



Better Health Care for All Floridians

MDS 3.0 Coding of Section M

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Objectives

- Identify major changes in Section M
- Identify clinical skills needed
- Review National Pressure Ulcer Advisory Panel (NPUAP) 2007
- Review correct and accurate coding

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Major Changes in Section M

- Risk assessment
- Staging- new definitions
 - No more reverse staging
 - Deepest pressure ulcer
 - Worsening pressure ulcer
 - Unstageable/DTI separate items

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Major Changes in Section M

- Pressure ulcer present admission/reentry
- Date of oldest stage 2 pressure ulcer
- Dimension in centimeters
- Type of tissue

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Clinical Skills Needed

- Risk Assessment
- New pressure ulcer staging
- Ulcer measurement
- Wound identification

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NPUAP Pressure Ulcer Definition

- CMS has adopted 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.

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Determination of Risk

- Presence or indicators of pressure ulcers
- Assessment using a formal tool
- Physical examination of skin and /or medical record

M0100 Determination of Pressure Ulcer Risk

M0100

M0100. Determination of Pressure Ulcer Risk	
↓ Check all that apply	
<input type="checkbox"/>	A. Resident has a stage 1 or greater, a scar over bony prominence, or a non-removable dressing/device
<input type="checkbox"/>	B. Formal assessment instrument/tool (e.g., Braden, Norton, or other)
<input type="checkbox"/>	C. Clinical assessment
<input type="checkbox"/>	Z. None of the above



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Assessment Tools

- Definition: Screening tools that are designed to help identify residents who might develop a pressure ulcer. Common risk assessment tools are:
 - Braden Scale
 - Norton Scale
 - Other Institution Scales

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Clinical Assessment

- It is important to recognize and evaluate each resident's risk factors and to identify and evaluate all areas at risk of constant pressure.

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Clinical Assessment

- Would include the following risk factors:
 - Impaired/decreased mobility and functional ability
 - Co-morbid conditions, ESRD, DM, Thyroid disease
 - Drugs, such as steroids, that may effect wound healing
 - Impaired diffuse or localized blood flow

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Clinical Assessment

- Resident refusal of care
- Cognitive impairment
- Urinary and fecal incontinence
- Under nutrition, malnutrition and/or hydration deficits
- Healed Stage 3 or 4 ulcers, which are more likely to reoccur

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Unhealed Pressure Ulcers

- Code based on the presence of any pressure ulcer (regardless of stage) in the last 7 days.
 - Each ulcer is coded only once
 - If surgically repaired, it is coded as a surgical wound (if graft fails, continue to code a surgical wound)

Current number of Unhealed Pressure Ulcers at Each Stage

- Determine Deepest Anatomical Stage
 - Observe the base of the ulcer to determine the depth of tissue layers involved
 - Do not reverse or back stage (consider current and historical levels of tissue involvement)
 - ❖ *If a pressure ulcer has ever been classified at a deeper stage than what is observed now, it should be classified at the deeper stage, based on history in the record*



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Coding Stage 1

- Pressure ulcers with suspected deep tissue injury should **not** be coded as Stage 1 pressure ulcers

Definition: Non-blanchable – Reddened areas of tissue that do not turn white or pale when firmly pressed with a finger. Dark pigmented skin may not blanch.

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Coding Stage 2

- A Stage 2 pressure ulcer presents as a shiny or dry shallow ulcer without slough or bruising. This stage should not be used to describe skin tears, perineal dermatitis, maceration, excoriation, or suspected deep tissue injury.

- ❖ Do not leave date boxes empty, use leading zeros if necessary, and enter dashes in every box if date is unknown

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Coding Stage 3

- Definition – Full thickness skin loss involving damage to, or necrosis of, subcutaneous tissue that may extend down to, but not through, underlying fascia. The ulcer presents clinically as a deep crater with or without undermining of adjacent tissue.

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Coding Stage 3

- Stage 3 pressure ulcers can be shallow, particularly on areas that do not have subcutaneous tissue, such as the bridge of the nose, ear, occiput, and malleolus.
- In contrast, areas of significant adiposity can develop extremely deep Stage 3 pressure ulcers.
- Bone/tendon/muscle is not visible or directly palpable in a Stage 3 pressure ulcer.

