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Section M: More Than Just Numbers and Checkboxes

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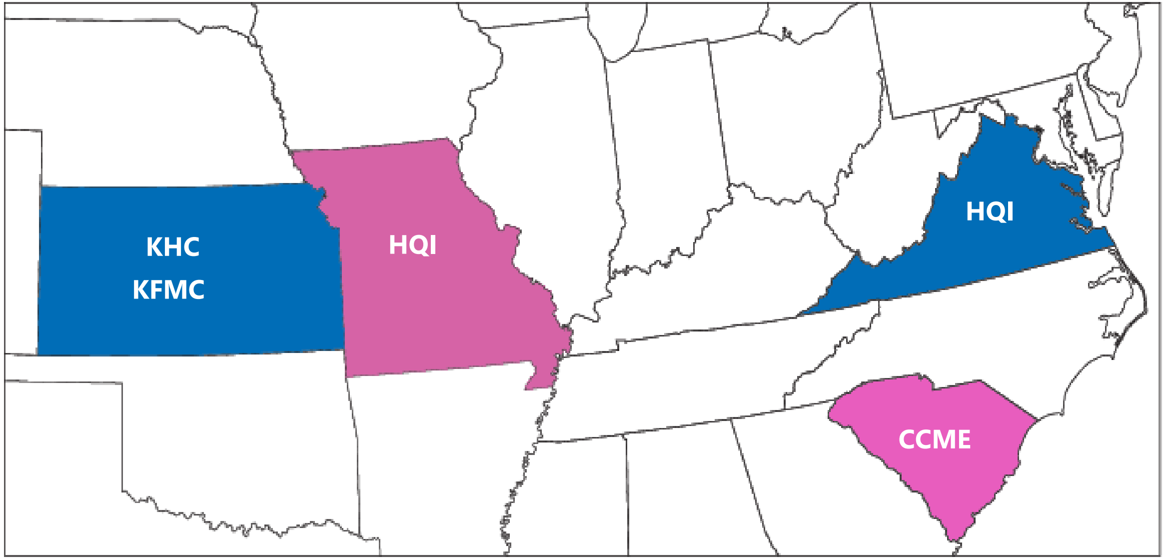

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Today's Speaker

Allison Spangler, RN, BSN, RAC-CT, QCP
Quality Improvement Advisor

Objectives

- Discuss impact of Section M
- Discuss steps for assessment
- Discuss coding tips to assist in accurate MDS documentation

Impact of Section M

1. Very complex and accurate understanding of coding instructions is crucial.
2. Affects many areas that are important to nursing homes.
    - QMs and Survey
    - 5 Star Quality Rating
    - PDPM
    - Medicaid Case Mix
    - Skilled Nursing Facility Quality Reporting Program

M0100 & M0150 Determination of Pressure Ulcer/Injury Risk

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M0100 Steps for Assessment

- Review the medical record
- Speak with treatment nurse and direct care staff
- Examine the resident

M0100 Check All That Apply

A. Resident has a pressure ulcer/injury, a scar over bony prominence, or a non-removable dressing/device

B. Formal assessment instrument/tool

C. Clinical assessment

D. None of the above

M0150 Steps for Assessment

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Determine if the resident is at risk

↓

If resident currently has PI, scar over bony prominence or non-removable dressing, resident is at risk for worsening or new PI

↓

Review formal risk assessment

↓

Review clinical assessment

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M0210: Unhealed Pressure Ulcers/Injuries

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M0210 Steps for Assessment

Review	Speak	Examine	Identify
Review the medical record	Speak with direct care staff and treatment nurse	Examine the resident	Identify any known or likely unstageable PIs

Pressure Ulcers **NOT** coded in Section M

Oral Mucosal Ulcers

- Code in item L0200C, Abnormal Mouth Tissue

Mucosal Pressure Ulcers

Examples related to:

- Nasogastric tube
- Nasal oxygen tubing
- Endotracheal tubes
- Urinary catheters

Eschar Versus Scabs

Eschar
Collection of dead tissue within the wound that is flush with the surface of the wound.

Scab
Dried blood cells and serum, sits on top of the skin, and forms over exposed wounds.

- Evidence of wound healing

Other Tips

Residents with diabetes mellitus (DM)

- Can have pressure, venous, arterial, or diabetic neuropathic ulcer
- Heel ulcers/injury can be due to pressure
- Ulcers on the plantar surface of the foot closer to the metatarsals are diabetic foot ulcers

If two PIs occur on the same bony prominence and are separated by skin, count them as two separate PIs.

If a resident had a pressure ulcer/injury that healed during the look-back, **do not** code on the assessment.

M0300A-G: Current Number of Unhealed Pressure Ulcers/Injuries

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M0300 Steps for Completing

Determine Deepest Anatomical Stage

Identify Unstageable Pressure Ulcers

Determine "Present on Admission"

Deepest Anatomical Stage

Observe and palpate the base of any identified pressure ulcers.

