### 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 undermining and tunneling on page M-179).

### Coding Instructions

*Check all that apply in the last 7 days.*

*Pressure ulcers coded in M0210 through M0300 should not be coded here.*

### Example M0100-M1200

1. Mrs. 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 her skin was intact, but upon assessment using the Braden scale, was found to be at risk for skin breakdown. On the 14-day PPS (ARD of 11/5/2019), the resident was noted to have a Stage 2 pressure ulcer that was identified on her 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. Mrs. P does not have any arterial or venous ulcers, wounds, or skin problems. She is receiving ulcer care with application of a dressing applied to the coccygeal ulcer. Mrs. P. also has pressure reducing devices on both her bed and chair and has been placed on a 1½ hour turning and repositioning schedule per tissue tolerance. In order to stay closer to her family, Mrs. P was discharged to another nursing home on 11/5/2019. This was a planned discharge (A0310G = 2), and her OBRA Discharge assessment was coded at A0310F as 10, Discharge assessment – return not anticipated.

### 5-Day PPS #4:
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**M1030. Number of Venous and Arterial Ulcers**
- [ ] Enter the total number of venous and arterial ulcers present

**M1040. Other Ulcers, Wounds and Skin Problems**
- [ ] Check all that apply
  - **Foot Problems**
    - [ ] A. Infection of the foot (e.g., cellulitis, pariental drainage)
    - [ ] B. Diabetic foot ulcer(s)
    - [ ] C. Other open lesion(s) on the foot
  - **Other Problems**
    - [ ] D. Open lesion(s) other than ulcers, rashes, cuts (e.g., cancer lesion)
    - [ ] E. Surgical wound(s)
    - [ ] F. Burn(s) (second or third degree)
    - [ ] G. Skin tear(s)
    - [ ] H. Moisture Associated Skin Damage (MASD) (e.g., incontinence-associated dermatitis (IAD), perspiration, drainage)
    - [ ] None of the Above
    - [ ] 2. None of the above were present

**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)
  - [ ] 2. None of the above were provided
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<td>M-40</td>
<td>14-Day <strong>PPS Discharge Assessment:</strong></td>
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<td><strong>Coding:</strong></td>
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<td>• <strong>M0100A</strong> (Resident has a pressure ulcer/injury, a scar over bony prominence, or a non-removable dressing/device), Check box.</td>
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<td>• <strong>M0100B</strong> (Formal assessment instrument), Check box.</td>
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<td>• <strong>M0100C</strong> (Clinical assessment), Check box.</td>
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<td>• <strong>M0150</strong> (Risk of Pressure Ulcers/Injuries), Code 1.</td>
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<td>• <strong>M0210</strong> (One or more unhealed Pressure Ulcers/Injuries), Code 1.</td>
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<td>• <strong>M0300A</strong> (Number of Stage 1 pressure ulcers), Code 0.</td>
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<td>• <strong>M0300B1</strong> (Number of Stage 2 pressure ulcers), Code 1.</td>
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<td>• <strong>M0300B2</strong> (Number of these Stage 2 pressure ulcers present on admission/entry or reentry), Code 0.</td>
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<td>• <strong>M0300C1</strong> (Number of Stage 3 pressure ulcers), Code 0 and skip to <strong>M0300D</strong> (Stage 4).</td>
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<td>• <strong>M0300D1</strong> (Number of Stage 4 pressure ulcers), Code 0 and skip to <strong>M0300E</strong> (Unstageable – Non-removable dressing/device).</td>
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<td>• <strong>M0300E1</strong> (Unstageable – Non-removable dressing/device), Code 0 and skip to <strong>M0300F</strong> (Unstageable – Slough and/or eschar).</td>
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<td>• <strong>M0300F1</strong> (Unstageable – Slough and/or eschar), Code 0 and skip to <strong>M0300G</strong> (Unstageable – Deep tissue injury).</td>
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<td>• <strong>M0300G1</strong> (Unstageable – Deep tissue injury), Code 0 and skip to <strong>M1030</strong> (Number of Venous and Arterial Ulcers).</td>
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<td>• <strong>M1030</strong> (Number of Venous and Arterial Ulcers), Code 0.</td>
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<td>• <strong>M1040</strong> (Other Ulcers, Wounds and Skin Problems), Check Z (None of the above).</td>
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<td>• <strong>M1200A</strong> (Pressure reducing device for chair), <strong>M1200B</strong> (Pressure reducing device for bed), <strong>M1200C</strong> (Turning/repositioning program), and <strong>M1200E</strong> (Pressure ulcer/injury care) are all checked.</td>
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<td><strong>Rationale:</strong> 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. The resident <strong>has a pressure ulcer</strong>. On the 5-day PPS assessment, the resident’s skin was noted to be intact; however, on the 14-day PPS 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 14-day PPS Discharge assessment completed, the 14-day PPS Discharge assessment would be coded 0 at A0310E. This is because the 14-day PPS Discharge assessment is <strong>not</strong> the first assessment since the most recent admission/entry or reentry. There were no other skin problems noted. However, the resident, since she is at an even higher risk of breakdown since the development of a new ulcer, had preventative measures put in place, with pressure-reducing devices for her chair and bed. She was also placed on a turning and repositioning program based on tissue tolerance. Therefore, items M1200A, M1200B, and M1200C were all checked. She also now requires ulcer care and application of a dressing to the coccygeal ulcer, so M1200E is also checked. M1200G (Application of nonsurgical dressings [with or without topical medications]) would <strong>not</strong> be coded here because any intervention for treating pressure ulcers is coded in M1200E (Pressure ulcer/injury care).</td>
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### Track Changes from Chapter 3 Section M v1.16 to Chapter 3 Section M v1.17.1

