Determine if resident is at risk for pressure ulcers.
- Recognize/evaluate each resident’s risk factors.
- Identify/evaluate all areas at risk of constant pressure.
- Determine if resident is at risk.

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**Item M0210**

Unhealed Pressure Ulcer(s)

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**M0210 Unhealed Pressure Ulcers Coding Instructions**

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**Item M0300**

Current Number of Unhealed Pressure Ulcer(s) at Each Stage

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**Pressure Ulcer Staging is Within Scope of Nursing Practice**

- Skin assessment part of health status.
- Skin assessment includes:
  - Differentiating from other wounds
  - Staging
- Determine nursing care needs and plan of care.

Lyder, DH, Krasner, DL, Ayello, EA. (2010). Clarification from the American Nurses Association on the Nurse’s role in pressure ulcer staging®. Advances in Skin and Wound Care. 23(1):8-10

New Staging Definitions

- Resources:
  - www.npuap.org
  - Free diagrams of ulcer stages can be downloaded for educational use.
- CMS has adapted these definitions.

M0300 Guidelines

1. Determine deepest anatomical stage of each pressure ulcer.
2. Identify unstageable pressure ulcers.
3. Determine “present on admission.”

M0300 Guidelines

- Do not reverse stage.
- Consider current and historical levels of tissue involvement.
- Do not code lesions not primarily related to pressure.
- Initial numerical staging 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 palpated, i.e. visible tissue, palpable bone) during the look-back period.

Item M0300A

Number of Stage 1 Pressure Ulcers

- Document number of Stage 1 pressure ulcers.
- Stage 1 pressure ulcers may deteriorate without adequate intervention.
- They are an important risk factor for further tissue damage.

M0300A Number of Stage 1 Pressure Ulcers

- Perform a head-to-toe, full body skin assessment.
- Focus on bony prominences and pressure-bearing areas, such as:
  - Sacrum
  - Heels
  - Buttocks
  - Ankles
### M0300A Conduct the Assessment

- Check any reddened areas for ability to blanch.
  - Firmly press finger into tissue then remove
  - Non-blanchable: no loss of skin color or pressure-induced pallor at the compressed site
- Search for other areas of skin that differ from surrounding tissue.
  - Painful
  - Soft
  - Firm
  - Warmer or cooler
  - Color change

### M0300A Assessment Guidelines

- Assessment to determine staging should be holistic.
- Stage 1 may be difficult to detect in individuals with dark skin tones.
- Determine whether an ulcer is a Stage 1 pressure ulcer or suspected deep tissue injury.
- Do not rely on only one descriptor as the descriptors for these two types of ulcers are similar.
- Code pressure ulcers with intact skin that are suspected deep tissue injury in M0300G Unstageable Pressure Ulcers Related to Suspected Deep Tissue Injury.

### Category/ Stage 1 Pressure Ulcer

- Intact skin with non-blanchable redness of a localized area usually over a bony prominence.
- Darkly pigmented skin may not have visible blanching.
- Color may differ from the surrounding area.

### Is this a Stage 1 Pressure Ulcer?

- This is moisture associated skin damage from incontinence.
- Do not document in M0300A.

### Not a Stage 1 Pressure Ulcer

- This is moisture associated skin damage from incontinence.
- Do not document in M0300A.

### Item M0300B

**Stage 2 Pressure Ulcers**
**Category/ Stage 2 Pressure Ulcer**

- **Partial thickness** loss of dermis presenting as:
  - Shallow open ulcer
  - Red or pink wound bed
  - Without slough

**Category/ Stage 2 Pressure Ulcer**

- May also present as an intact or open/ruptured blister.

**Category/ Stage 2 Pressure Ulcer**

- Do **NOT** code as a Stage 2 when a deep tissue injury is determined.
- Code in M0300G Unstageable Pressure Ulcers Related to Suspected Deep Tissue Injury.
- Clearly document assessment findings in the resident's medical record.
- Facilities may adapt NPUAP guidelines in their clinical practice and nursing documentation.

**M0300B Conduct the Assessment**

- Perform a head-to-toe, full body skin assessment.
- Focus on bony prominences and pressure-bearing areas.
- Examine the area adjacent to or surrounding any intact blister for evidence of tissue damage.
- Determine if lesion being assessed is primarily related to pressure.
- Rule out other conditions.
- Do not code here if pressure is not the primary cause.

