Section K: Swallowing/Nutritional Status

- Covers swallowing disorders
- Height and Weight, weight loss
- Nutritional approaches
- Nurse assessors should collaborate with the dietitian & dietary staff to ensure items in this section assessed & calculated correctly

Section K: Swallowing/Nutritional Status, cont.

- Ask if any difficulty swallowing during the past **7-days**, or had any symptom in **K0100A - K0100D**
- Observe during meals or any time eating, drinking, or swallowing
- Interview staff (all shifts) & review records
- Ability to swallow safely can be affected by many disease processes & functional decline

Section K: Swallowing/Nutritional Status, cont.

- Alternations in swallowing ability can result in choking & aspiration, which can increase the risk for malnutrition, dehydration, & aspiration pneumonia.
- Care planning should include provisions for monitoring during mealtimes & during functions/ activities that include eating & drinking.
- Further evaluations by other professionals may be necessary

K0100: Swallowing Disorder

- **See K0100: - Check all that apply.**
- **K0100A, loss of liquids/solids from mouth when eating or drinking.** Has food or liquid in their mouth, food or liquid dribbles down chin, or falls out of mouth.
- **K0100B, holding food in mouth/cheeks or residual food in mouth after meals.** Holds food in mouth or cheeks for prolonged periods of time (pocketing), or food left in mouth

K0100: Swallowing Disorder, cont.

- **See K0100: Check all that apply cont.**
- **K0100C, coughing /choking during meals or when swallowing medications.** May cough, gag, turn red, have labored breathing, difficulty speaking when eating, drinking, or taking meds. May c/o food or meds "going down the wrong way"
- **K0100D, complaints of difficulty or pain with swallowing.** May refuse food because it's painful or difficult to swallow.

K0100: Swallowing Disorder, cont.

- **See K0100:– Check all that apply cont.**
- **K0100Z, none of the above: No signs or symptoms present during the look-back.**
- **Code even if the symptom occurred only once in the past 7 days**
- **Do not code** swallowing problem if interventions have been successful in treating the problem & therefore signs/symptoms (**K0100A - K0100D**) did not occur during past 7 days

NEW

K0200A – Height

- **K200A: On admission, record ht. in inches**
- Use mathematical rounding - record height to the nearest whole inch
- Height of 62.5 in. round up = 63 inches
- Height of 62.4 in. round down = 62 inches

K0200A - Height

- Measure ht. consistently in accordance with facility policy & procedure (e.g., shoes off) & current standards of practice
- For later assessments, if last ht. recorded more than 1 yr. ago, measure & record ht. again

K200B - Weight

- **K200A: On admission, record wt.**
- **Use mathematical rounding - record weight to nearest whole pound**
- Weight of 152.4 lbs. – round down to 152 lbs.
- Weight of 152.5 lbs. – round up to 153 lbs.

K200B – Weight, cont.

- For subsequent assessments, check medical record & enter wt. taken within 30 days of the ARD of this assessment
- If last recorded wt. was taken > 30 days prior to the ARD of this assessment or previous wt. not available, weigh resident again
- If wt. taken more than once during preceding month, record the most recent wt.

K200B – Weight, cont.

- If resident cannot be weighed, for example because of extreme pain, immobility, or risk of pathological fractures
- Use the standard no-information code (-), and document rationale on the resident's medical record.

K0300: Weight Loss

- 5% wt. loss in 30 days; 10% or + in past 6 mo.
- K0300 compares wt. in the current observation period with wt. at 2 (two) snapshots in time:
- <u>Point closest to 30-days</u> **preceding current wt**.
- <u>Point closest to 180-days</u> **preceding current wt.**
- Does not consider wt. fluctuation outside these 2 time points, though wt. should be monitored on a continual basis & wt. gain/ loss assessed & in care plan as necessary

K0300: Weight Loss

- Start with wt. closest to 30 days ago, & multiply by .95 (or 95%) = a 5% loss in wt.
- If current wt. is = to or < less than the resulting figure, resident has lost more than 5% body wt.
- E.g.- Wt. 3 wks. ago = 172 lbs. x 95% = 163.4 lbs.
- Current wt. = 169 lbs. so **has not** lost 5% in 30 days

K0300: Weight Loss, cont.