Review the history of each pressure ulcer.

Pressure ulcer's **DO NOT** heal in reverse sequence.

Clinical standards do not support reverse staging or backstaging as a way to document healing.

Identify Unstageable Pressure Ulcers

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Visualization of the wound bed is necessary for accurate staging.

If, after careful cleansing of the pressure ulcer/injury, anatomical tissues remain obscured, it is considered unstageable.

Pressure ulcers that have eschar or slough tissue present such that anatomic depth cannot be visualized or palpated, classify as unstageable.

Deep Tissue Injuries (DTI) should be coded as unstageable

Known pressure Ulcers/injuries covered by non-removable dressing/device should be coded as unstageable.

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Present on Admission

For **each** pressure ulcer/injury, determine if the pressure ulcer/injury was present at the time of admission/entry or reentry and not acquired while the resident was in the care of the nursing home. Consider current and historical levels of tissue involvement.

DEFINITION
On Admission- As close to the actual time of admission as possible.

Not Present on Admission

Admitted to the NH WITH a PI (Not facility acquired)

→ PI increases in stage (worsens)

→ Discharged to hospital

→ Readmitted to NH with same PI

→ NOT Present on Admission

Present on Admission

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Admitted to the NH WITH a PI (Not facility acquired) → Discharged to hospital → Readmitted to NH with same PI that was not facility acquired → Present on Admission

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Steps for Assessment

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1

Perform head-to-toe assessment

2

Determine that the lesion being assessed is **primarily** related to pressure and that other conditions have been ruled out

3

Identify all pressure ulcers currently present

4

Identify the number of pressure ulcers that were present on admission/entry or reentry

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Stage 1

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- Need more than one descriptor to determine staging between Stage 1 and deep tissue injury.
- Check reddened areas for ability to blanch.
- Search for areas of skin that differ from surrounding tissue that may be painful, firm, soft, warmer, or cooler compared to adjacent tissue. Especially important in dark skin tones.

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Stage 2

- Examine the area adjacent to or surrounding an intact blister for evidence of tissue damage.
- Stage 2 PIs will generally lack the surrounding characteristics found with a deep tissue injury.
- Granulation tissue, slough, and eschar are not present in Stage 2.
- Do **not** code skin tears, tape burns, moisture associated skin damage (MASD), or excoriation here.

Stage 3

- The depth of a Stage 3 pressure ulcer varies by anatomical location.
- Areas of significant adiposity can develop extremely deep Stage 3 pressure ulcers.
- Do **not** code moisture-associated skin damage (MASD) or excoriation here.
- Bone/tendon/muscle is not visible or directly palpable in a Stage 3 pressure ulcer.

Stage 4

- The depth of a Stage 4 pressure ulcer varies by anatomical location.
- Stage 4 pressure ulcers can extend into muscle and/or supporting structures (e.g., fascia, tendon, or joint capsule) making osteomyelitis possible.
- Exposed bone/tendon/muscle is visible or directly palpable.
- Cartilage serves the same anatomical function as bone.
- Assess and measure tunneling and undermining.

Unstageable r/t Non-removable Dressing/Device

Pressure Injury is known but not stageable due to the non-removable device or dressing

Examples

- Primary surgical dressing*
- Orthopedic device*
- Cast

* Must not be removed per physician's order

Unstageable r/t Slough and/or Eschar

- Base of ulcer covered by slough and/or eschar.
- Once the pressure ulcer is debrided of slough and/or eschar such that the anatomic depth of soft tissue damage 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.

Unstageable r/t Deep Tissue Injury

- Once 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 be rapid, exposing additional layers of tissue even with optimal treatment.
- If the surrounding tissue does not show signs of tissue damage, do **not** code as deep tissue injury.

M1030: Number of Venous and Arterial Ulcers

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Steps for Assessment

Review	Review the medical record
Speak	Speak with direct care staff and treatment/wound nurse
Examine	Examine the resident

Venous Ulcers

- Key areas for development- area proximal to the lateral and medial malleolus.
- May start with some kind of minor trauma.
- Does not typically occur over a bony prominence.
- Pressure plays virtually **no** role in development of the ulcer.

Arterial Ulcers

- Key areas for development - distal part of the foot, dorsum of the foot, or tips and tops of toes.
- Trophic skin changes
- May start with some kind of minor trauma.
- Does not typically occur over a bony prominence, however, can occur on the tops of the toes.
- Pressure may play a part.
- Ischemia is major etiology.
- Lower extremity and foot pulses may be diminished or absent.

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M1040: Other Ulcers, Wounds and Skin Problems

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Steps for Assessment

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Review	Review the medical record
Speak	Speak with direct care staff and treatment/wound nurse
Examine	Examine the resident

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M1040B Diabetic Foot Ulcers

- Because of decreased circulation and sensation, resident may not be aware of the wound.
- Neuropathy can cause changes in the structure of the bones and tissue in the foot.
- Do **not** include pressure ulcers/injuries that occur on residents with diabetes mellitus here.