**M0300B Assessment Guidelines**

- Assessment to determine staging should be holistic.
- Determine if tissue adjacent to or surrounding the blister demonstrates signs of tissue damage:
  - Color change
  - Bogginess or firmness
  - Tenderness
  - Warmth or coolness

**M0300B Assessment Guidelines**

- Stage 2 ulcers will **generally** lack the surrounding characteristics found with a deep tissue injury.
- Blood-filled blisters related primarily to pressure are more likely than serous filled blisters to be associated with a suspected deep tissue injury.
- Ensure, again, a complete, and comprehensive, assessment of the resident and the site of injury.
- Do **not** code skin tears, tape burns, perineal dermatitis, maceration, exoriation, or suspected deep tissue injury in M0300B.
M0300B Stage 2 Pressure Ulcers Coding Instructions

1. Number of Stage 2 pressure ulcers
2. Number of Stage 2 pressure ulcers present upon admission/reentry
   - Number of pressure ulcers first noted at time of admission
   - Number of pressure ulcers acquired during a hospital stay if being readmitted
3. Date of oldest Stage 2 pressure ulcer
   - Code suspected deep tissue injury at M0300G.

Pressure Ulcer Blister

1. What steps should you take to assess this?
2. How would this be coded?

Blood - Filled Blister

1. What steps should you take to assess this?
2. How would this be coded?

Blisters from Burns

1. What steps should you take to assess this?
2. How would this be coded?

Items M0300C & M0300D

Stage 3 Pressure Ulcers/Stage 4 Pressure Ulcers

M0300C Conduct the Assessment

- Perform a head-to-toe, full body skin assessment.
- Focus on bony prominences and pressure-bearing areas.
- Determine if lesion being assessed is primarily related to pressure.
  - Rule out other conditions.
  - Do not code here if pressure is not the primary cause.
Category/ Stage 3 Pressure Ulcer

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

M0300C Stage 3 Pressure Ulcers Coding Instructions

1. Number of Stage 3 pressure ulcers
   - Identify all Stage 3 pressure ulcers currently present.
2. Number of Stage 3 pressure ulcers present upon admission/ reentry
   - Code the number of pressure ulcers first noted at time of admission.
   - Code number of pressure ulcers acquired during a hospital stay if being readmitted.

Category/ Stage 4 Pressure Ulcer

- 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.
- Depth varies by anatomical location (bridge of nose, ear, occiput, and malleous ulcers can be shallow).

M0300D Stage 4 Pressure Ulcers Coding Instructions

1. Number of Stage 4 pressure ulcers
2. Number of Stage 4 pressure ulcers present upon admission/ reentry

M0300A - D Scenario #1

- A pressure ulcer described as a Stage 2 was noted and documented in the resident’s medical record at the time of admission.
- On a later assessment, the wound is noted to be a full thickness ulcer.
- Thus it is now a Stage 3 pressure ulcer.

M0300A - D Scenario #1 Coding

- Code M0300C1. Number of Stage 3 pressure ulcers as 1.
- Code M0300C2 as 0 (not present on admission).
- The designation of “present on admission” requires that the pressure ulcer be at the same location and not have worsened to a deeper anatomical stage.
- This pressure ulcer worsened after admission.
**M0300A - D Scenario #2**

- 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.
- The third has worsened to a Stage 3 pressure ulcer.

**M0300A - D Scenario #2 Coding1**

- Code the two merged pressure ulcers:
  - M0300B1. Number of Stage 2 pressure ulcers as 1.
  - M0300B2 as 1 present upon admission.
- Two of the pressure ulcers on the coccyx have merged.
- They have remained at the same stage as they were at the time of admission.

**M0300A - D Scenario #2 Coding2**

- Code the Stage 3 pressure ulcer:
  - M0300C1. Number of Stage 3 pressure ulcers as 1.
  - M0300C2 as 0 (not present on admission).
- The pressure ulcer has increased to a Stage 3 since admission.
- Therefore, it cannot be coded as present on admission.

**M0300A - D Scenario #3**

- A resident develops a Stage 2 pressure ulcer while at the nursing facility.
- The resident is hospitalized due to pneumonia for 8 days.
- The resident returns with a Stage 3 pressure ulcer in the same location.

**M0300A - D Scenario #3 Coding**

- Code M0300C1 Number of Stage 3 pressure ulcers as 1.
- Code M0300C2 as 1 present on admission.
- Even though the resident had a pressure ulcer in the same anatomical location prior to transfer, because it worsened to a Stage 3 during hospitalization, it should be coded as a Stage 3, present on admission.