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Coding Examples

- A pressure ulcer was noted in the medical record at the time of admission. It was described as a Stage 2. On a later assessment, the wound is noted to be a full thickness ulcer, thus it is now a Stage 3 pressure ulcer.
- **Coding: Not present on admission**
- A resident develops a Stage 2 pressure ulcer while at the nursing home. The resident is hospitalized and returns with a Stage 3 pressure ulcer in the same location.
- **Coding: Stage 3, present on admission**

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Coding Examples

- On admission, the resident has three small Stage 2 pressure ulcers on the coccyx. Two weeks later, the coccyx is assessed. Two of the Stage 2 pressure ulcers have merged and the third has worsened to a Stage 3 pressure ulcer.
- **Coding: Stage 2, present on admission; Stage 3 not present on admission**
- A resident developed two Stage 2 pressure ulcers during a stay. At some point they are hospitalized and returns with two pressure ulcers. One is a Stage 2 on the coccyx and the other is a Stage 3 on the left trochanter.
- **Coding: Stage 2, not present on admission; Stage 3 present on admission**

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Coding Stage 4

- Definition – Full thickness skin loss with extensive destruction, tissue necrosis, or damage to muscle, bone, or supporting structures (e.g., tendon, joint capsule). Undermining and tunneling also may be associated with Stage 4 pressure ulcers.

Coding Stage 4

- The depth of a Stage 4 pressure ulcer can vary depending on location
- Stage 4 pressure ulcers can extend into muscle and/or supporting structures
- Exposed bone/tendon/muscle is visible or directly palpable

Unstageable Pressure Ulcers

- Three types to differentiate
- Number of the **E. Unstageable - Non-removable dressing:** present upon admission/

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

1. Number of unstageable pressure ulcers due to non-removable dressing/device - If 0 → Skip to M0300F, Unstageable: Slough and/or eschar.

2. Number of these ulcers noted at the time of admission

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 - If 0 → Skip to M0300G, Unstageable: Deep tissue

2. Number of these ulcers noted at the time of admission

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

1. Number of unstageable pressure ulcers with suspected deep tissue injury in evolution - If 0 → Skip to M0610, Dimension of Unhealed Stage 3 or 4 Pressure Ulcers or Eschar

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

Unstageable Pressure Ulcers due to Non-removable Dressing

- Enter the number of unstageable pressure ulcers due to non-removable dressing/device that were first noted at the time of admission **AND** for residents who are being readmitted after a hospital stay – that were acquired during hospitalization.

Unstageable Pressure Ulcers due to Slough and/or Eschar

- **Definitions:**

- Slough Tissue - Necrotic/avascular tissue in the process of separating from the viable portions of the body; usually light colored, soft, moist, and stringy.
- Eschar Tissue - Thick, Leathery, frequently black, brown, necrotic (dead) or devitalized tissue that has lost its usual physical properties and biological activity. Eschar may be loose or firmly adhered to the wound.

Unstageable Pressure Ulcers due to Suspected Deep Tissue Injury

- Deep tissue injury may indicate the subsequent development of a Stage 3 or 4 pressure ulcer even with optimal treatment.
- Suspected deep tissue injury require vigilant monitoring because of the potential for rapid deterioration. Such monitoring should be charted and care planned.



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Unstageable Pressure Ulcers due to Suspected Deep Tissue Injury

- Once suspected deep tissue injury has opened to an ulcer, reclassify the ulcer into the appropriate stage. Then code the ulcer for the reclassified stage.
- Deep tissue injury may be difficult to detect in individuals with dark skin tones. Evolution may include a thin blister over a dark wound bed. The wound may further evolve and become covered by thin eschar. Evolution may be rapid, exposing additional layers of tissue even with optimal treatment.

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Dimensions of Unhealed or Unstageable Stage 3 or 4 Pressure Ulcers

- If the resident has one or more unhealed (non-epithelialized) Stage 3 or 4 pressure ulcers or an unstageable pressure ulcer due to slough or eschar, identify the pressure ulcer with the largest surface area (length × width) and record in centimeters including depth if known, if not code dashes.

