M0300G: Unstageable Pressure Injuries Related to Deep Tissue Injury

Enter Number ☐

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G. Unstageable - Deep tissue injury:

1. **Number of unstageable pressure injuries presenting as deep tissue injury** - If 0 → Skip to M1030, Number of Venous and Arterial Ulcers

2. **Number of <u>these</u> unstageable pressure injuries 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

Deep tissue injury may precede the development of a Stage 3 or 4 pressure ulcer even with optimal treatment.

Quality health care begins with prevention and risk assessment, and care planning begins with prevention. Appropriate care planning is essential in optimizing a resident's ability to avoid, as well as recover from, pressure (as well as all) wounds/injuries. Deep tissue injuries may sometimes indicate severe damage. Identification and management of deep tissue injury (DTI) is imperative.

DEFINITION

DEEP TISSUE INJURY

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

Planning for Care

Deep tissue injury requires vigilant monitoring because of the potential for rapid deterioration. Such monitoring should be reflected in the care plan.

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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 a result of pressure and that other conditions have been ruled out. If pressure is **not** the primary cause, do **not** code here.

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 deep tissue injury.

In dark-skinned individuals, the area of injury is probably not purple/maroon, but rather darker than the surrounding tissue.

Determine the number of pressure injuries that are unstageable related to deep tissue injury.

Identify the number of **these** pressure injuries that were present on admission/entry or reentry (see page M-8 for instructions).

Clearly document assessment findings in the resident's medical record, and track and document appropriate wound care planning and management.

Coding Instructions for M0300G

M0300G1

Enter the number of unstageable pressure injuries related to deep tissue injury. Based on skin tone, the injured tissue area may present as a darker tone than the surrounding intact skin. These areas of discoloration are potentially areas of deep tissue injury.

Enter 0 if no unstageable pressure injuries related to deep tissue injury are present and skip to M1030, Number of Venous and Arterial Ulcers.

M0300G2

Enter the number of these unstageable pressure injuries related to deep tissue injury that were first noted at the time of admission/entry AND—for residents who are reentering the facility after a hospital stay, that were acquired during the hospitalization (i.e., the unstageable pressure injury related to deep tissue injury was not acquired in the nursing facility prior to admission to the hospital).

Enter 0 if no unstageable pressure injuries related to deep tissue injury were first noted at the time of admission/entry or reentry.

M0300G: Unstageable Pressure Injuries Related to Deep Tissue Injury (cont.)

Coding Tips

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.

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 (see definition of Stage 2 pressure ulcer on page M-12).

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.*