



# Home Health Virtual Training Program – Part 1

## Section M: Skin Conditions

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# Objectives

- Describe the coding updates for Section M items.
- Summarize the implications of the Section M updates.



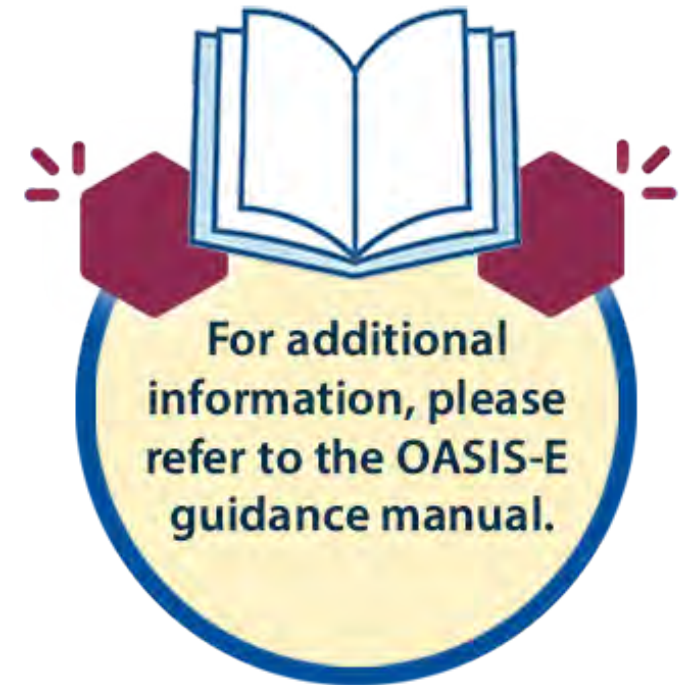
# Section M: Intent

- The items in this section assess the presence of pressure ulcers, stasis ulcers, and surgical wounds.



# Overview of Changes for Section M

- Updated the National Pressure Ulcer Advisory Panel (NPUAP) to [National Pressure Injury Advisory Panel \(NPIAP\)](#) throughout.
- Clarified consistent data sources.
  - Physical assessment and observation are the preferred approaches.
  - Patient/caregiver reports, and medical records, including physician or allowed practitioner orders and input, may be used.



# Overview of Changes for Section M (cont.)

- Updated response specific instructions for the following items:
  - **M1307. The Oldest Stage 2 Pressure Ulcer that is present at discharge.**
  - **M1311. Current Number of Unhealed Pressure Ulcers/Injuries at Each Stage.**
  - **M1330. Does this patient have a Stasis Ulcer?**
  - **M1340. Does this patient have a Surgical Wound?**
- Updated coding instructions:
  - **M1324. Stage of Most Problematic Unhealed Pressure Ulcer/Injury that is Stageable.**
- Update to instructions for surgical wound assessment:
  - **M1342. Status of Most Problematic Surgical Wound that is Observable.**

# M1307: The Oldest Stage 2 Pressure Ulcer That Is Present at Discharge

M1307. The Oldest Stage 2 Pressure Ulcer that is present at discharge: (Excludes healed Stage 2 pressure ulcers)	
<div>Enter Code</div> <div><div></div></div>	<div>1. Was present at the most recent SOC/ROC assessment</div> <div>2. Developed since the most recent SOC/ROC assessment. Record date pressure ulcer first identified: <div><div><div></div><div></div></div> - <div><div></div><div></div></div> - <div><div></div><div></div><div></div><div></div></div><div>MonthDayYear</div></div></div> <div>NA No Stage 2 pressure ulcers are present at discharge</div>



# M1307: Response Specific Instructions



- Do not reverse stage pressure ulcers as a way to document healing as it does not accurately characterize what is physiologically occurring as the ulcer heals.
  - For example, over time, even though a Stage 4 pressure ulcer has been healing and contracting such that it is less deep, wide, and long, the tissues that were lost (muscle, fat, dermis) will never be replaced with the same type of tissue.
  - Clinical standards require that this ulcer continue to be documented as a Stage 4 pressure ulcer until it has healed **or becomes unstageable**.



