Are You Coding Your MDS Under "Pressure"?
Make sure that you know the difference!

There are 2 areas on the MDS that will separately cause a resident to trigger under your
Percent of High Risk Residents with Pressure Ulcers (Long Stay) Quality Measure....

- *Section M0300 (Skin Conditions)*

or

- *Section I8000 (Active Diagnoses/Other)*

M0300. Current Number of Unhealed Pressure Ulcers at Each Stage –

M0300 B. 1 (Stage 2) = 1 or greater

OR

M0300 C. 1 (Stage 3) = 1 or greater

OR

M0300 D. 1 (Stage 4) = 1 or greater

A CODE OF "1" or greater on ANY of these 3 MDS items (above)
will trigger that resident in your
Percent of High Risk Residents with Pressure Ulcers (Long Stay) Quality Measure..

Pressure Ulcer - MDS Definition: "A pressure ulcer is localized injury to the skin and/or underlying tissue usually over a bony prominence, as a result of pressure, or pressure in combination with shear and/or friction." (Source- CMS's RAI Version 3.0 Manual, Page M-4)

One reason your facility's High Risk Pressure Ulcer (Long Stay) Quality Measure may be incorrect is that ulcers might be coded on the MDS that are not related to pressure. Prior to the final submission of any MDS, check to verify that if there is any code other than "0" on item M0210... that the resident did, in fact, have a pressure ulcer within the 7-day look-back period.

If the resident had a pressure ulcer that resolved prior to the 7-day look-back period, it should NOT be considered while coding M0300 on the MDS. Any healed pressure ulcers should be captured when completing Healed Pressure Ulcers (Item M0900).

I8000. Additional Active Diagnoses – Any ICD Code of…

707.22 (Stage 2)
707.23 (Stage 3)
707.24 (Stage 4)

in Section I (Active Diagnoses) I8000 (Other)
will trigger that resident in your
Percent of High Risk Residents with Pressure Ulcers (Long Stay) Quality Measure.

Prior to the final submission of any MDS, check to verify that if there are any ICD Diagnosis codes between 707.22 and 707.24 on item I8000... that the resident did, in fact, have a Stage 2, 3 or 4 pressure ulcer within the 7-day look-back period.

If the resident has an ulcer not specified as pressure-related, it should NOT be coded with any ICD code specific to "pressure-related ulcers".... and the code should be corrected before submission.

There are two look-back periods for this section:

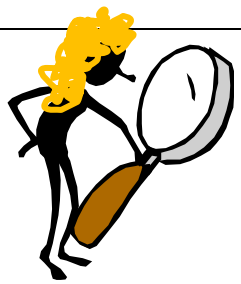
Diagnosis identification (Step 1) is a 60-day look-back period. The disease conditions in this section require a physician-documented diagnosis (or by a nurse practitioner, physician assistant, or clinical nurse specialist if allowable under state licensure laws) in the last 60 days.

Diagnosis status: Active or Inactive (Step 2) is a 7-day look-back period (except for Item I2300 UTI, which does not use the active 7-day look-back period).

Active Diagnoses – MDS Definition: "Diagnoses that have a direct relationship to the resident's functional status, cognitive status, mood or behavior, medical treatments, nursing monitoring, or risk of death during the 7-day look-back period." (Source- CMS's RAI Version 3.0 Manual, Page I-3)

Determine whether diagnoses are active: Once a diagnosis is identified, it must be determined if the diagnosis is active. Do not include conditions that have been resolved or have no longer affected the resident's functioning or plan of care during the last 7 days.

Code diseases that have a documented diagnosis in the last 60 days and have a relationship to the resident's functional status, cognitive status, mood or behavior status, medical treatments, nursing monitoring, or risk of death during the 7-day look-back period.



Make sure to have all of your completed MDSs verified prior to submission to ensure proper coding!

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