M1200: Skin and Ulcer/Injury Treatments

M1200.	Skin and Ulcer/Injury Treatments
↓	Check all that apply
☐	A. **Pressure reducing device for chair**
☐	B. **Pressure reducing device for bed**
☐	C. **Turning/repositioning program**
☐	D. **Nutrition or hydration intervention** to manage skin problems
☐	E. **Pressure ulcer/injury care**
☐	F. **Surgical wound care**
☐	G. **Application of nonsurgical dressings** (with or without topical medications) other than to feet
☐	H. **Applications of ointments/medications** other than to feet
☐	I. **Application of dressings to feet** (with or without topical medications)
☐	Z. **None of the above** were provided

Item Rationale

Health-related Quality of Life

- Appropriate prevention and treatment of skin changes and ulcers reduce complications and promote healing.

Planning for Care

- These general skin treatments include basic pressure ulcer/injury prevention and skin health interventions that are a part of providing quality care and consistent with good clinical practice for those with skin health problems.
- These general treatments should guide more individualized and specific interventions in the care plan.
- If skin changes are not improving or are worsening, this information may be helpful in determining more appropriate care.

DEFINITION

PRESSURE REDUCING DEVICE(S)
Equipment that aims to relieve pressure away from areas of high risk. May include foam, air, water gel, or other cushioning placed on a chair, wheelchair, or bed. Include pressure relieving, pressure reducing, and pressure redistributing devices. Devices are available for use with beds and seating.

Steps for Assessment

1. Review the medical record, including treatment records and health care provider orders for documented skin treatments during the past 7 days. Some skin treatments may be part of routine standard care for residents, so check the nursing facility's policies and procedures and indicate here if administered during the look-back period.
2. Speak with direct care staff and the treatment nurse to confirm conclusions from the medical record review.
3. Some skin treatments can be determined by observation. For example, observation of the resident's wheelchair and bed will reveal if the resident is using pressure-reducing devices for the bed or wheelchair.

M1200: Skin and Ulcer/Injury Treatments (cont.)

Coding Instructions

Check all that apply in the last 7 days. Check Z, None of the above were provided, if none applied in the past 7 days.

- **M1200A,** Pressure reducing device for chair
- **M1200B,** Pressure reducing device for bed
- **M1200C,** Turning/repositioning program
- **M1200D,** Nutrition or hydration intervention to manage skin problems
- **M1200E,** Pressure ulcer/injury care
- **M1200F,** Surgical wound care
- **M1200G,** Application of non-surgical dressings (with or without topical medications) other than to feet. Non- surgical dressings do not include Band-Aids.
- **M1200H,** Application of ointments/medications other than to feet
- **M1200I,** Application of dressings to feet (with or without topical medications)
- **M1200Z,** None of the above were provided

M1200: Skin and Ulcer/Injury Treatments (cont.)

Coding Tips

M1200A/M1200B Pressure Reducing Devices

- Pressure reducing devices redistribute pressure so that there is some relief on or near the area of the ulcer/injury. The appropriate pressure reducing device should be selected based on the individualized needs of the resident.
- Do **not** include egg crate cushions of any type in this category.
- Do **not** include doughnut or ring devices in chairs.

M1200C Turning/Repositioning Program

- The turning/repositioning program is specific as to the approaches for changing the resident's position and realigning the body. The program should specify the intervention (e.g., reposition on side, pillows between knees) and frequency (e.g., every 2 hours).
- Progress notes, assessments, and other documentation (as dictated by facility policy) should support that the turning/repositioning program is monitored and reassessed to determine the effectiveness of the intervention.

M1200D Nutrition or Hydration Intervention to Manage Skin Problems

- The determination as to whether or not one should receive nutritional or hydration interventions for skin problems should be based on an individualized nutritional assessment. The interdisciplinary team should review the resident's diet and determine if the resident is taking in sufficient amounts of nutrients and fluids or are already taking supplements that are fortified with the US Recommended Daily Intake (US RDI) of nutrients.