- **Code 0, no or unknown:** 5% or + wt. loss in last 30 days, or 10% or + in last 180 days, or prior wt. unknown
- **Code 1, Yes** on Dr. prescribed **wt. loss plan**: 5% or + wt. loss in last 30 days, or 10% or + in last 180 days, **&** wt. loss planned & pursuant to Dr.'s order AND expressed goal of the diet must be inducing wt.loss
- **Code 2, Yes, not** on Dr. prescribed **wt. loss plan:** 5% or + wt. loss -last 30 days, or 10% or + last 180 days, **& wt. loss not** planned & prescribed by Dr.

K0500: Nutritional Approaches

- **See K0500 – check all that apply:**
- **K0500A,** parenteral/IV feeding
- **K0500B,** feeding tube (PEG)
- **K0500C,** mechanically altered diet (pureed)
- **K0500D,** therapeutic diet (low NA, diabetic, etc.)
- **K0500Z,** none of the above

K0500: Nutritional Approaches, cont.

- **K0500A -** the following fluids may be coded **when administered for nutrition /hydration:**
  - Hyperalimentation (TPN), continuously or intermittently
  - IV fluids at KVO (Keep Vein Open) rate
  - IV fluids administered via heparin locks
  - Hypodermoclysis & SubQ ports in hydration therapy

K0500A -IV fluids given to prevent dehydration must have active dx. of dehydration & documentation present to code MDS.

K0500A: Do NOT code these as IV fluids:

- IV Medications/ Additives, (e.g., K+, insulin) added to TPN or IV fluids — Code these in (O0100H)
- IV fluids to reconstitute /dilute Rx. for IV admin. unless a documented need for additional fluid intake for nutrition and/or hydration – have supporting notes according to State or NH policy
- IV fluids given as routine part of surgery, diagnostic procedure, recovery room stay, or IV fluids administered solely as flushes.
- Parenteral/IV fluids given in conjunction w/ chemo or dialysis

K0500: Coding Reminders

- **K0500 (Nutritional Approaches)** includes any **nutrition / hydration** – with supporting documentation -rec'd in the last 7 days:
  - **either at the nursing home,**
  - **at a hospital as an outpatient**
  - **as an inpatient**
- **K0500D, Therapeutic Diet –** Can only code Enteral formulas in K0500D when formula is altered to manage problematic conditions, e.g. formula specific to diabetes…

K0700A-B: Percent Intake by Artificial Route

- **See K0700A** – Proportion of total calories rec'd through parenteral or tube feeding
  - 1 = 25% or less
  - 2 = 26 - 50%
  - 3 = 51% or more
- **See K0700B** – Average fluid intake/day by IV or tube feeding
  - 1 = 500 cc/day or less
  - 2 = 501 cc/day or more

Section K: Q & A

- When coding for average fluid intake from IV fluids or tube feeding, the assessor should review the resident's intake records & include fluids for the past 7 days from:
  - a. IV fluids
  - b. Free water from tube feeding flushes
  - c. Water given before and after meds via tube
  - d. Fluids taken by mouth during meals
  - e. All of the above
  - f. All except d

Answer: F-All except D. Don't include po fluids in this item

Section L – Oral/Dental Status

- Periodontal disease ⟶ to systemic conditions: e.g., aspiration, malnutrition, pneumonia, endocarditis, & poor diabetic control
- Ask resident, family, others about presence of chewing problems, mouth/ facial pain/discomfort, or ill-fitting dentures – may need a referral
- Conduct oral exam, & if resident unable to report, observe resident eating
- **Mouth or facial pain captured here should also be coded in pain items, J0100 through J0850**

➢See L0200 – check all that apply:

A - broken, or loosely fitting full / partial denture
B - no natural teeth, tooth fragment(s)
C - abnormal mouth tissue
D - obvious or likely cavity / broken natural teeth
E - inflamed or bleeding gums / loose natural teeth
F - mouth or facial pain/discomfort w/ chewing
G - unable to examine
Z - none of the above were present

Section M: Skin Conditions

- Document & evaluate risk factors, presence, appearance, & change of pressure ulcers (PU), other types of skin ulcers, surgical wounds, or lesions
- Documents some skin treatments related to skin injury or avoiding injury
- A complete skin assessment essential to a PU prevention & skin treatment program – use a holistic approach

Section M: Skin Conditions, cont.

