Section M: Skin Conditions
Part 1

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June 15, 2016
Caution

Because skin conditions require visualization of wounds and skin conditions showing tissue damage that may also be in “private” parts of the body, please be aware of this when viewing photos in this presentation.
Objectives

• Discuss pressure ulcer risk assessment for MDS 3.0 Section M: Skin Conditions
• Describe pressure ulcer staging as required in MDS 3.0 Section M: Skin Conditions
• Differentiate pressure ulcers from other skin conditions coded in Section M: Skin Conditions
MDS Section M: Skin Conditions
Pressure ulcer Risk Assessment is a **multifactorial** process that involves:

- Reviewing information in the resident’s medical record
- Talking with LTC to confirm information in the medical record and resident observation
- Actual examination and assessment of the resident
General Assessment Guidelines

- Perform a head-to-toe skin assessment
- Use visual inspection with adequate lighting
- Use palpation of the resident’s skin
- Pay special attention to bony prominences and pressure-bearing areas
  - Sacrum
  - Heels
  - Ankles
  - Skin under medical devices
Pressure Ulcer Risk Based on Resident Clinical Assessment

• Impaired/decreased mobility and decreased functional ability
• Co-morbid conditions
  – Diabetes mellitus
  – End-stage renal disease
  – Thyroid disease
• Medications
  – Steroids
• Impaired blood flow
Pressure Ulcer Risk Based on Resident Clinical Assessment (cont.)

- Resident refusal of some aspects of care and treatment
- Cognitive impairment
- Urinary and/or fecal impairment
- Under nutrition, malnutrition, and hydration deficits
- Healed pressure ulcers
  - (Especially Stage 3 or 4)
Pressure Ulcer Risk

Multiple Factors to Consider for Clinical Decision Making to Determine Pressure Ulcer Risk

Is my resident at risk for developing a pressure ulcer?

YES  NO
Based on your comprehensive assessment, the clinical decision is:
Resident is at risk for developing pressure ulcers

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<tr>
<th>Enter Code</th>
<th>Is this resident at risk of developing pressure ulcers?</th>
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<tbody>
<tr>
<td>1</td>
<td>0. No</td>
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<td>1. Yes</td>
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Resident is **not** at risk for developing pressure ulcers

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<tr>
<td>0</td>
<td>0. No</td>
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<tr>
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<td>1. Yes</td>
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</table>
Planning for Pressure Ulcer Prevention Care

• Stabilize, reduce, or remove underlying modifiable risk factors
• Tensile strength of healed pressure ulcer is 80% of normal skin tensile strength
• Use preventative measures to mitigate opening of a closed ulcer due to fragility of the tissue
### M0210. Unhealed Pressure Ulcer(s)

<table>
<thead>
<tr>
<th>Enter Code</th>
<th>Does this resident have one or more unhealed pressure ulcer(s) at Stage 1 or higher?</th>
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<tbody>
<tr>
<td></td>
<td>0. No ➞ Skip to M0900, Healed Pressure Ulcers</td>
</tr>
<tr>
<td></td>
<td>1. Yes ➞ Continue to M0300, Current Number of Unhealed Pressure Ulcers at Each Stage</td>
</tr>
</tbody>
</table>
Wound Bed Preparation 2015

Identify, Prevent & Treat the Cause

Person with a Chronic Wound

Patient/Family Centered Concerns

Determine Heaability for Patient Outcomes & Local Wound Care

Debridement
Inflammation/Infection
Moisture Balance

Edge Effect

© Sibbald et al., Advances in Skin and Wound Care – Oct 2015
Make Sure You Have the Correct Wound Etiology

• Wound Bed Preparation (WBP)
  – Identify the cause

• Wound skin condition etiology is **not always** so easy to identify

• Ask resident or family about history of wound or skin condition
Step 1: Determine deepest anatomical stage

- For each pressure ulcer, determine the deepest anatomical stage
- Do not reverse or back stage
- If the 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

Step 2: Identify unstageable pressure ulcers

Step 3: Determine “present on admission”
Coding Pressure Ulcers

Coding Pressure Ulcers
by Stage M0300A–G
What Is Pressure Ulcer Staging?