DEFINITIONS

TURNING/ REPOSITIONING PROGRAM
Includes a consistent program for changing the resident's position and realigning the body. "Program" is defined as a specific approach that is organized, planned, documented, monitored, and evaluated based on an assessment of the resident's needs.

NUTRITION OR HYDRATION INTERVENTION TO MANAGE SKIN PROBLEMS
Dietary measures received by the resident for the purpose of preventing or treating specific skin conditions, e.g., wheat-free diet to prevent allergic dermatitis, high calorie diet with added supplementation to prevent skin breakdown, high-protein supplementation for wound healing.

M1200: Skin and Ulcer/Injury Treatments (cont.)

- Additional supplementation above the US RDI has not been proven to provide any further benefits for management of skin problems including pressure ulcers/injuries. Vitamin and mineral supplementation should only be employed as an intervention for managing skin problems, including pressure ulcers/injuries, when nutritional deficiencies are confirmed or suspected through a thorough nutritional assessment. If it is determined that nutritional supplementation, that is, adding additional protein, calories, or nutrients is warranted, the facility should document the nutrition or hydration factors that are influencing skin problems and/or wound healing and tailor nutritional supplementation to the individual's intake, degree of under-nutrition, and relative impact of nutrition as a factor overall; and obtain dietary consultation as needed.
- It is important to remember that additional supplementation is not automatically required for pressure ulcer/injury management. Any interventions should be specifically tailored to the resident's needs, condition, and prognosis.

M1200E Pressure Ulcer/Injury Care

- Pressure ulcer care includes **any** intervention for treating pressure ulcers coded in Current Number of Unhealed Pressure Ulcers/Injuries at Each Stage (M0300A–G). Examples may include the use of topical dressings; enzymatic, mechanical or surgical debridement; wound irrigations; negative pressure wound therapy (NPWT); and/or hydrotherapy.

M1200F Surgical Wound Care

- Does not include post-operative care following eye or oral surgery.
- Surgical debridement of a pressure ulcer does not create a surgical wound. Surgical debridement is used to remove necrotic or infected tissue from the pressure ulcer in order to facilitate healing, and thus, any wound care associated with pressure ulcer debridement would be coded in **M1200E, Pressure Ulcer Care**. The only time a surgical wound would be created is if the pressure ulcer itself was excised and a flap and/or graft used to close the pressure ulcer.
- Surgical wound care may include any intervention for treating or protecting any type of surgical wound. Examples may include topical cleansing, wound irrigation, application of antimicrobial ointments, application of dressings of any type, suture/staple removal, and warm soaks or heat application.
- Surgical wound care for pressure ulcers that require surgical intervention for closure (e.g., excision of pressure ulcer with flap and/or graft coverage) can be coded in this item, as once a pressure ulcer is excised and flap and/or graft applied, it is no longer considered a pressure ulcer, but a surgical wound.

M1200: Skin and Ulcer/Injury Treatments (cont.)

M1200G Application of Non-surgical Dressings (with or without Topical Medications) Other than to Feet

- Do **not** code application of non-surgical dressings for pressure ulcers/injuries other than to feet in this item; use M1200E, Pressure ulcer/injury care.
- Dressings do not have to be applied daily in order to be coded on the MDS assessment. If any dressing meeting the MDS definitions was applied even once during the 7-day look-back period, the assessor should check that MDS item.
- This category may include, but is not limited to, dry gauze dressings, dressings moistened with saline or other solutions, transparent dressings, hydrogel dressings, and dressings with hydrocolloid or hydroactive particles used to treat a skin condition, compression bandages, etc. Non-surgical dressings do not include adhesive bandages (e.g., BAND-AID® bandages, wound closure strips).

M1200H Application of Ointments/Medications Other than to Feet

- Do **not** code application of ointments/medications (e.g., chemical or enzymatic debridement) for pressure ulcers here; use M1200E, Pressure ulcer/injury care.
- This category may include ointments or medications used to treat a skin condition (e.g., cortisone, antifungal preparations, chemotherapeutic agents).
- Ointments/medications may include topical creams, powders, and liquid sealants used to treat or prevent skin conditions.
- This category does not include ointments used to treat non-skin conditions (e.g., nitropaste for chest pain, testosterone cream).

