M0300C: Stage 3 Pressure Ulcers

Enter Number ☐

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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 <u>these</u> 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

Item Rationale

Health-related Quality of Life

Pressure ulcers affect quality of life for residents because they may limit activity, may be painful, and may require time-consuming treatments and dressing changes.

Planning for Care

Pressure ulcers at more advanced stages typically require more aggressive interventions, including more frequent repositioning, attention to nutritional status, and care that may be more time or staff intensive.

An existing pressure ulcer may put residents at risk for further complications or skin injury.

DEFINITION

STAGE 3 PRESSURE ULCER

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 (see definition of

If a pressure ulcer fails to show some evidence toward healing within 14 days, the pressure ulcer (including potential complications) and the resident's overall clinical condition should be reassessed.

Tissue characteristics of pressure ulcers should be considered when determining treatment options and choices.

Changes in tissue characteristics over time are indicative of wound healing or degeneration.

Steps for Assessment

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

For the 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.

Identify all Stage 3 pressure ulcers currently present.

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

M0300C: Stage 3 Pressure Ulcers (cont.)

Coding Instructions for M0300C

M0300C1

Enter the number of pressure ulcers that are currently present and whose deepest anatomical stage is Stage 3.

Enter 0 if no Stage 3 pressure ulcers are present and skip to M0300D, Stage 4.

M0300C2

Enter the number of these Stage 3 pressure ulcers that were first noted at Stage 3 at the time of admission/entry AND—for residents who are reentering the facility after a hospital stay, enter the number of Stage 3 pressure ulcers that were acquired during the hospitalization (i.e., the Stage 3 pressure ulcer was not acquired in the nursing facility prior to admission to the hospital).

Enter 0 if no Stage 3 pressure ulcers were first noted at the time of admission/entry or reentry.

Coding Tips

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. Do **not** code moisture-associated skin damage or excoriation here.

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

M0300C: Stage 3 Pressure Ulcers (cont.)

Examples

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* 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.

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. *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: *T*he resident *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.*

M0300C: Stage 3 Pressure Ulcers (cont.)

On admission, the resident has three small Stage 2 pressure ulcers on *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*wo 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.

A resident *was admitted with no pressure ulcers/injuries and* developed two Stage 2 pressure ulcers during *their* stay; one on the coccyx and the other on the left lateral malleolus. At some point *they are* hospitalized and return 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*he Stage 2 pressure ulcer *on the coccyx, which 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*, which was 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 ulcer*s 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*he 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 *on the assessment*.

M0300C: Stage 3 Pressure Ulcers (cont.)

A resident is admitted to a nursing facility with a short leg cast to the right lower extremity. *They 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 removal of the cast, 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*ode **M0300C1 as 1**, and **M0300C2 as 1, present on admission/entry or reentry**.

Rationale: *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.*

Resident P was admitted to the nursing facility 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. Three weeks after admission, the right-heel blister is drained and conservatively debrided at the bedside. After debridement, the right heel is staged as a Stage 3 pressure ulcer. On the subsequent assessment, the right heel remains at Stage 3.

Coding: Code **M0300C1 as 1**, and **M0300C2 as 1**, present on admission/entry or reentry.

Rationale: This resident was admitted with an unstageable DTI that subsequently was debrided and could be numerically staged. The first numerical stage was 3, and it remained a Stage 3 for the subsequent assessment; therefore, it is coded as present on admission/entry or reentry.

M0300C: Stage 3 Pressure Ulcers (cont.)

Resident H was admitted with a known pressure ulcer/injury *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:*** *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.*