• A description and classification assessment system
• Staging based on the deepest **anatomic type** of soft tissue damage
  – **Not based on centimeters**
• Tissue damage can be seen or palpated in the wound bed
• Adequate lighting is important for detecting color changes
Pressure Ulcer Staging Definitions

• Definitions in the RAI Manual are adapted (not adopted) from the National Pressure Ulcer Advisory Panel (NPUAP 2007)

• Can use NPUAP definitions in clinical documentation

but

Must use the CMS RAI definitions for Coding purposes on MDS 3.0 Section M Skin Conditions
If an ulcer arises from a combination of factors which are primarily caused by pressure, then the ulcer should be in this section as a pressure ulcer.
Polling Question

How should this pressure ulcer on the lip (mucosa) be coded on the MDS?

A. Stage 1 (M0300A)
B. Stage 2 (M0300B)
C. Stage 3 (M0300C)
D. Stage 4 (M0300D)
E. Unstageable related to slough and/or eschar (M300F)
F. Unstageable related to suspected deep tissue injury (M0300G)
G. Not coded in section M pressure ulcers

Photo: © E. Ayello
Coding Tips—Oral Mucosa Ulcers Caused by Pressure

• Do not code in Section M

• These ulcers are captured in item L0200C, Abnormal mouth tissue

• Mucosal ulcers are not staged using the skin pressure ulcer staging system because anatomical tissue comparisons cannot be made

Photo: © E. Ayello
How to Code a Pressure Ulcer Closed by a Flap or Graft

Case Example - Gluteal Thigh Flap Sacral Pressure Ulcer Closure

• If a pressure ulcer is surgically closed with a flap or graft, it should be coded as a surgical wound (M01040E) and not as a pressure ulcer.

• If the flap or graft fails, continue to code it as a surgical wound until healed.

Photos © E. Chiu
Scabs vs Eschar—Coding Tips

• Scabs and eschar are different both physically and chemically

• Staff need training to distinguish scabs from eschar
**Scabs vs Eschar—Coding Tips (cont.)**

**Scab**
- Made up of dried blood cells and serum, sits on top of skin
- Forms over exposed wounds such as wounds with granulating surfaces (pressure ulcers, lacerations, etc.)
- Evidence of wound healing
- A pressure ulcer that was staged as a 2 and now has a scab indicates it is a healing stage 2, and therefore, staging should not change

**Eschar**
- Collection of dead tissue within the wound that is flush with the surface of the wound
- Eschar characteristics and level of damage it causes to tissues is what makes it easy to distinguish from a scab
**M0300A: Number of Stage 1 Pressure Ulcers**

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<thead>
<tr>
<th>Enter Number</th>
<th>A. Number of Stage 1 pressure ulcers</th>
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<td><strong>Stage 1:</strong> 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</td>
</tr>
</tbody>
</table>

Photo © J. Niezgota
“An observable pressure-related alteration of intact skin, whose indicators as compared to an adjacent or opposite area on the body may include changes in one or more of the following parameters:

– Skin temperature (warmth or coolness)
– Tissue consistency (firm or boggy)
– Sensation (pain, itching)
And/or a defined area of persistent redness in lightly pigmented skin, whereas in darker skin tones, the ulcer may appear with persistent red, blue or purple hues

• **Non-blanchable**
  
  – Reddened areas of tissue that do not turn white or pale when pressed firmly with a finger or device”
M0300A: Stage 1 Pressure Ulcer—Steps for Assessment

1. Perform head-to-toe assessment. Conduct a full body skin assessment focusing on bony prominences and pressure-bearing areas (sacrum, buttocks, heels, ankles, etc.)