M1200I Application of Dressings to the Feet (with or without Topical Medications)

- Includes interventions to treat any foot wound or ulcer **other than a pressure ulcer/injury**.
- Do **not** code application of dressings to pressure ulcers/injuries on the foot; use M1200E, Pressure ulcer/injury care.
- Do not code application of dressings to the ankle. The ankle is not considered part of the foot.

M1200: Skin and Ulcer/Injury Treatments (cont.)

Examples

1. A resident is admitted with a Stage 3 pressure ulcer on the sacrum. Care during the last 7 days has included one debridement by the wound care consultant, application of daily dressings with enzymatic ointment for continued debridement, nutritional supplementation, and use of a pressure reducing pad on the resident's wheelchair. The medical record documents delivery of care and notes that the resident is on a two-hour turning/repositioning program that is organized, planned, documented, monitored, and evaluated based on an individualized assessment of their needs. The physician documents, after reviewing the resident's nutritional intake, healing progress of the resident's pressure ulcer, *dietitian*'s nutritional assessment, and laboratory results, that the resident has protein-calorie malnutrition. In order to support proper wound healing, the physician orders an oral supplement that provides all recommended daily allowances for protein, calories, nutrients, and micronutrients. All mattresses in the nursing home are pressure reducing mattresses.

   Coding: Check items **M1200A, M1200B, M1200C, M1200D, and M1200E.**
   Rationale: Interventions include pressure reducing pad on the wheelchair (M1200A) and pressure reducing mattress on the bed (M1200B), turning and repositioning program (M1200C), nutritional supplementation (M1200D), enzymatic debridement and application of dressings (M1200E).

2. A resident has a venous ulcer on the right leg. During the last 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 reducing mattress and pad for the wheelchair.

   Coding: Check items **M1200A, M1200B, and M1200G.**
   Rationale: Treatments include pressure reducing mattress (M1200B) and pad (M1200A) in the wheelchair and application of the compression-bandaging system (M1200G).

3. Resident S has a diagnosis of right-sided hemiplegia from a previous stroke. As part of their assessment, it was noted that while in bed Resident S is able to tolerate pressure on each side for approximately 3 hours before showing signs of the effects of pressure on their skin. Staff assist them to turn every 3 hours while in bed. When they are in their wheelchair, it is difficult for them to offload the pressure to their buttocks. Their assessment indicates that their skin cannot tolerate pressure for more than 1 hour without showing signs of the effect of the pressure when they are sitting, and therefore, Resident S is assisted hourly by staff to stand for at least 1 full minute to relieve pressure. Staff document all of these interventions in the medical record and note the resident's response to the interventions.

   Coding: Check **M1200C.**
   Rationale: Treatments meet the criteria for a turning/repositioning program (i.e., it is organized, planned, documented, monitored, and evaluated), that is based on an assessment of the resident's unique needs.

M1200: Skin and Ulcer/Injury Treatments (cont.)

4. Resident J has a diagnosis of Advanced Alzheimer's and is totally dependent on staff for all of their care. Their care plan states that they are to be turned and repositioned, per facility policy, every 2 hours.

   Coding: Do **not** check item **M1200C.**

   Rationale: 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.