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Dimensions of Unhealed or Unstageable Stage 3 or 4 Pressure Ulcers Coding

- Position the resident in a consistent neutral position for wound measurement.
- Select a uniform, consistent method for measuring wound length and width to facilitate meaningful comparisons of wound measurements across time.
- Assessments of the pressure ulcer for tunneling and undermining is an important part of the complete pressure ulcer assessment, that is not recorded on the MDS.

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Most Severe Tissue Type for Any Pressure Ulcer

M0700. Most Severe Tissue Type for Any Pressure Ulcer

Enter Code <input type="text"/>	Select the best description of the most severe type of tissue present in any pressure ulcer bed <ol style="list-style-type: none"> 1. Epithelial tissue - new skin growing in superficial ulcer. It can be light pink and shiny, even in persons with darkly pigmented skin 2. Granulation tissue - pink or red tissue with shiny, moist, granular appearance 3. Slough - yellow or white tissue that adheres to the ulcer bed in strings or thick clumps, or is mucinous 4. Necrotic tissue (Eschar) - black, brown, or tan tissue that adheres firmly to the wound bed or ulcer edges, may be softer or harder than surrounding skin
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Option 1.

1. **Epithelial tissue** - new skin growing in superficial ulcer. It can be light pink and shiny, even in persons with darkly pigmented skin

M0700. Most Severe Tissue Type for Any Pressure Ulcer

Enter Code

Select the best description of the most severe type of tissue present in any pressure ulcer bed.

1. **Epithelial tissue** - new skin growing in superficial ulcer. It can be light pink and shiny, even in persons with darkly pigmented skin
2. **Granulation tissue** - pink or red tissue with shiny, moist, granular appearance
3. **Slough** - yellow or white tissue that adheres to the ulcer bed in strings or thick clumps, or is mucinous
4. **Necrotic tissue (Eschar)** - black, brown, or tan tissue that adheres firmly to the wound bed or ulcer edges, may be softer or harder than surrounding skin

Option 2.

2. **Granulation tissue** - pink or red tissue with shiny, moist, granular appearance

M0700. Most Severe Tissue Type for Any Pressure Ulcer

Enter Code

Select the best description of the most severe type of tissue present in any pressure ulcer bed.

1. **Epithelial tissue** - new skin growing in superficial ulcer. It can be light pink and shiny, even in persons with darkly pigmented skin
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4. **Necrotic tissue (Eschar)** - black, brown, or tan tissue that adheres firmly to the wound bed or ulcer edges, may be softer or harder than surrounding skin

Option 3.

3. **Slough** - yellow or white tissue that adheres to the ulcer bed in strings or thick clumps, or is mucinous

M0700. Most Severe Tissue Type for Any Pressure Ulcer

Enter Code

Select the best description of the most severe type of tissue present in any pressure ulcer bed

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Option 4.

4. **Necrotic tissue (Eschar)** - black, brown, or tan tissue that adheres firmly to the wound bed or ulcer edges, may be softer or harder than surrounding skin

M0700. Most Severe Tissue Type for Any Pressure Ulcer

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Select the best description of the most severe type of tissue present in any pressure ulcer bed

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Coding Tips

- All Stage 2 pressure ulcers should be **coded as 1** for this item.
- Stage 2 pressure ulcers should **not** be coded with granulation, slough, or necrotic tissue.
- If wound bed is covered with a mix of different tissue, code the **most severe** type.

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Worsening in Status Since Prior Assessment

- Look-back period for this item is back to the ARD of the prior assessment. If there is no prior assessment, do not complete this item.

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Healed Pressure Ulcers

- Definition – Completely closed, fully epithelialized, covered completely with epithelial tissue, or resurfaced with new skin, even if the area continues to have some surface discoloration.
- If the prior assessment documents that a pressure ulcer healed between MDS assessments, but another pressure ulcer occurred at the same location, do not consider the first pressure ulcer to have healed, and do **not** record the pressure ulcer as healed.

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Number of Venous & Arterial Ulcers

- Definition - Venous Ulcers: Ulcers caused by peripheral venous disease, which most commonly occur proximal to the medial or lateral malleolus, above the inner or outer ankle, or on the lower calf area of the leg.
- Coding tip: The wound may start with some kind of minor trauma. The wound does not typically occur over a bony prominence, and pressure forces play virtually no role in the development of the ulcer.