- Throughout Section M terminology referring to "healed" vs. "unhealed" refers to whether or not an ulcer is "closed" vs. "open"
- However, a Stage I, DTI, and/or Unstageable would not be considered "healed" *just because they are "closed"*
- Definition Boxes are throughout Section M, plus Steps for Assessment, Coding Tips
- Coding Scenarios when coding OBRA -Admission, Quarterly, Quarterly, and PPS -5-day, 14-day, and Discharge MDSs

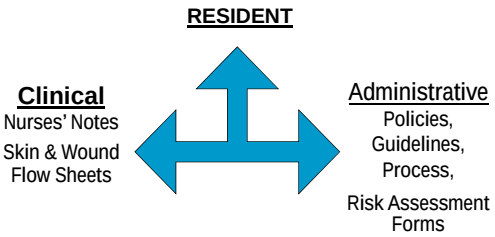
Reminders for Section M

- For MDS purposes, staging ulcers is coded in terms of what is seen & palpated, i.e. visible tissue, palpable bone - during initial look-back
- CMS - adapted NPUAP guidelines for MDS purposes, definitions do not perfectly correlate with each stage as described by NPUAP
- Code the MDS according to MDS 3.0 instructions
- NHs may adopt NPUAP guidelines in their clinical practice & nursing documentation

More Coding Tips for Section M

- If resident with a PU is hospitalized & returns with that pressure ulcer at the same stage, the pressure ulcer **should not be coded as "present on admission**" because it was present at the facility prior to the hospitalization.
- If a current PU worsens to a higher stage during a hospitalization, it is coded at the higher stage upon reentry and **should be coded as "present on admission."**
- **Critical concept – See page M-6**

Clinical/Administrative Interface



Organization Assessment

- Review your current facility systems & ask:
  - Who does data collection & how is documentation done? Who's responsible?
- Review current policy & procedures for:
  - PU policies & guidelines; Risk Assessments
  - Development & implementation of care plan for at -risk residents
- Clinician Skills needed:
  - Risk Assessment, new Pressure Ulcer Staging,Ulcer Measurement, Wound Identification

NPUAP Pressure Ulcer Definition

- CMS adapted the NPUAP 2007 definition of a PU as well as categories & staging
- A Pressure Ulcer (PU) is a localized injury to skin and/or underlying tissue usually over a bony prominence, as a result of pressure or pressure in combination with shear and/or friction.
- Exact mechanisms unknown; many theories; we just know the results…

Pressure Ulcer Risk Factors

- Immobility & decreased functional ability
- Co-morbid conditions (ESRD, diabetes, etc.)
- Drugs such as steroids
- Impaired diffuse or localized blood flow
- Resident refusal of care / treatment
- Cognitive Impairment
- Exposure of skin to incontinence (bowel/bladder)
- Under nutrition, malnutrition, dehydration
- History of a healed PU

M0100: Determination of PU Risk

- Review medical record, including skin care flow sheets, any skin tracking forms, nurses' notes, & PU risk assessments
- Speak with tx. nurse & direct care staff on all shifts to confirm documentation review & resident observations
- Examine resident & determine whether any ulcers, scars, or non-removable dressings/devices are present.
- Check key areas for PU development e.g., sacrum, coccyx, trochanters, ischial tuberosities, & heels. Also check bony prominences, e.g., elbows, ankles & skin under braces or subjected to friction, e.g., oxygen tubing by ears

➢ See M0100: Determination of PU Risk

- Report **Highest** stage of existing ulcer(s) **at its worst**; do NOT "reverse stage" – **Check all that apply**
- ➢ **Check A - resident has a Stage 1 or greater pressure ulcer, a scar over bony prominence, or a non-removable dressing/device.**
- Examples of non- removable dressings/devices include a primary surgical dressing, cast, or brace.