# M1311: Current Number of Unhealed Pressure Ulcers/Injuries at Each Stage – Start of Care (SOC)/Resumption of Care (ROC)

SOC/ROC	
M1311. Current Number of Unhealed Pressure Ulcers/Injuries at Each Stage	
Enter Number <input type="text"/>	A1. <b>Stage 2:</b> 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/ruptured blister. <b>Number of Stage 2 pressure ulcers</b>
Enter Number <input type="text"/>	B1. <b>Stage 3:</b> 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. <b>Number of Stage 3 pressure ulcers</b>
Enter Number <input type="text"/>	C1. <b>Stage 4:</b> 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. <b>Number of Stage 4 pressure ulcers</b>
Enter Number <input type="text"/>	D1. <b>Unstageable: Non-removable dressing/device:</b> Known but not stageable due to non-removable dressing/device <b>Number of unstageable pressure ulcers/injuries due to non-removable dressing/device</b>
Enter Number <input type="text"/>	E1. <b>Unstageable: Slough and/or eschar:</b> Known but not stageable due to coverage of wound bed by slough and/or eschar <b>Number of unstageable pressure ulcers due to coverage of wound bed by slough and/or eschar</b>
Enter Number <input type="text"/>	F1. <b>Unstageable: Deep tissue injury</b> <b>Number of unstageable pressure injuries presenting as deep tissue injury</b>





# M1311: Current Number of Unhealed Pressure Ulcers/Injuries at Each Stage – Discharge

Discharge	
M1311. Current Number of Unhealed Pressure Ulcers/Injuries at Each Stage	
Enter Number <input type="text"/>	A1. <b>Stage 2:</b> 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/ruptured blister. <b>Number of Stage 2 pressure ulcers</b> – If 0 → <i>Skip to M1311B1, Stage 3</i>
Enter Number <input type="text"/>	A2. <b>Number of <u>these</u> Stage 2 pressure ulcers that were present at most recent SOC/ROC</b> – enter how many were noted at the time of most recent SOC/ROC
Enter Number <input type="text"/>	B1. <b>Stage 3:</b> 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. <b>Number of Stage 3 pressure ulcers</b> – If 0 → <i>Skip to M1311C1, Stage 4</i>
Enter Number <input type="text"/>	B2. <b>Number of <u>these</u> Stage 3 pressure ulcers that were present at most recent SOC/ROC</b> – enter how many were noted at the time of most recent SOC/ROC
Enter Number <input type="text"/>	C1. <b>Stage 4:</b> Full thickness tissue loss with exposed bone, tendon, or muscle. Slough or eschar may be visible but does not obscure the wound bed. Often includes undermining and tunneling. <b>Number of Stage 4 pressure ulcers</b> – If 0 → <i>Skip to M1311E1, Stage 5</i>
Enter Number <input type="text"/>	C2. <b>Number of <u>these</u> Stage 4 pressure ulcers that were present at most recent SOC/ROC</b> – enter how many were noted at the time of most recent SOC/ROC



Enter Number <input type="text"/>	D1. <b>Unstageable: Non-removable dressing/device:</b> Known but not stageable due to non-removable dressing/device <b>Number of unstageable pressure ulcers/injuries due to non-removable dressing/device</b> – If 0 → <i>Skip to M1311E1, Unstageable: Slough and/or eschar</i>
Enter Number <input type="text"/>	D2. <b>Number of <u>these</u> unstageable pressure ulcers/injuries that were present at most recent SOC/ROC</b> – enter how many were noted at the time of most recent SOC/ROC
Enter Number <input type="text"/>	E1. <b>Unstageable: Slough and/or eschar:</b> Known but not stageable due to coverage of wound bed by slough and/or eschar <b>Number of unstageable pressure ulcers due to coverage of wound bed by slough and/or eschar</b> – If 0 → <i>Skip to M1311F1, Unstageable: Deep tissue injury</i>
Enter Number <input type="text"/>	E2. <b>Number of <u>these</u> unstageable pressure ulcers that were present at most recent SOC/ROC</b> – enter how many were noted at the time of most recent SOC/ROC
Enter Number <input type="text"/>	F1. <b>Unstageable: Deep tissue injury</b> <b>Number of unstageable pressure injuries presenting as deep tissue injury</b> – If 0 → <i>Skip to M1324, Stage of Most Problematic Unhealed Pressure Ulcer/Injury that is Stageable</i>
Enter Number <input type="text"/>	F2. <b>Number of <u>these</u> unstageable pressure injuries that were present at most recent SOC/ROC</b> – enter how many were noted at the time of most recent SOC/ROC

