Track Changes
from Chapter 3 Section M v1.17.1
to Chapter 3 Section M v1.18.11

Chapter	Section	Page(s) in version 1.18.11	Change
3	—	—	Updated language throughout to be gender neutral.
3	—	—	Updated screen captures of all items.
3	M0210	M-5	**Coding Tips** • If an ulcer/injury arises from a combination of factors that are primarily caused by pressure, then the area should be included in this section as a pressure ulcer/injury. • ~~Oral~~ Mucosal ulcers caused by pressure should not be coded in Section M. ~~These~~Oral mucosal ulcers are captured in item L0200C, Abnormal mouth tissue.
3	M0210	M-6	• If two pressure ulcers/injuries occur on the same bony prominence and are separated, at least superficially, by skin, then count them as two separate pressure ulcers/injuries. Stage and measure each pressure ulcer/injury separately. • If a resident had a pressure ulcer/injury that healed during the look-back period of the current assessment, do not code the ulcer/injury on the assessment. • Skin changes at the end of life (SCALE), also referred to as Kennedy Terminal Ulcers (KTUs) and skin failure, are not primarily caused by pressure and are not coded in Section M.
3	M0300	M-7	*For each pressure ulcer, determine the deepest anatomical stage. At admission, code based on findings from the first skin assessment that is conducted on or after and as close to the admission as possible. Do not reverse or back stage. Consider current and historical levels of tissue involvement.*

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3	M0300	M-7	1. Ulcer staging should be based on the ulcer's deepest anatomic soft tissue damage that is visible or palpable. 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). 3. Review the history of each pressure ulcer in the medical record. If the stageable pressure ulcer has ever been classified at a higher numerical stage than what is observed now, it should continue to be classified at the higher numerical stage until healed unless it becomes unstageable. Nursing homes that carefully document and track pressure ulcers will be able to more accurately code this item. [Note: divided bullet #2 into bullets #2 and #3; renumbered subsequent bullets]

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3	M0300	M-7–M-8	5. Clinical standards do not support reverse staging or back-staging as a way to document healing, as it does not accurately characterize what is occurring physiologically 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 staging or back-staging would have permitted identification of such a pressure ulcer as a Stage 3, then a Stage 2, and so on, when it reached a depth consistent with these stages. Clinical standards now would require that this ulcer continue to be documented as a Stage 4 pressure ulcer until it has completely healed unless it becomes unstageable. 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 healed Stage 4 pressure ulcer would remain at increased risk for future breakdown or injury and would require continued monitoring and preventative care. 6. A previously closed pressure ulcer that opens again should be reported at its worst stage, unless currently presenting at a higher stage or unstageable.
3	M0300	M-8	1. Visualization of the wound bed is necessary for accurate staging. 2. If, after careful cleansing of the pressure ulcer/injury, a pressure ulcer's/injury's anatomical tissues ~~remain~~are obscured such that the extent of soft tissue damage cannot be observed or palpated, the pressure ulcer/injury is considered unstageable.

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3	M0300	M-8	3. Pressure ulcers that have eschar (tan, black, or brown) or slough (yellow, tan, gray, green or brown) tissue present such that the anatomic depth of soft tissue damage cannot be visualized or palpated in the wound bed, should be classified as unstageable, as illustrated at ~~http://www.npuap.org/wp-content/uploads/2012/03/NPUAP-Unstage2.jpg~~. https://npiap.com/page/PressureInjuryStages 4. 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. 5. A pressure injury with intact skin that is a deep tissue injury (DTI) should not be coded as a Stage 1 pressure injury. It should be coded as unstageable, as illustrated at ~~http://www.npuap.org/wp-content/uploads/2012/03/NPUAP-SuspectDTI.jpg~~ https://npiap.com/page/PressureInjuryStages. 6. Known pressure ulcers/injuries covered by a non-removable dressing/device (e.g., primary surgical dressing, cast) should be coded as unstageable. "Known" refers to when documentation is available that says a pressure ulcer/injury exists under the non-removable dressing/device.
3	M0300	M-9	9. If a pressure ulcer was numerically staged, then became unstageable, and is subsequently debrided sufficiently to be numerically staged, compare its numerical stage before and after it was unstageable. If the numerical stage has increased, code this pressure ulcer as **not present on admission.** 10. If a resident has a pressure ulcer/injury that was documented on admission then closed that reopens at the same stage (i.e., not a higher stage), the ulcer/injury **is coded as "present on admission."** [Note: added bullet #10; renumbered subsequent bullet]
3	M0300–M1200	M-16–M-44	Page length changed due to revised content.

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3	M0300C	M-16	**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 ulcer without exposed bone, tendon, or muscle, thus it is now a Stage 3 pressure ulcer in the same location. **Coding:** The admission coding would be **M0300B1 as 1, and M0300B2 as 1, present upon admission/entry or reentry.** On the current assessment, the coding for the Stage 2 data elements would be **M0300B1 as 0 and M0300B2 is skipped since there is no longer a Stage 2 pressure ulcer.** The ~~current~~ Stage 3 pressure ulcer currently assessed would be coded at **M0300C1 as 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 stage or become unstageable due to slough or eschar. This pressure ulcer worsened from Stage 2 to Stage 3 after admission. **M0300C1 is coded as 1 and M0300C2 is coded as 0 on the current assessment** because the ulcer was not a Stage 3 pressure ulcer on admission.