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Number of Venous & Arterial Ulcers

- Definition - Arterial Ulcers: Ulcers caused by peripheral arterial disease, which commonly occur on the tips of toes, top of the foot, or distal to the medial malleolus.
- Coding tip: Trophic skin changes (e.g., dry skin, loss of hair growth, muscle atrophy, brittle nails) may also be present. The wound may start with some kind of minor trauma. The wound does not typically occur over a bony prominence, and pressure forces play virtually no role in the development of the ulcer. Lower extremities and foot pulses may be diminished or absent.

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Other Ulcers, Wounds and Skin Problems

- Definition - Diabetic Foot Ulcers: Ulcers caused by the neuropathic and small blood vessel complications of diabetes. Diabetic foot ulcers typically occur over the plantar surface of the foot on load bearing areas. Ulcers are usually deep, with necrotic tissue, moderate exudate, and callused wound edges. The wounds are very regular in shape and the edges are even with a punched-out appearance. These wounds are typically not painful.

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Other Ulcers, Wounds and Skin Problems

- Coding Tip:
- Diabetic neuropathy affects the lower extremities of individuals with diabetes. They can have decreased awareness of pain in their feet. This means that they are at high risk for foot injury, due to decreased circulation and sensation, and awareness of the wound.

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Other Ulcers, Wounds and Skin Problems

- Coding Tip:
- Neuropathy can also cause changes in the structure of the bones and tissue in the foot. This means that they experience pressure on the foot in areas not meant to bear pressure.

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Other Ulcers, Wounds and Skin Problems

- Coding Tip:
- Do **not** include pressure ulcers that occur on residents with DM here, an ulcer caused by pressure on the heel of a diabetic resident is a pressure ulcer and not a diabetic foot ulcer.

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Other Ulcers, Wounds and Skin Problems

- Surgical wounds: Any healing and non-healing, open or closed surgical incisions, skin grafts or drainage sites on any part of the body.
- Do **not** include stomas, PICC sites, central or peripheral sites.
- Do **not** include surgical debridement of pressure ulcers.
- Coding **is** appropriate for pressure ulcers that are surgically repaired with grafts and flap procedures.

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Other Ulcers, Wounds and Skin Problems

- Open Lesion Other Than Ulcers, Rashes, Cuts: Most typically skin ulcers that develop as a result of disease and conditions such as syphilis and cancer.
- Do **not** code skin tears, cuts, or abrasions here. Although not recorded on the MDS assessment, these open lesions need to be addressed in the care plan.

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Other Ulcers, Wounds and Skin Problems

- Burns (second and third degree): Skin and tissue injury caused by heat or chemicals and may be in any stage of healing.
- Do **not** include first degree burns (changes in skin color only)

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Skin and Ulcer Treatments

- Code equipment that aims to relieve pressure including: pressure relieving, pressure reducing, and pressure redistributing devices.
- Do **not** include egg crate cushions of any type.
- Do **not** include doughnut or ring devices.

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Skin and Ulcer Treatments

- Turning/Repositioning Programs: Must be specific as to the approaches for changing the resident's position and realigning the body. The program should specify the interventions and frequency. Progress notes, assessments, and other documentation should support that the program is monitored and reassessed to determine the effectiveness of the intervention.

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Skin and Ulcer Treatments

- **Ulcer Care:** Includes any intervention for treating pressure ulcers coded in “Current Number of Unhealed Pressure ulcers at Each Stage” **M0300** (e.g., topical dressings, chemical or surgical debridement, wound irrigations, wound vacuum assisted closure, and/or hydrotherapy).

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Skin and Ulcer Treatments

- **Surgical Wound Care:** Do not include post-operative care following eye or oral surgery.
- Surgical debridement continues to be coded as a pressure ulcer.
- Surgical wound care may include any intervention for treating or protecting any type of surgical wound.

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Skin and Ulcer Treatments

- Application of non-surgical dressing other than to feet.
- Application of Ointments/Medications other than to feet.
- Applications of Dressings to the feet.
Interventions to treat any foot wound or ulcer, other than pressure.

QUESTIONS ?