2. For purposes of coding, determine that the lesion being assessed is primarily related to pressure and that other conditions have been ruled out. If pressure is not the primary cause, do not code here.
3. Reliance on only one descriptor is inadequate to determine the staging of the pressure ulcer between Stage 1 and suspected deep tissue ulcers. The descriptors are similar for these two types of ulcers (e.g., temperature (warmth or coolness); tissue consistency (firm or boggy))
Polling Question

Is this a Stage 2 pressure ulcer?

A. Yes, Stage 2 (M0300B)
B. No, a burn (M1040F)
C. No, none of the above wound type present (M1040H)
D. No, Unstageable related to suspected deep tissue injury (M0300G)
E. Maybe, need more assessment information

☑️ 30
“Partial thickness loss of dermis presenting as a shallow open ulcer with a red-pink wound bed, without slough.

May also present as an intact of open/ruptured blister.”
**M0300B: Stage 2 Pressure Ulcers**

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**B. 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

1. **Number of Stage 2 pressure ulcers** - If 0 ➔ Skip to M0300C, Stage 3

2. **Number of these Stage 2 pressure ulcers that were present upon admission/entry or reentry** - Enter how many were noted at the time of admission/entry or reentry

3. **Date of oldest Stage 2 pressure ulcer** - Enter dashes if date is unknown:

<table>
<thead>
<tr>
<th>Month</th>
<th>Day</th>
<th>Year</th>
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<tbody>
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</table>
3. “Examine the area adjacent to or surrounding an intact blister for evidence of tissue damage. If other conditions are ruled out and the tissue adjacent to, or surrounding the blister demonstrates signs of tissue damage, (e.g., color change, tenderness, bogginess or firmness, warmth or coolness) these characteristics suggest a suspected deep tissue injury (sDTI) rather than a Stage 2 Pressure Ulcer”
Staging of Blister Pressure Ulcers

- RAI Manual provides specific guidance on how to stage pressure ulcers that present as a blister
- Definitions in the RAI manual for blister pressure ulcers differ from that of the NPUAP staging definitions
- Unlike the NPUAP staging definitions, CMS RAI definitions are not dependent on the color of the fluid in the blister pressure ulcer to determine the stage
- CMS RAI Manual definitions are more holistic and require assessment of the skin surrounding the blister pressure ulcer to determine the stage
Staging of Blister Pressure Ulcers (cont.)

Examine skin surrounding Blister Pressure Ulcer for signs of tissue damage (color change, tenderness, bogginess, or firmness, warmth or coolness)

Yes Signs Present
- Code as M0300G Unstageable Suspected Deep Tissue Injury (sDTI)

No Signs NOT Present
- Code as M0300B Stage 2

Blister Pressure Ulcer has yellow fluid

Photo © D. Weir
Polling Question

Is this a Stage 2 pressure ulcer?

A. Yes, Stage 2 (M0300B)
B. No, a burn (M1040F)
C. No, none of the above wound type present (M1040H)
D. No, Unstageable related to suspected deep tissue injury (M0300G)
Staging of Blister Pressure Ulcers (cont.)

Examine skin surrounding Blister Pressure Ulcer for signs of tissue damage (color change, tenderness, bogginess, or firmness, warmth or coolness)

- **YES Signs Present**
  - Code as M0300G Unstageable Suspected Deep Tissue Injury (sDTI)

- **NO Signs NOT Present**
  - Code as M0300B Stage 2

Blister Pressure Ulcer has bloody fluid

Photo © C. Labish
**M0300C: Stage 3 Pressure Ulcers**

C. **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

1. **Number of Stage 3 pressure ulcers** - If 0 → Skip to M0300D, Stage 4

2. **Number of these Stage 3 pressure ulcers that were present upon admission/entry or reentry** - enter how many were noted at the time of admission/entry or reentry
M0300C: Stage 3 Pressure Ulcers—Definition

• 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
“The depth of a Stage 3 pressure ulcer varies by anatomical location. 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. Therefore, observation and assessment of skin folds should be part of overall skin assessment.