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3	M0300C	M-16	2. A resident develops a Stage 2 pressure ulcer while at the nursing facility. The resident is discharged to an acute-care hospital and was hospitalized. ~~due to pneumonia for 8 days and~~ The resident returns to the nursing facility with a Stage 3 pressure ulcer in the same location. **Coding:** The Stage 3 pressure ulcer, assessed on reentry, would be coded at **M0300C1 as 1, and at M0300C2 as 1, present on admission/entry or reentry.** **Rationale:** ~~Even though t~~The resident ~~had a pressure ulcer in the same anatomical location prior to transfer, because the pressure ulcer increased in numerical stage to Stage 3 during hospitalization, it should be coded as Stage 3, present on admission/entry or reentry.~~ developed a Stage 2 pressure ulcer while at the nursing facility. This is a "facility acquired" pressure ulcer and was not "present on admission." The resident is hospitalized and returns with a pressure ulcer in the same location, which has now worsened to a Stage 3. Although the pressure ulcer was originally acquired in the nursing facility it is coded as "present on admission/entry or reentry," because it increased in numerical stage while the resident was in the hospital.

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3	M0300C	M-17	3. On admission, the resident has three small Stage 2 pressure ulcers on ~~her~~their 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 to a Stage 3 pressure ulcer. **Coding:** The admission coding would be **M0300B1 as 3, and M0300B2 as 1, present on admission/entry or reentry.** On the subsequent assessment, 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:** On the subsequent assessment, ~~T~~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; therefore, **M0300B1 and M0300B2 would be coded as 1**; the pressure ulcer that increased in numerical stage to a **Stage 3 is coded in M0300C1 as 1 and in M0300C2 as 0**, not present on admission/entry or reentry since the Stage 3 ulcer was not present on admission/entry or reentry and developed a deeper level of tissue damage in the time since admission.

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3	M0300C	M-17	4. A resident was admitted with no pressure ulcers/injuries and developed two Stage 2 pressure ulcers during ~~her~~their stay; one on the coccyx and the other on the left lateral malleolus. At some point ~~she~~they ~~is~~are hospitalized and return~~s~~ 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:** On admission, the resident had no pressure ulcers/injuries. The two Stage 2 pressure ulcers developed during the stay and are coded at **M0300B1 as 2 and M0300B2 as 0** when the resident is discharged to the hospital. On return from the hospital, ~~T~~the **Stage 2** pressure ulcer on the coccyx, that was present prior to the resident's discharge, would be coded at **M0300B1 as 1, and at M0300B2 as 0, not present on admission/entry or reentry; the Stage 3** pressure ulcer identified upon reentry is new and would be coded **at M0300C1 as 1, and at M0300C2 as 1, present on admission/entry or reentry.** **Rationale:** The Stage 2 pressure ulcers that were facility acquired are coded as not present on admission when the resident is discharged to the hospital. When the resident returns to the facility, the Stage 2 pressure ulcer on the coccyx was present prior to hospitalization and therefore would be not be considered as present on reentry. ~~; t~~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~~on the assessment.

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3	M0300C	M-18	5. A resident is admitted to a nursing facility with a short leg cast to the right lower extremity. ~~He~~They ~~has~~have no visible wounds on admission but arrives with documentation that a pressure ulcer/injury exists under the cast. Two weeks after admission to the nursing facility, the cast is removed by the physician. Following ~~the~~ removal of the cast, ~~the right heel is observed and assessed as~~ a Stage 3 pressure ulcer is observed on the right heel, which remains until the subsequent assessment. **Coding:** On admission, code **M0300E1 and M0300E2 as 1, present on admission, entry or reentry.** On subsequent assessment, ~~C~~code **M0300C1 as 1**, and **M0300C2 as 1**, present on admission/entry or reentry. **Rationale:** ~~The resident was admitted with a documented unstageable pressure ulcer/injury due to non-removable dressing/device. The cast was removed, and a Stage 3 pressure ulcer was assessed. Because this is the first time the ulcer has been numerically staged, this stage will be coded as present on admission/entry or reentry.~~Because the resident was admitted to the nursing facility with documentation that a pressure ulcer/injury was present under the cast, and the cast could not be removed for the first two weeks, the pressure ulcer is coded on the Admission assessment as an unstageable pressure ulcer/injury due to non-removable dressing/device. On the subsequent assessment the pressure ulcer is coded as present on admission/entry or reentry as a Stage 3, the stage at which it was first able to be assessed after the removal of the cast.