**Item M0300E/M0300F/M0300G**

Unstageable Pressure Ulcers
Unstageable Pressure Ulcers

- Three types to differentiate
- Number of these unstageable pressure ulcers present upon admission/reentry

M0300E Unstageable Non-Removable Device

- Ulcer covered with eschar under plaster cast
- Known but not stageable because of the non-removable device

M0300E Unstageable Non-Removable Dressing

- Known but not stageable because of the non-removable dressing

M0300F Unstageable Slough and/or Eschar

- Known but not stageable related to coverage of wound bed by slough and/or eschar
- Full thickness tissue loss
- Base of ulcer covered by slough (yellow, tan, gray, green or brown) and/or eschar (tan, brown or black) in the wound bed

M0300G Unstageable Suspected Deep Tissue Injury

- Localized area of discolored (darker than surrounding tissue) intact skin
- Related to damage of underlying soft tissue from pressure and/or shear
- Area of discoloration may be preceded by tissue that is painful, firm, mushy, boggy, warmer or cooler as compared to adjacent tissue
- Deep tissue injury may be difficult to detect in individuals with dark skin tones

M0300G Unstageable Suspected Deep Tissue Injury2

- Quality health care begins with prevention and risk assessment
- 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
**M0300G Unstageable Suspected Deep Tissue Injury**

- Clearly document assessment findings in the resident’s medical record.
- Track and document appropriate wound care planning and management.
- Deep tissue injuries can indicate severe damage.
- Identification and management is imperative.

**M0300E, M0300F, M0300G Coding Instructions**

- Code number of each type of pressure ulcer.
- Code number of each type of ulcer present upon admission/reentry.
- Do not code M0300G when a lesion related to pressure presents with an intact blister and the surrounding or adjacent soft tissue does not have the characteristics of Deep Tissue Injury.
- Code under M0300B Unhealed Pressure Ulcers -- Stage 2.

**M0300E - G Scenario #1**

- 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.

**M0300E – G Scenario #1 Coding**

- Reclassify as a Stage 4 pressure ulcer.
- On the subsequent MDS:
  - Code M0300D1 Number of Stage 4 pressure ulcers as 1.
  - Code M0300D2 as 1 present on admission.
- After debridement, the pressure ulcer is no longer unstageable because it can be observed to be a Stage 4 pressure ulcer.
- Enter this pressure ulcer’s dimensions at M0610 if it has the largest surface area of all Stage 3 or Stage 4 pressure ulcers for this resident.

**M0300E – G Scenario #2**

- 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.
- The wound bed is covered with slough.

**M0300E – G Scenario #2 Coding**

- Code M0300F1 Number of unstageable pressure ulcers related to coverage of wound bed by slough and/ or eschar as 1.
- Code M0300F2 as 0 not present on admission.
- The pressure ulcer is coded as unstageable due to coverage of the wound bed by slough.
- It is not coded as present on admission because it can no longer be coded as a Stage 2.
Pressure Ulcer Staging Quiz

Pressure Ulcer Quiz #1
- Stage 1
- Stage 2
- Stage 3
- Stage 4
- Unstageable - slough or eschar
- Unstageable - sDTI

Pressure Ulcer Quiz #2
- Stage 1
- Stage 2
- Stage 3
- Stage 4
- Unstageable - slough or eschar
- Unstageable - sDTI

Pressure Ulcer Quiz #3
- Stage 1
- Stage 2
- Stage 3
- Stage 4
- Unstageable - slough or eschar
- Unstageable - sDTI

Pressure Ulcer Quiz #4
- Stage 1
- Stage 2
- Stage 3
- Stage 4
- Unstageable - slough or eschar
- Unstageable - sDTI

Pressure Ulcer Quiz #5
- Stage 1
- Stage 2
- Stage 3
- Stage 4
- Unstageable - slough or eschar
- Unstageable - sDTI
Pressure Ulcer Quiz #6
- Stage 1
- Stage 2
- Stage 3
- Stage 4
- Unstageable - slough or eschar
- Unstageable - sDTI

Pressure Ulcer Quiz #7
- Stage 1
- Stage 2
- Stage 3
- Stage 4
- Unstageable - slough or eschar
- Unstageable - sDTI

Pressure Ulcer Quiz #8
- Stage 1
- Stage 2
- Stage 3
- Stage 4
- Unstageable - slough or eschar
- Unstageable - sDTI

Pressure Ulcer Quiz #9
- Stage 1
- Stage 2
- Stage 3
- Stage 4
- Unstageable - slough or eschar
- Unstageable - sDTI

Item M0610
Dimensions of Unhealed Stage 3 or 4 Pressure Ulcers or Unstageable Pressure Ulcer Due to Slough or Eschar

Dimensions of a Pressure Ulcer
What to Measure
- Identify pressure ulcer with the largest surface area from the following:
  - Unhealed (nonepithelialized) Stage 3 or 4
  - Unstageable pressure ulcer related to slough or eschar
- Measure every Stage 3, Stage 4, and unstageable related to slough or eschar pressure ulcer to determine the largest.
M0610A Length
- Measure the longest length from head to toe using a disposable device.