Bone/tendon/muscle is not visible or directly palpable in a Stage 3 pressure ulcer.”
D. 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

1. Number of Stage 4 pressure ulcers - If 0 → Skip to M0300E, Unstageable: Non-removable dressing

2. Number of these Stage 4 pressure ulcers that were present upon admission/entry or reentry - enter how many were noted at the time of admission/entry or reentry
M0300D: Stage 4 Pressure Ulcers

Definition

• “Full thickness tissue loss with exposed bone, tendon or muscle
• Slough or eschar may be preset on some parts of the wound bed
• Often includes undermining and tunneling”
Clinical Example M0300D
Stage 4 Pressure Ulcer

Photo © H. Smart
## Clinical Example M0300D
### Stage 4 Pressure Ulcer (cont.)

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**D. 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

1. **Number of Stage 4 pressure ulcers** - If 0 ➔ Skip to M0300E, Unstageable: Non-removable dressing

2. **Number of these Stage 4 pressure ulcers that were present upon admission/entry or reentry** - enter how many were noted at the time of admission/entry or reentry

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This resident is admitted to your facility and on initial assessment this is what you observe

![Image of Stage 4 Pressure Ulcer](Photo © R.G. Sibbald)
Tunneling Definition

“A passage way of tissue destruction under the skin surface that has an opening at the skin level from the edge of the wound”

Photo © R.G. Sibbald
Undermining Definition

“The destruction of tissue of ulceration extending under the skin edges (margins) so that the pressure ulcer is larger at its base than at the skin surface”

Photo © R.G. Sibbald
M0300D: Stage 4 Pressure Ulcers—Coding Tips

• “The depth of a Stage 4 pressure ulcer varies by anatomical location. The bridge of the nose, ear, occiput, and malleolus do not have subcutaneous tissue, and these ulcers can be shallow

• 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. Therefore, pressure ulcers that have exposed cartilage should be classified as a Stage 4”
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 unstageable pressure ulcers that were present upon admission/entry or reentry - enter how many were noted at the time of admission/entry or reentry
M0300E: Unstageable Pressure Ulcers Related to Non-removable Dressing/Device (cont.)

• Includes, for example, a primary surgical dressing that cannot be removed, an orthopedic device, or cast
### M0300F: Unstageable Pressure Ulcers Related to Slough and/or Eschar

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<th>Enter Number</th>
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**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 unstageable pressure ulcers that were present upon admission/entry or reentry** - enter how many were noted at the time of admission/entry or reentry
Clinical Example of Unstageable Pressure Ulcer (M0300F)

Photo © Hiske Smart
M0300F: Unstageable Pressure Ulcers Related to Slough and/or Eschar Definition

- Known but not stageable due to coverage of wound bed by slough and/or eschar
Definitions of Slough Tissue

“Non-viable yellow, tan, gray, green or brown tissue usually moist, can be soft, stringy and mucinous in texture. Slough may be adherent to the base of the wound or present in clumps throughout the wound bed.”

Photo © L. Levine

Photo © E. Ayello
Definitions of Eschar Tissue

“Dead or devitalized tissue that is hard or soft in texture;
Usually **black**, brown, or tan in color, may appear “scab” like
Necrotic tissue and eschar are usually firmly adherent to the base of the wound and often the sides/edges of the wound”
“Pressure ulcers that are covered with slough and/or eschar should be coded as unstageable because the true anatomic depth of soft tissue damage (and therefore stage) cannot be determined. Only until enough slough and/or eschar is removed to expose the anatomic depth of soft tissue damage involved, can the stage of the wound be determined”
• “Stable eschar (i.e., dry, adherent, intact without erythema or fluctuance) on the heels serves as “the body’s natural (biological) cover” and should only be removed after careful clinical consideration, including ruling out ischemia, and consultation with the resident’s physician, or nurse practitioner, physician assistant, or clinical nurse specialist if allowable under state licensure laws”
• “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”
Case Example—Initial Presentation: Ischial Pressure Ulcer

This unstageable pressure ulcer was present on admission.