# M1311: Item Rationale



- It is important to recognize and evaluate each patient's risk factors for developing skin ulcers, wounds, or lesions, and to identify and evaluate all areas at risk of constant pressure. A complete assessment of skin is essential to an effective pressure ulcer/injury prevention and skin treatment program. It is imperative to determine the etiology of all wounds and lesions, as this will determine and direct the proper treatment and management of the wound.

# M1311: Response Specific Instructions



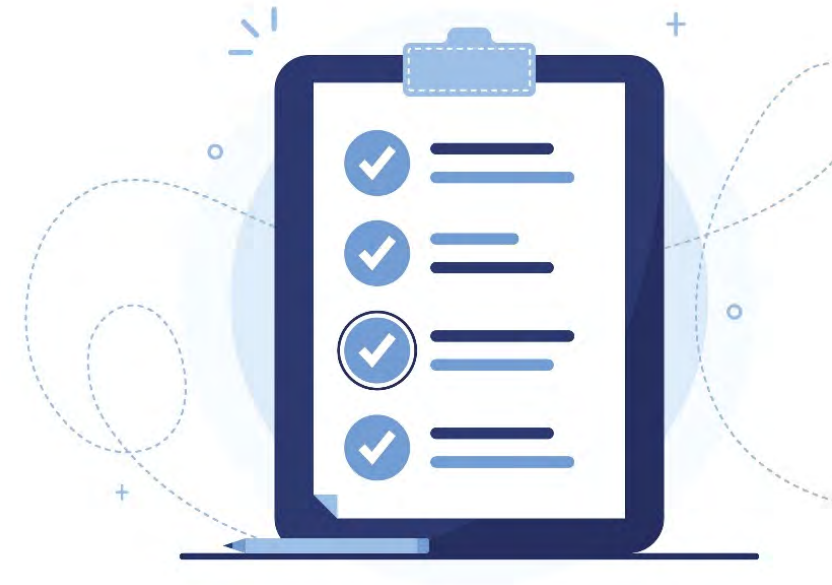
- The general standard of practice for patients starting or resuming care is that patient assessments are completed as close to the actual time of the SOC/ROC as possible.
  - When the assessing clinician is unable to complete a full skin assessment at the first visit, the assessing clinician may collaborate with a second clinician who completes the first clinical skin assessment, within the assessment timeframe.



# M1311: Response Specific Instructions (cont.)



- For **B1**: A previously closed Stage 3 pressure ulcer that is currently open again should be reported as a Stage 3 pressure ulcer, **unless currently presenting at a higher stage or unstageable**.
- For **C1**: A previously closed Stage 4 pressure ulcer that is currently open again should be reported as a Stage 4 pressure ulcer, **unless currently unstageable**.



# M1311: Determining “Present at the Most Recent SOC/ROC”



- If the patient has a pressure ulcer that was documented at SOC/ROC and at discharge is documented at the same stage, it would be considered as “**present at the most recent SOC/ROC**,” even if during the episode the original pressure ulcer healed and reopened.