Example

Resident with DM has an ulcer on the plantar surface of the foot closer to the metatarsals.

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M1040D Open Lesion(s) Other than Ulcers, Rashes, Cuts

- Wounds, boils, cysts, and vesicles are coded here.
- Do **not** code rashes, abrasions, or cuts/lacerations here.
- Do **not** code pressure ulcers/injuries, venous or arterial ulcers, diabetic foot ulcers, or skin tears here.

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M1040E Surgical Wounds

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- Does not include healed surgical sites and healed stomas or lacerations that require suturing or butterfly closure. PICC sites, central line sites, and peripheral IV sites are not coded here.
- A pressure ulcer that has been surgically debrided should continue to be coded as a pressure ulcer.
- Code pressure ulcers that require surgical intervention for closure with graft and/or flap procedures in this item.

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M1040F Burns

- Do **not** include first degree burns

M1040G Skin Tear(s)

- Code all skin tears in this item, even if already coded in Item J1900B (Number of Falls Since Admission/Entry or Reentry or Prior Assessment (OBRA or Scheduled PPS)) that resulted in an injury (except major).
- Do not code cuts/lacerations or abrasions here.

M1040H Moisture Associated Skin Damage (MASD)

- Also referred to as maceration and includes:
  - Incontinence associated dermatitis (IAD)
  - Intertriginous dermatitis (ITD)
  - Periwound moisture-associated dermatitis
  - Peristomal moisture-associated dermatitis
- If pressure and moisture are both present, code the skin damage as a pressure ulcer/injury in M0300.
- If there is tissue damage extending into the subcutaneous tissue or deeper and/or necrosis is present, code the skin damage as a pressure ulcer in M0300.

M1200: Skin and Ulcer/Injury Treatments

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Steps for Assessment

Review	Review the medical record
Speak	Speak with direct care staff and treatment/wound nurse
Observe	Observe skin treatments

M1200A/M1200B Pressure Reducing Devices

- Do **not** include egg crate cushions of any type.
- Do **not** include doughnut or ring devices in chairs.

M1200C Turning/Repositioning Program

- Should specify the intervention.
- Documentation should support that the program is monitored and reassessed.

M1200D Nutrition or Hydration Interventions

- Should be based on an individualized nutritional assessment.
- Documentation should support nutrition or hydration factors that are influencing skin problems and/or wound healing.
- Interventions must be tailored to the resident’s needs, condition, and prognosis.

M1200E Pressure Ulcer/Injury Care

Includes **any** intervention for treating pressure ulcers coded in M0300A-G Current Number of Unhealed Pressure Ulcers/Injuries at Each Stage.

Examples

- Topical dressings
- Enzymatic, mechanical, or surgical debridement
- Wound irrigations
- Negative pressure wound therapy
- Hydrotherapy

M1200F Surgical Wound Care

- Do **not** include post-operative care following eye or oral surgery.
- Do **not** include surgical debridement of a pressure ulcer.
- Includes surgical wound care for pressure ulcers that require surgical intervention for closure (e.g., flap and/or graft coverage).
- Includes any intervention for treating or protecting any type of surgical wound.
    - Topical cleansing
    - Wound irrigation
    - Application of antimicrobial ointments
    - Application of dressings of any type
    - Suture/staple removal

M1200G Application of Non-Surgical Dressings Other than to Feet

- Do **not** code dressings for pressure ulcers/injuries.
- Dressings do not have to be applied daily in order to be coded.
- Do **not** include adhesive bandages (e.g., Band-Aid®, wound closure strips).

Examples of what to code

- Dry gauze dressings
- Dressings moistened with saline or other solutions
- Transparent dressings
- Hydrogel dressings
- Dressings with hydrocolloid or hydroactive particles
- Compression bandages

M1200H Application of Ointments/Medications Other than to Feet

Do **not** code applications of ointments/medications for pressure ulcers.

Examples of what to code

- Cortisone
- Antifungal preparations
- Chemotherapeutic agents

Does not include ointments used to treat non-skin conditions (e.g., nitropaste, testosterone cream).

M1200I Application of Dressings to the Feet

- Do **not** code application of dressings to pressure ulcers/injuries on the foot.
- Do **not** code application of dressings to the ankle.

Case Study

Mrs. S was admitted without a PI. Three days after admission she develops a partial thickness PI on her coccyx. Two weeks after admission she was hospitalized due to sepsis. When she returns, the PI on her coccyx is now a full thickness PI.

Six weeks after readmission, Ms. S is ready to return home with home health. Her PI has improved and is now a partial thickness PI.

Next Session Date and Topics

- **Session 5 (August 3):** The CNA Role: Identifying and Reporting
- **Session 6 (August 17):** Care Planning: Resident/Family Engagement/Education
- **Session 7 (August 31):** Ongoing Practices and Monitoring: Best Practices from High Performing Nursing Homes

FOR MORE INFORMATION

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