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3	M0300C	M-19	7. ~~Mr.~~Resident H was admitted with a known pressure ulcer/injury ~~due to~~under a non-removable dressing/device. Ten days after admission, the surgeon removed the dressing, and a Stage 2 pressure ulcer was identified. Two weeks later the pressure ulcer is determined to be a full thickness ulcer and is at that point assessed as a Stage 3. It remained a Stage 3 at the time of the next assessment. ~~**Coding:** Code **M0300C1 as 1**, and **M0300C2 as 0**, not present on admission/entry reentry.~~ ~~**Rationale:** This resident was admitted with an unstageable pressure ulcer due to non-removable dressing or device. The dressing was removed to reveal a Stage 2 pressure ulcer, and this is the first numerical stage. Subsequent to this first stage, the ulcer worsened to Stage 3 and therefore is not coded as present on admission/entry or reentry.~~ **Coding:** On admission, code **M0300E1 as 1, unstageable pressure ulcer/injury due to non-removable dressing/device, and M0300E2 as 1, present on admission/entry or reentry.** On the subsequent assessment, code **M0300C1 as 1, Stage 3 pressure ulcer, and M0300C2 as 0, not present on admission/entry reentry**. **Rationale:** Resident H was admitted with a documented pressure ulcer/injury that was unstageable due to a non-removable dressing/device. The dressing was removed to reveal a Stage 2 pressure ulcer, and this is the first numerical stage documented in the medical record. Subsequent to this first documented stage, the ulcer worsened to Stage 3 and remained a Stage 3 until the next assessment. On the next assessment, because this pressure ulcer was previously staged as Stage 2 upon initial removal of the dressing, and it increased in numerical stage to a Stage 3, it is not considered as present on admission/entry or reentry.

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3	M0300F	M-26	4. ~~Mr.~~Resident M~~.~~ was admitted to the nursing facility with pressure ulcers that were unstageable due to eschar ~~tissue covering both the right and left~~on both heels, as well as a Stage 2 pressure ulcer on the coccyx. ~~Mr.~~Resident M's pressure ulcers were reassessed before the subsequent assessment, and it was noted in the medical record that the Stage 2 coccyx pressure ulcer had healed. The left-heel eschar became fluctuant, showed signs of infection, and had to be debrided at the bedside.~~, and~~ The left heel was subsequently numerically staged as a Stage 4 pressure ulcer. The right-heel eschar remained stable and dry (i.e., remained unstageable). ~~**Coding:** Code **M0300D1 as 1**, and **M0300D2 as 1**, present on admission/entry or reentry. Code **M0300F1 as 1**, and **M0300F2 as 1**, present on admission/entry or reentry.~~ ~~**Rationale:** Mr. M was admitted with an unstageable pressure injury due to slough/eschar on each heel. One of the heels was subsequently debrided, and the first numerical stage was Stage 4; thus this is coded as present on admission/entry or reentry. The other heel eschar remained unstageable, and is coded as present on admission/entry or reentry.~~

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3	M0300F	M-26	**Coding:** On admission, code **M0300B1, Stage 2 as 1, M0300B2, present on admission/entry or reentry as 1;** and **M0300F1 Unstageable due to slough/eschar as 2** and **M0300F2 as 2, present on admission, entry or reentry.** On the subsequent assessment, code **M0300D1 as 1,** and **M0300D2 as 1, present on admission/entry or reentry;** and **M0300F1 as 1,** and **M0300F2 as 1, present on admission/entry or reentry**. **Rationale:** Since both of Resident M's heels cannot be numerically staged, because the level of tissue damage cannot be determined due to the eschar present, they are coded on admission as unstageable pressure ulcer due to slough/eschar. The left heel eschar was subsequently debrided, and is coded as a Stage 4 on the subsequent assessment. Since the left heel eschar was debrided, and the first time an unstageable ulcer/injury is staged, it is considered as present on admission/entry or reentry at the stage it is initially assessed. The other heel eschar remained unstageable, and is coded as present on admission/entry or reentry, and the Stage 2 pressure ulcer on the coccyx healed, so it is not coded on the subsequent assessment.

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3	M0300G	M-29	**Example** 1. A resident is admitted with a blood-filled blister on the right heel. After further assessment of the surrounding tissues, it is determined that the heel blister is a DTI. Four days after admission, the right heel blister is drained and conservatively debrided at the bedside. After debridement, the right heel is assessed and staged as a Stage 3 pressure ulcer. On the subsequent assessment, the right heel remains a Stage 3. **Coding:** On admission, the pressure injury to the right heel would be coded at **M0300G1 as 1, and at M0300G2 as 1, present on admission/entry or reentry.** On the subsequent assessment, the pressure ulcer is coded at **M0300C1, Stage 3 pressure ulcer** and at **M0300C2 as 1, present on admission/entry or reentry.** **Rationale:** After a thorough clinical and skin examination, an assessment of the right heel and surrounding tissues revealed skin injury consistent with a DTI, which was observed at the time of admission. The heel DTI blister is drained, tissue is debrided, and the ulcer is subsequently numerically staged as a Stage 3. Because this was the first time the ulcer was able to be assessed and numerically staged, and it remained at that same stage at the time of the current assessment, it is considered to have been present on admission.