Photo © F. Ross

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

On Subsequent MDS- it is no longer unstageable, now a stage 4 as into muscle

<table>
<thead>
<tr>
<th>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</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Number of Stage 4 pressure ulcers - If 0 → Skip to M0300E, Unstageable: Non-removable dressing</td>
</tr>
<tr>
<td>2. Number of these Stage 4 pressure ulcers that were present upon admission/entry or reentry - enter how many were noted at the time of admission/entry or reentry</td>
</tr>
</tbody>
</table>
Case Example—Initial Presentation: Ischial Pressure Ulcer (cont.)

Do not back or reverse stage as it heals

“if the pressure ulcer has ever been classified at a higher numerical stage that what is observed now, it should continue to be classified at the higher numerical stage.”

Nursing homes that carefully document and track pressure ulcers will be able to more accurately code this item

On Subsequent MDS- it continues to be a healing stage 4

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<tr>
<td>Enter Number</td>
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</table>

D. 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

1. Number of Stage 4 pressure ulcers - If O Skipto M0300E, Unstageable: Non-removable dressing

2. Number of these Stage 4 pressure ulcers that were present upon admission/entry or reentry - enter how many were noted at the time of admission/entry or reentry
M0300G: Unstageable Pressure Ulcers Related to Suspected Deep Tissue Injury

G. Unstageable - Deep tissue injury: 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/entry or reentry - enter how many were noted at the time of admission/entry or reentry
“Purple or maroon area of discolored intact skin due to damage of underlying soft tissue
The area may be preceded by tissue that is painful, firm, mushy, boggy, warmer or cooler as compared to adjacent tissue”
Clinical Example of Unstageable Pressure Ulcer Related to Suspected Deep Tissue Injury (M0300G)

Photo © Hiske Smart
• “Examine the area adjacent to, or surrounding, an intact blister for evidence of tissue damage. If the tissue adjacent to, or surrounding, the blister **does not show** signs of tissue damage (e.g., color change, tenderness, bogginess or firmness, warmth or coolness), do **not** code as a suspected deep tissue injury

• In dark-skinned individuals, the area of injury is probably not purple/maroon, but rather darker than the surrounding tissue”
“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 be rapid, exposing additional layers of tissue even with optimal treatment.

When a lesion due to pressure presents with an intact blister AND the surrounding or adjacent soft tissue does NOT have the characteristics of deep tissue injury, do **not** code here.”
Staging of Blister Pressure Ulcers

Examine skin surrounding Blister Pressure Ulcer for signs of tissue damage (color change, tenderness, bogginess, or firmness, warmth or coolness)

- YES Signs Present: Code as M0300G Unstageable Suspected Deep Tissue Injury (sDTI)
- NO Signs NOT Present: Code as M0300B Stage 2

Blister Pressure Ulcer has yellow fluid

Photo © D. Weir
Staging of Blister Pressure Ulcers (cont.)

Photo © C. Labish
M0610. **Dimensions of Unhealed Stage 3 or 4 Pressure Ulcers or Eschar**

Complete only if M0300C1, M0300D1 or M0300F1 is greater than 0

If the resident has one or more unhealed 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 x width) and record in centimeters:

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<thead>
<tr>
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<tbody>
<tr>
<td>A. <strong>Pressure ulcer length:</strong></td>
<td>Longest length from head to toe</td>
<td></td>
</tr>
<tr>
<td></td>
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<td>cm</td>
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<tr>
<td>B. <strong>Pressure ulcer width:</strong></td>
<td>Widest width of the same pressure ulcer, side-to-side perpendicular (90-degree angle) to length</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>cm</td>
</tr>
<tr>
<td>C. <strong>Pressure ulcer depth:</strong></td>
<td>Depth of the same pressure ulcer from the visible surface to the deepest area (if depth is unknown, enter a dash in each box)</td>
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Pressure Ulcer Dimensions—M0610