# M1324: Stage of Most Problematic Unhealed Pressure Ulcer/Injury That Is Stageable

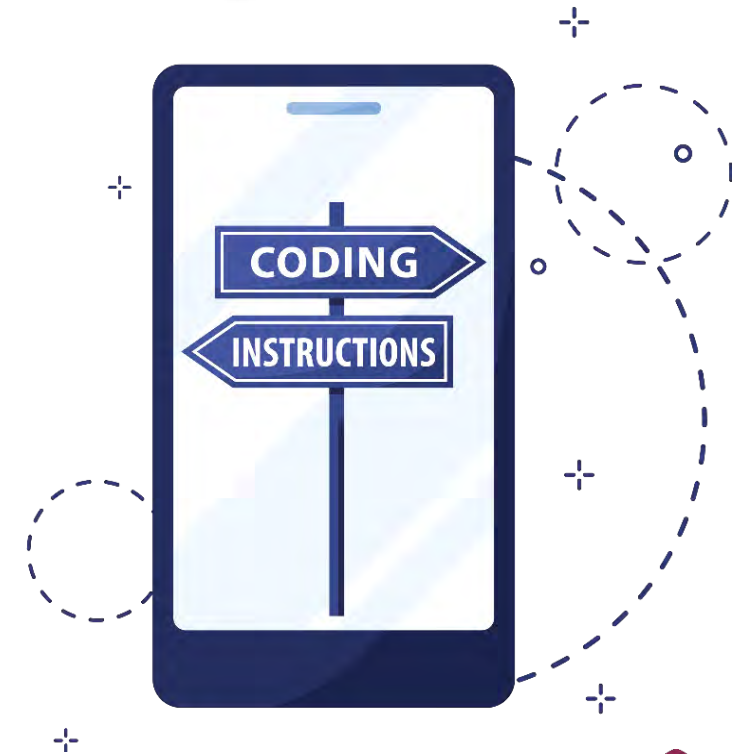
<b>M1324. Stage of Most Problematic Unhealed Pressure Ulcer/Injury that is Stageable</b> Excludes pressure ulcer/injury that cannot be staged due to a non-removable dressing/device, coverage of wound bed by slough and/or eschar, or deep tissue injury.	
<div>Enter Code</div> <div><input type="text"/></div>	<div>1. Stage 1</div> <div>2. Stage 2</div> <div>3. Stage 3</div> <div>4. Stage 4</div> <div>NA Patient has no pressure ulcers/injuries or no stageable pressure ulcers/injuries</div>





# M1324: Coding Instructions

- Stage 1 pressure injuries, although closed (intact skin), would not be considered healed.



# M1330: Does This Patient Have a Stasis Ulcer?

M1330. Does this patient have a Stasis Ulcer?	
Enter Code <div></div>	<div>0. No →Skip to M1340, Surgical Wound</div> <div>1. Yes, patient has BOTH observable and unobservable stasis ulcers</div> <div>2. Yes, patient has observable stasis ulcers ONLY</div> <div>3. Yes, patient has unobservable stasis ulcers ONLY (known but not observable due to non-removable dressing/device) → Skip to M1340, Surgical Wound</div>

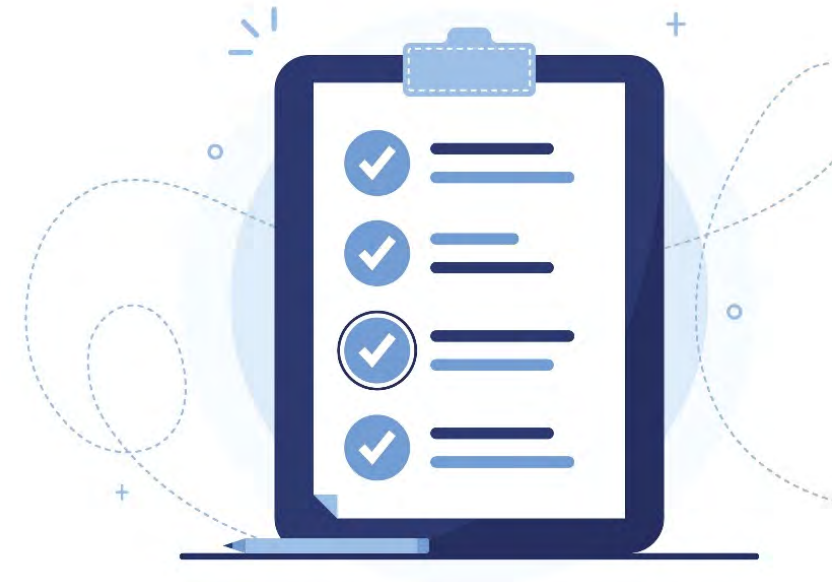




# M1330: Response Specific Instructions



- Unobservable stasis ulcers are reported stasis ulcer(s) that cannot be observed because of a dressing or device, such as a cast or Unna boot, that cannot be removed.
- Information may be obtained from the physician or patient/caregiver regarding the presence of a stasis ulcer underneath the cast or dressing.