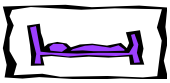
➢ See M0100: Determination of PU Risk, cont.

- **Check B if a formal assessment has been completed.**
  - An example of a established PU risk tool is the Braden Scale for Predicting Pressure Sore Risk
- **Check C if resident's risk for PU development is based on clinical assessment.**
  - E.g., head-to-toe exam, record review of PU risk factors, such as: impaired/decreased mobility, decreased functionality, ESRD, diabetes mellitus; steroids, impaired blood flow

➢ See M0100: Determination of PU Risk, cont.

- **Check Z if none of the above apply.**
- **Planning for Care:**
  - The care planning process should include efforts to stabilize, reduce, or remove underlying risk factors; to monitor the impact of the interventions; & to modify the interventions as appropriate based on the **individualized needs of the resident.**

M0150: Risk of Pressure Ulcers



- **Planning for Care**
- The care planning process should include
  - efforts to stabilize, reduce, or remove underlying risk factors
  - monitor the impact of interventions
  - modify interventions as appropriate based on the individualized needs of the resident

M0150: Risk of Pressure Ulcers

- **See M0150: Is resident at risk of developing pressure ulcers?**
- **Code 0, no:** Resident not at risk for developing pressure ulcers based on a review of items in **M0100**.
- **Code 1, yes:** Resident at risk of developing pressure ulcers based on information gathered for **M0100**.

M0210: Unhealed Pressure Ulcer(s)

- **M0210: Has 1 or more PU(s) Stage I or higher**
- Code based on presence of any PU (regardless of stage) in past 7 days.
- **Code 0, no**: Did not have a PU in past 7-days. **Skip Items M0300–M0800.**
- **Code 1, yes:** Had any PU (Stage 1, 2, 3, 4, or unstageable) in past 7-days.
  - Proceed to Current Number of Unhealed PUs at Each Stage (M0300).

M0300A-G: Steps for Assessment

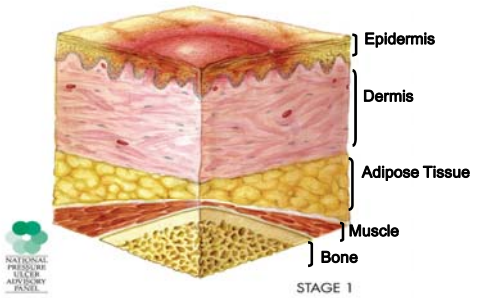
- Perform head-to-toe assessment -focusing on bony prominences & pressure-bearing areas (sacrum, buttocks, heels, ankles, etc)
- For coding: determine if lesion being assessed is **primarily** related to pressure & that other conditions have been ruled out
- **If pressure is NOT the primary cause, do NOT code in M0300** – skip to M1030
- Reliance on only 1descriptor is inadequate to determine PU staging between Stage 1 & a suspected deep tissue ulcers

M0300A-G: Current # of Unhealed Pressure Ulcers at Each Stage

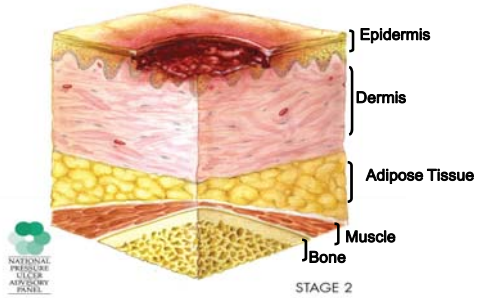
- **3 Steps for completing M0300A–G**
- **Step 1: Determine Deepest Anatomical Stage**
  - For each PU, determine deepest anatomical stage
  - Do not reverse or back stage
  - Consider current & historical levels of tissue involvement - Review & document hx. of each PU in the medical record

3 Steps for completing M0300A–G, cont.

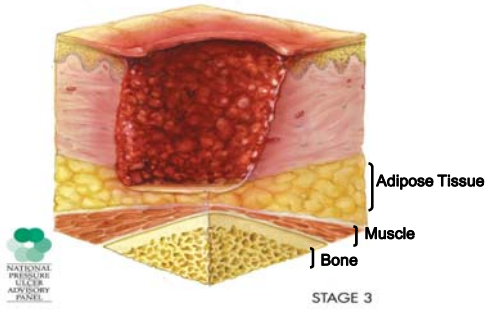
- **<u>Pressure ulcers healed before</u> the look-back period are not coded in this section. Code under Healed Pressure Ulcers - M0900**
- **See Guidance on staging pressure ulcers in Appendix C**