Scenarios for Pressure Ulcer Coding

Example M0100-M1200

1. Resident P was admitted to the nursing home on 10/23/2019 for a Medicare stay. In completing the PPS 5-day assessment (ARD of 10/28/2019), it was noted that the resident had a head-to-toe skin assessment and their skin was intact, but upon assessment using the Braden scale, was found to be at risk for skin breakdown. The resident was noted to have a Stage 2 pressure ulcer that was identified on their coccyx on 11/1/2019. This Stage 2 pressure ulcer was noted to have pink tissue with some epithelialization present in the wound bed. Dimensions of the ulcer were length 01.1 cm, width 00.5 cm, and no measurable depth. Resident P does not have any arterial or venous ulcers, wounds, or skin problems. They are receiving ulcer care with application of a dressing applied to the coccygeal ulcer. Resident P also has pressure reducing devices on both their bed and chair and has been placed on a 1½ hour turning and repositioning schedule per tissue tolerance. In order to stay closer to their family, Resident P was discharged to another nursing home on 11/5/2019. This was a planned discharge (A0310G = 2), and their OBRA Discharge assessment was coded at A0310F as 10, Discharge assessment – return not anticipated.

   5-Day PPS:

   Coding:

   - **M0100B** (Formal assessment instrument), Check box.
   - **M0100C** (Clinical assessment), Check box.
   - **M0150** (Risk of Pressure Ulcers/Injuries), Code 1.
   - **M0210** (One or more unhealed pressure ulcers/injuries), Code 0 and skip to M1030 (Number of Venous and Arterial Ulcers).
   - **M1030** (Number of Venous and Arterial Ulcers), Code 0.
   - **M1040** (Other ulcers, wounds and skin problems), Check Z (None of the above).
   - **M1200** (Skin and Ulcer Treatments), Check Z (None of the above were provided).

Scenarios for Pressure Ulcer Coding (cont.)

Rationale: The resident had a formal assessment using the Braden scale and also had a head-to-toe skin assessment completed. Pressure ulcer risk was identified via formal assessment. Upon assessment the resident's skin was noted to be intact, therefore, **M0210** was coded 0. **M1030** was coded 0 due to the resident not having any of these conditions. **M1040Z** was checked since none of these problems were noted. **M1200Z** was checked because none of these treatments were provided.

Discharge Assessment:

Coding:

- **M0100A** (Resident has a pressure ulcer/injury, a scar over bony prominence, or a non-removable dressing/device), Check box.
- **M0210** (Unhealed Pressure Ulcers/Injuries), Code 1.
- **M0300B1** (Number of Stage 2 pressure ulcers), Code 1.
- **M0300B2** (Number of these Stage 2 pressure ulcers present on admission/entry or reentry), Code 0.
- **M0300C1** (Number of Stage 3 pressure ulcers), Code 0 and skip to M0300D (Stage 4).
- **M0300D1** (Number of Stage 4 pressure ulcers), Code 0 and skip to M0300E (Unstageable – Non-removable dressing/device).
- **M0300E1** (Unstageable – Non-removable dressing/device), Code 0 and skip to M0300F (Unstageable – Slough and/or eschar).
- **M0300F1** (Unstageable – Slough and/or eschar), Code 0 and skip to M0300G (Unstageable – Deep tissue injury).
- **M0300G1** (Unstageable – Deep tissue injury), Code 0 and skip to M1030 (Number of Venous and Arterial Ulcers).

Rationale: The resident has a pressure ulcer. On the 5-day PPS assessment, the resident's skin was noted to be intact; however, on the Discharge assessment, it was noted that the resident had a new Stage 2 pressure ulcer. Since the resident has had both a 5-day PPS and Discharge assessment completed, the Discharge assessment would be coded 0 at A0310E. This is because the Discharge assessment is **not** the first assessment since the most recent admission/entry or reentry.

SECTION N: MEDICATIONS

Intent: The intent of the items in this section is to record the number of days, during the last 7 days (or since admission/entry or reentry if less than 7 days) that any type of injection, insulin, and/or select medications were received by the resident.

In addition, two medication sections have been added. The first is an Antipsychotic Medication Review. Including this information will assist facilities to evaluate the use and management of these medications. Each aspect of antipsychotic medication use and management has important associations with the quality of life and quality of care of residents receiving these medications. The second is a series of data elements addressing Drug Regimen Review. These data elements document whether a drug regimen review was conducted upon the start of a SNF PPS stay through the end of the SNF PPS stay and whether any clinically significant medication issues identified were addressed in a timely manner.