# M1340: Does This Patient Have a Surgical Wound?

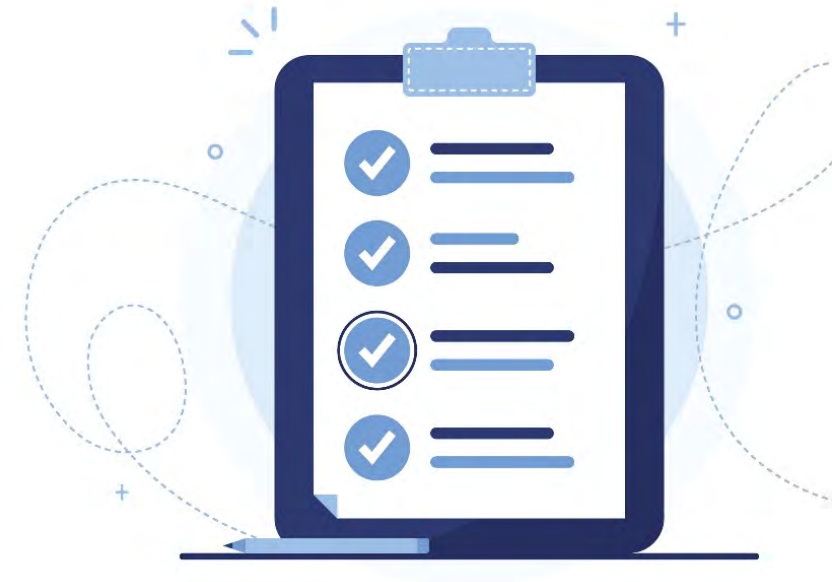
M1340. Does this patient have a <b>Surgical Wound</b> ?	
<div>Enter Code</div> <div><input type="text"/></div>	<div>0. <b>No</b> → <i>Skip to N0415, High-Risk Drug Classes: Use and Indication</i></div> <div>1. <b>Yes, patient has at least one observable surgical wound</b></div> <div>2. <b>Surgical wound known but not observable due to non-removable dressing/device</b> → <i>Skip to N0415, High-Risk Drug Classes: Use and Indication</i></div>



# M1340: Response Specific Instructions



- For coding this item, the agency may use any skin assessment conducted during the assessment time frame.



# M1342: Status of Most Problematic Surgical Wound That Is Observable

M1342. Status of Most Problematic Surgical Wound that is Observable	
<div>Enter Code</div> <div><input type="text"/></div>	<div>0. Newly epithelialized</div> <div>1. Fully granulating</div> <div>2. Early/partial granulation</div> <div>3. Not healing</div>

