Scenarios for Pressure Ulcer Coding

Example M0100-M1200

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.

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.*