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#### M01.00. Determination of Pressure Ulcer/Injury Risk

- **A.** Resident has a pressure ulcer/injury, a scar over bony prominence, or a non-removable dressing/device
- **B.** Formal assessment instrument/bed (e.g., Braden, Norton, or other)
- **C.** Clinical assessment
- **D.** None of the above

#### M01.50. Risk of Pressure Ulcers/Injuries

- Is this resident at risk of developing pressure ulcers/injuries?
  - **0.** No
  - **1.** Yes

#### M02.10. Unhealed Pressure Ulcers/Injuries

- Does this resident have one or more unhealed pressure ulcers/injuries?
  - **0.** No ➔ Skip to M0300. Number of Venous and Arterial Ulcers
  - **1.** Yes ➔ Continue to M0300. Current Number of Unhealed Pressure Ulcers/Injuries at Each Stage

#### M0300. Current Number of Unhealed Pressure Ulcers/Injuries at Each Stage

- **A.** Stage 1: intact skin with non-blanchable redness of a localized area usually over a bony prominence. Darkly pigmented skin may not have a visible blanching in dark skin tones only it may appear with persistent blue or purple hue
  - **1.** Number of Stage 1 pressure injuries

- **B.** Stage 2: Partial thickness loss of dermis presenting as a shallow open ulcer with a red or pink wound bed, without slough. May also present as an intact or open/nurtured blister
  - **1.** Number of Stage 2 pressure ulcers ➔ Skip to M0300C. Stage 2
  - **2.** Number of these Stage 2 pressure ulcers that were present upon admission/entry or reentry: enter how many were noted at the time of admission/entry or reentry

- **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 ➔ Skip to M0300D, Stage 4
  - **2.** Number of these 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

- **D.** Stage 4: Full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present on some parts of the wound bed. Often includes undermining and tunneling
  - **1.** Number of Stage 4 pressure ulcers ➔ Skip to M0300E, Unstageable - Non-removable dressing/device
  - **2.** Number of these Stage 4 pressure ulcers that were present upon admission/entry or reentry: enter how many were noted at the time of admission/entry or reentry

**M0300 continued on next page**

#### M03.00. Current Number of Unhealed Pressure Ulcers/Injuries at Each Stage - Continued

- **E.** Unstageable - Non-removable dressing/device: Known but not stageable due to non-removable dressing/device
  - **1.** Number of these unstageable pressure ulcers/injuries that were present upon admission/entry or reentry: enter how many were noted at the time of admission/entry or reentry

- **F.** Unstageable - Slough and/or eschar: Known but not stageable due to coverage of wound bed by slough and/or eschar
  - **1.** Number of these unstageable pressure ulcers due to coverage of wound bed by slough and/or eschar ➔ Skip to M0300G, Unstageable - Deep tissue injury
  - **2.** Number of these unstageable pressure ulcers that were present upon admission/entry or reentry: enter how many were noted at the time of admission/entry or reentry

- **G.** Unstageable - Deep tissue injury
  - **1.** Number of these unstageable pressure injuries presenting as deep tissue injury ➔ Skip to M0300L, Number of Venous and Arterial Ulcers
  - **2.** Number of these unstageable pressure injuries that were present upon admission/entry or reentry: enter how many were noted at the time of admission/entry or reentry
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**M1030. Number of Venous and Arterial Ulcers**
- Enter the total number of venous and arterial ulcers present

**M1040. Other Ulcers, Wounds and Skin Problems**
- Check all that apply
  - **Foot Problems**
    - A. Infection of the foot (e.g., cellulitis, persistent drainage)
    - B. Diabetic foot ulcer(s)
    - C. Other open lesion(s) on the foot
  - Other Problems
    - D. Open lesion(s) other than ulcers, rashes, cuts (e.g., cancer lesion)
    - E. Surgical wound(s)
    - F. Burn(s) (second or third degree)
    - G. Skin tear(s)
    - H. Moisture Associated Skin Damage (MASD) (e.g., incontinence-associated dermatitis) (IASD), perspiration, drainage
  - None of the Above
  - Z. None of the above were present

**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