• “Use a disposable measuring device or a cotton-tipped applicator
• Determine the longest length (white arrow line) head to toe and greatest width (black arrow line) of each Stage 3, Stage 4, or unstageable pressure ulcer due to slough and/or eschar
• Measure the longest length of the pressure ulcer. If using a cotton tip applicator, mark on the applicator the distance between healthy skin tissue at each margin and lay the applicator next to a centimeter ruler to determine length.”
• **Moisten** a sterile cotton-tipped applicator with 0.9% sodium chloride (NaCl) solution or sterile water
• Place applicator tip in **deepest** aspect of the ulcer and measure distance to the skin level
• If depth cannot be assessed due to slough and/or eschar, enter dashes in M0610C
### M0700. Most Severe Tissue Type for Any Pressure Ulcer

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. **Eschar** - black, brown, or tan tissue that adheres firmly to the wound bed or ulcer edges, may be softer or harder than surrounding skin.
5. **None of the Above**
M0700: Most Severe Tissue Type for Any Pressure Ulcer (cont.)

1. Epithelial Tissue
2. Granulation Tissue
3. Slough
4. Eschar
9. None of the above

Photos © D. Weir
M0700: Most Severe Tissue Type for Any Pressure Ulcer (cont.)

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<tr>
<th>Enter Code</th>
<th>Select the best description of the most severe type of tissue present in any pressure ulcer bed</th>
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<tr>
<td>1</td>
<td>Epithelial tissue - new skin growing in superficial ulcer. It can be light pink and shiny, even in persons with darkly pigmented skin</td>
</tr>
<tr>
<td>2</td>
<td>Granulation tissue - pink or red tissue with shiny, moist, granular appearance</td>
</tr>
<tr>
<td>3</td>
<td>Slough - yellow or white tissue that adheres to the ulcer bed in strings or thick clumps, or is mucinous</td>
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<tr>
<td>4</td>
<td>Eschar - black, brown, or tan tissue that adheres firmly to the wound bed or ulcer edges, may be softer or harder than surrounding skin</td>
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<tr>
<td>9</td>
<td>None of the Above</td>
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Photos © D. Weir
M0700: Most Severe Tissue Type for Any Pressure Ulcer (cont.)

<table>
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<th>Enter Code</th>
<th>Description</th>
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<tr>
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Photos © D. Weir
M0700: Most Severe Tissue Type for Any Pressure Ulcer (cont.)

**M0700. Most Severe Tissue Type for Any Pressure Ulcer**

<table>
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<th>Enter Code</th>
<th>Description</th>
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<tr>
<td>1</td>
<td>Epithelial tissue - new skin growing in superficial ulcer. It can be light pink and shiny, even in persons with darkly pigmented skin</td>
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<tr>
<td>2</td>
<td>Granulation tissue - pink or red tissue with shiny, moist, granular appearance</td>
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<tr>
<td>3</td>
<td>Slough - yellow or white tissue that adheres to the ulcer bed in strings or thick clumps, or is mucinous</td>
</tr>
<tr>
<td>4</td>
<td>Eschar - black, brown, or tan tissue that adheres firmly to the wound bed or ulcer edges, may be softer or harder than surrounding skin</td>
</tr>
<tr>
<td>9</td>
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</tr>
</tbody>
</table>

Photos © D. Weir
M0700: Most Severe Tissue Type for Any Pressure Ulcer (cont.)