M0610B Width
- Measure widest width of the pressure ulcer side to side perpendicular (90° angle) to length.
- The depth of this pressure ulcer is 3.7 cm.

M0610C Depth
- Moisten a cotton-tipped applicator with 0.9% sodium chloride (NaCl) solution or sterile water.
- Place applicator tip in deepest aspect of the wound and measure distance to the skin level.

M0700 Most Severe Tissue Type for Any Pressure Ulcer
- Determine type(s) of tissue in the wound bed.
- Code for most severe type of tissue present in pressure ulcer wound bed.
- Code for most severe type if wound bed is covered with a mix of different types of tissue.
M0700 Scenario #1

- A resident has a Stage 2 pressure ulcer on the right ischial tuberosity that is healing.
- The resident has a Stage 3 pressure ulcer on the sacrum that is also healing with red granulation tissue that has filled 75% of the ulcer and epithelial tissue that has resurfaced 25% of the ulcer.

M0700 Scenario #1 Coding

- Code M0700 Most Severe Tissue Type for Any Pressure Ulcer as 2. Granulation tissue.
- 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.
M0700 Scenario #2

A resident has a pressure ulcer on the left trochanter that has:
- 25% black necrotic tissue present
- 75% granulation tissue present
- Some epithelialization at the edges of the wound

M0700 Scenario #2 Coding

- Code M0700 as 4. Necrotic tissue (Eschar).
- Coding is for the most severe tissue type present.
- This is not always the majority of type of tissue.
- Therefore, code M0700 as 4. Necrotic tissue.

Item M0800

Worsening in Pressure Ulcer Status Since Prior Assessment (OBRA, PPS, or Discharge)

M0800 Assessment Guidelines

- Complete only if this is not the first assessment since the most recent admission (A0310E = 0).
- Look-back period is back to the ARD of the prior assessment.

M0800 Coding Instructions

- Enter the number of pressure ulcers that:
  - Were not present.
  - Were at a lesser stage on prior assessment.
- Code 0 if:
  - No pressure ulcers have worsened.
  - There are no new pressure ulcers.

M0800 Scenario #1

- A resident is admitted with an unstageable pressure ulcer on the sacrum.
- The pressure ulcer is debrided and reclassified as a Stage 4 pressure ulcer 3 weeks later.
- The initial MDS assessment listed the pressure ulcer as unstageable.
**M0800 Scenario #1 Coding**

- Code M800A Stage 2 as \(0\).
- Code M800B Stage 3 as \(0\).
- Code M800C Stage 4 as \(0\).

The unstageable pressure ulcer was present on the initial MDS assessment.
- After debridement, it was a Stage 4.
- This is the first staging since debridement and should not be counted as worsening on the MDS assessment.

**M0800 Scenario #2**

- 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:
  - Stage 3 pressure ulcer on the sacrum
  - Stage 4 pressure ulcer on the right heel
  - Stage 2 pressure ulcer on the left trochanter

**M0800 Scenario #2 Coding**

- Code M0800A Stage 2 as \(1\).
- Code M0800B Stage 3 as \(1\).
- Code M0800C Stage 4 as \(1\).

M0800A is coded \(1\) because the new Stage 2 pressure ulcer on the left trochanter was not present on the prior assessment.
- M0800B and M0800C are coded \(1\) for the worsening in pressure ulcer status (i.e. increased severity) of the sacrum and right heel pressure ulcers.

**Item M0900**

**Healed Pressure Ulcers**

Complete only if this is not the first assessment since the most recent admission (A0310E=0).
Item M1030

Number of Venous and Arterial Ulcers

M1030 Conduct the Assessment

- Review the medical record.
  - Skin care flow sheet or other skin tracking form
- Speak with direct care staff and treatment nurse.
  - Confirm conclusions from the medical record review.
- Examine the resident.