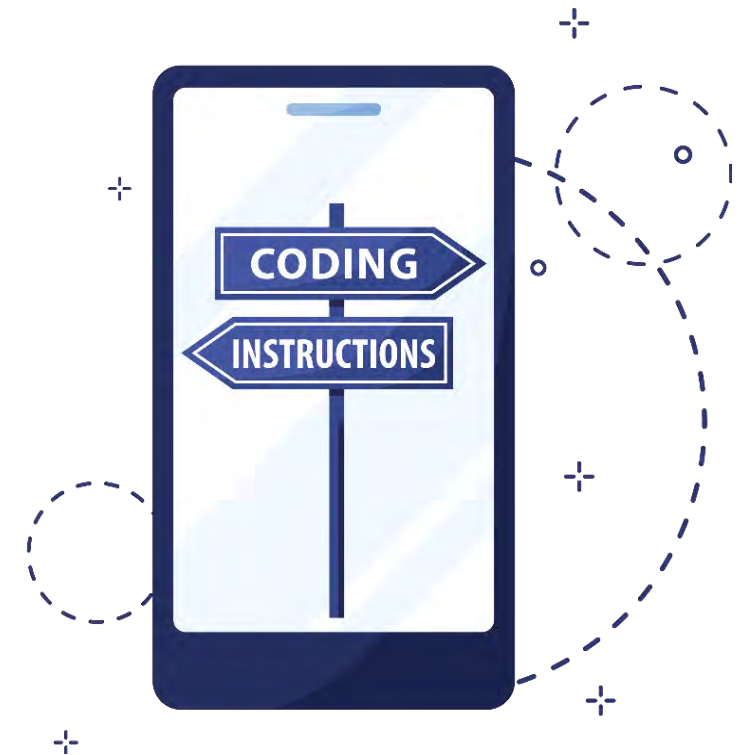


# M1342: Review of “Most Problematic”

- “Most problematic” is determined by the clinician’s professional evaluation of the individual’s overall wound status and may be based on factors including, but not limited to:
  - Healing status, such as an ulcer that is infected or resistant to treatment.
  - Size (may be the largest ulcer).
  - Location (may be difficult to access for treatment).

# M1342: Surgical Wound Assessment

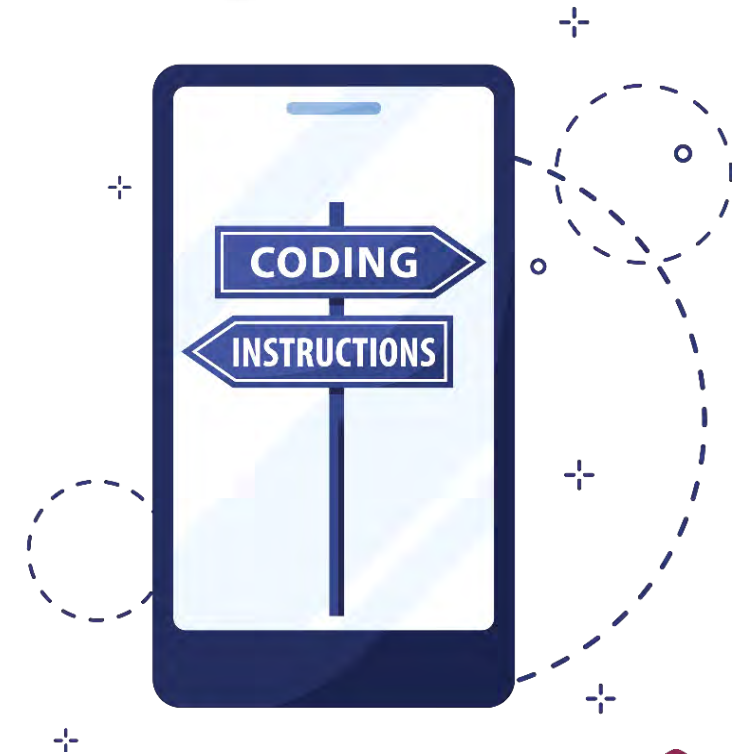
- Surgical wounds healing by primary intention (approximated incisions) do not granulate; therefore, the only appropriate responses are Response 0. – “Newly epithelialized” or Response 3. – “Not healing.”
  - A surgical incision is not automatically coded as Response 3. – “Not healing” solely due to the presence of staples.



# M1342: Surgical Wound Assessment (cont.)



- Surgical wounds with incisional separation heal by secondary intention.
- Surgical incisions healing by secondary intention do granulate; therefore, **in addition to meeting the definition for 0. – Newly epithelialized or 3. – Not healing**, these **secondary intention wounds** may **also fit the definitions for Response 1. – “Fully granulating” or Response 2. – “Early, partial granulation”** if appropriate.



# Summary



- Outlined the changes to item guidance language in Section M.
- Summarized the coding updates for pressure ulcers/injuries, stasis ulcers, and surgical wounds.



# Submitting Questions

- If you have questions about this presentation, please submit them to [PACTraining@Econometricalnc.com](mailto:PACTraining@Econometricalnc.com) by August 31, 2022.
- Select questions will be answered in a Q&A session during the September 2022 virtual live event.