M0700. Most Severe Tissue Type for Any Pressure Ulcer

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<tr>
<th>Enter Code</th>
<th>Select the best description of the most severe type of tissue present in any pressure ulcer bed</th>
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<td></td>
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<td></td>
</tr>
<tr>
<td></td>
<td>B.</td>
<td>Stage 3</td>
<td></td>
</tr>
<tr>
<td></td>
<td>C.</td>
<td>Stage 4</td>
<td></td>
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</table>

**M0800. Worsening in Pressure Ulcer Status Since Prior Assessment (OBRA or Scheduled PPS) or Last Admission/Entry or Reentry**

Complete only if A0310E = 0

Indicate the number of current pressure ulcers that were **not present or were at a lesser stage** on prior assessment (OBRA or scheduled PPS) or last entry. If no current pressure ulcer at a given stage, enter 0.
“Pressure ulcer “worsening” is defined as a pressure ulcer that has progressed to a deeper level of tissue damage and is therefore staged at a higher number using a numerical scale of 1–4 (using the staging assessment system classifications assigned to each stage; starting at Stage 1, and increasing in severity to Stage 4) on an assessment as compared to the previous assessment.

For the purposes of identifying the absence of a pressure ulcer, zero pressure ulcers is used when there is no skin breakdown or evidence of damage.”
“If a pressure ulcer was unstageable on admission/entry or reentry, do not consider it to be worsened on the first assessment that it is able to be numerically staged”

This is not coded in M0800 Worsening
M0800: Worsening in Pressure Ulcer Status—Coding Tips (cont.)

“If a pressure ulcer was numerically staged and becomes unstageable”

Pressure ulcer debrided

Compare its numerical stage before and after debridement

Numerical stage increased?

Yes

Consider pressure ulcer worsened and code M0800

No

Consider pressure ulcer not worsened
Case Example M0800: Worsening in Pressure Ulcer Status

- A resident’s pressure ulcer on admission was initially covered with eschar and staged as unstageable (coded in M0300F).
- The pressure ulcer was surgically debrided and is then numerically coded Stage 3 (M0300C). Do not code this as worsened on M0800.
  - “if a pressure ulcer was unstageable on admission/entry or reentry, do not consider it to be worsened on the first assessment that is able to be numerically staged”
- Unfortunately for the resident on subsequent assessment of the pressure ulcer, it is now into muscle and thus coded as a Stage 4 (M0300D). This pressure ulcer has now worsened and needs to be coded in section M0800.
  - “However if the pressure ulcer subsequently increases in numerical stage after that assessment, if should be considered worsened”
A resident’s pressure ulcer on admission was initially covered with eschar and staged as unstageable (coded in M0300F)
The pressure ulcer was surgically debrided and is then numerically coded Stage 3 (M0300C). Do not code this as worsened on M0800.
“if a pressure ulcer was unstageable on admission/entry or reentry, do not consider it to be worsened on the first assessment that is able to be numerically staged”
## M0900: Healed Pressure Ulcers

Complete only if A0310E = 0

<table>
<thead>
<tr>
<th>Enter Code</th>
<th>A. Were pressure ulcers present on the prior assessment (OBRA or scheduled PPS)?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0. <strong>No</strong> → Skip to M1030, Number of Venous and Arterial Ulcers</td>
</tr>
<tr>
<td></td>
<td>1. <strong>Yes</strong> → Continue to M0900B, Stage 2</td>
</tr>
</tbody>
</table>

Indicate the number of pressure ulcers that were noted on the prior assessment (OBRA or scheduled PPS) that have completely closed (resurfaced with epithelium). If no healed pressure ulcer at a given stage since the prior assessment (OBRA or scheduled PPS), enter 0.

<table>
<thead>
<tr>
<th>Enter Number</th>
<th>B. Stage 2</th>
</tr>
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</table>

<table>
<thead>
<tr>
<th>Enter Number</th>
<th>C. Stage 3</th>
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<table>
<thead>
<tr>
<th>Enter Number</th>
<th>D. Stage 4</th>
</tr>
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</table>
Case Example

M0900: Healed Pressure Ulcers

Remember this pressure ulcer?

Thanks to the implemented care plan, it is healed

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Questions