Venous Ulcers

- Wound may start due to minor trauma.
- Usual location is lower leg area or medial or lateral malleolus.
- Characterized by:
  - Irregular wound edges
  - Hemosiderin staining
  - Leg edema

Arterial Ulcers$_1$

- Wound may start due to minor trauma.
- Usual location:
  - Toes
  - Top of foot
  - Distal to medial malleolus

Arterial Ulcers$_2$

- Characterized by:
  - Necrotic tissue or pale pink wound bed
  - Diminished or absent pulses
- Trophic skin changes:
  - Dry skin
  - Loss of hair
  - Brittle nails
  - Muscle atrophy

M1030 Coding Instructions

- Enter the total number of venous and arterial ulcers present.
Item M1040 & M1200

Other Ulcers, Wounds and Skin Problems

Skin and Ulcer Treatments

M1040/ M1200 Conduct the Assessment

- Review the medical record.
  - Skin care flow sheet or other skin tracking form
  - Treatment records and orders for documented treatments in the look-back period
- Speak with direct care staff and treatment nurse.
  - Confirm conclusions from the medical record review.
- Examine the resident.
  - Determine if ulcers, wounds, or skin problems are present.
  - Observe skin treatments.

M1040B Diabetic Foot Ulcers

M1040D Open Lesions Other than Ulcers, Rashes, Cuts

M1040E Surgical Wounds

M1040F Burns
- Pressure-relieving devices do not include:
  - Egg crate cushions of any type
  - Doughnut or ring devices in chairs
- Turning/repositioning program
  - Specific approaches for changing resident’s position and realigning the body
  - Program should specify intervention and frequency
- Nutrition and hydration
  - High calorie diets with added supplements to prevent skin breakdown
  - High protein supplements for wound healing

• Turning/repositioning program
  - Specific approaches for changing resident’s position and realigning the body
  - Program should specify intervention and frequency

• Nutrition and hydration
  - High calorie diets with added supplements to prevent skin breakdown
  - High protein supplements for wound healing

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**M1200E Ulcer Care**

- Check all that apply
  - A. Pressure-relieving device for chair
  - B. Pressure-relieving device for bed
  - C. Turning/repositioning program
  - D. Nutrition and hydration interventions to manage skin problems
  - E. Ulcers
  - F. Surgical wound care
  - G. Application of non-surgical dressings (with or without topical medications) other than feet
  - H. Application of antibiotics/medications other than feet
  - I. Application of dressings to feet (with or without topical medications)
  - J. Name of Dressings were provided

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**Initial Presentation Then Went for Surgical Debridement**

- Initial presentation then went for surgical debridement.
- Slough returned after surgical debridement.
- Used enzyme for maintenance debridement.
- Used Negative Pressure Wound Therapy (NPWT).
M1040 Scenario #1

- A resident with diabetes mellitus presents with an ulcer on the heel that is due to pressure.

M1040 Scenario #1 Coding

- This ulcer is not checked at M1040B.
- This ulcer should be coded where appropriate under the Pressure Ulcer items (M0210-M0900).
- Persons with diabetes can still develop pressure ulcers.

M1040 Scenario #2

- A resident is readmitted from the hospital after flap surgery to repair a sacral pressure ulcer.

M1040 Scenario #2 Coding

- Check M1040E. Surgical Wound(s).
- A surgical flap procedure to repair pressure ulcers changes the coding to a surgical wound.

M1200 Scenario #1

- A resident has a venous ulcer on the right leg.
- During the past 7 days the resident has had a three-layer compression bandaging system applied once.
- Orders are to reapply the compression bandages every 5 days.
- The resident also has a pressure redistributing mattress and pad for the wheelchair.
**Minimum Data Set (MDS) 3.0 Section M August 2010**

### M1200 Scenario #1 Coding

- **Check items:**
  - M1200A Pressure reducing device for chair
  - M1200B Pressure reducing device for bed
  - M1200G Application of nonsurgical dressings

- **Treatments include pressure reducing (redistribution) mattress and pad in the wheelchair and application of the compression bandaging system.**

### M1200 Scenario #2

- **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.**

### M1200 Scenario #2 Coding

- **Do not check item M1200C. Turning/ Repositioning Program.**

- **Treatments provided do not meet the criteria for a turning/ repositioning program.**

- **There is no notation in the medical record about an assessed need for turning/ repositioning, nor is there a specific approach or plan related to positioning and realigning of the body.**

- **There is no reassessment of the resident’s response to turning and repositioning.**

- **There are not any skin or ulcer treatments being provided.**

### Acknowledgements

- **Photos provided by:**
  - Jane Fore MD, FAPWCA, FACCWS
  - Stanley K. McCallon, PT, DPT
  - Dot Weir RN, CWON, CWS
  - Cindy Labish, RN, MS, CWOCN

### Section M Scenario Instructions

- **Turn to Section M in the MDS 3.0 item set.**

- **Review the Section M scenario.**

- **Code the MDS for the three assessments in the scenario:**
  - Admission assessment
  - Quarterly #1 assessment
  - Quarterly #2 assessment