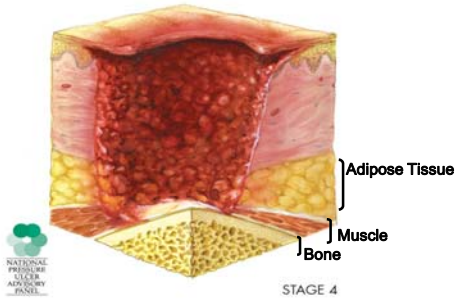
View of Stage I Pressure Ulcer – provided by NPUAP



View of Stage II Pressure Ulcer – provided by NPUAP



View of Stage III Pressure Ulcer – provided by NPUAP

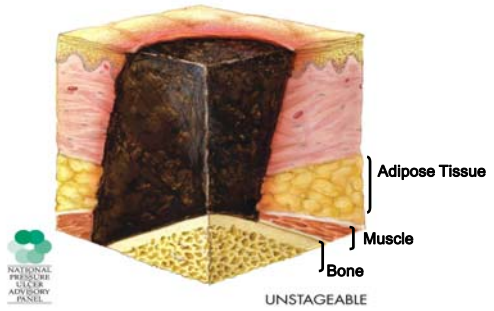


View of Stage IV Pressure Ulcer – provided by NPUAP

3 Steps for completing M0300A–G, cont.

- **Step 2: Identify Unstageable Pressure Ulcers**
- Visualization of wound bed necessary for accurate staging. **IF** wound bed partially covered by eschar or slough, <u>but depth of tissue loss can be measured</u>, **do not code as unstageable**
- PUs with necrotic /eschar (tan, black, or brown) present & tissue layers involved undetermined – classify as unstageable, REFER to:

http://www.npuap.org/images/NPUAP-Unstage2.jpg



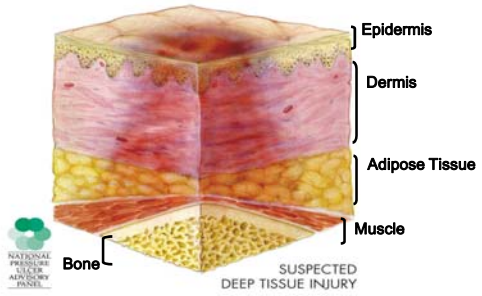
View of Unstageable Pressure Ulcer – provided by NPUAP

3 Steps for completing M0300A–G, cont.

- **Step 2 cont.**
- PUs with ulcer base covered by slough (yellow, tan, gray, green or brown) are <u>unstageable</u>
- PU with <u>suspected deep tissue injury</u> should <u>not be coded</u> as Stage 1 PU. Code as unstageable, as illustrated at:

http://www.npuap.org/images/NPUAP-SuspectDTI.jpg

- Known PUs covered by non-removable dressing and/or device (e.g., primary surgical dressing, cast) = <u>Code as unstageable.</u>



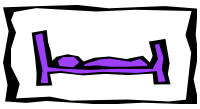
View of suspected Deep Tissue Injury Pressure Ulcer – from NPUAP

3 Steps for completing M0300A–G, cont.

- **Step 3: Determine "Present on Admission"**
- For **each PU**, determine if it was present at the time of Admission & **not** acquired while the resident was in the care of the NH.
- Review medical record for history of ulcer
- Review for **location & stage** at the time of Admission or Reentry.

3 Steps for completing M0300A–G, cont.

- **Step 3: Cont.**
- If PU present on Admission & subsequently worsened to a higher stage during resident's stay, code PU at that higher stage
- That higher stage **should not be considered as "present on admission."**



3 Steps for completing M0300A–G, cont.

- **Step 3: Cont.**
- **Example:**
- **Admission & 5-day PPS combined**
  - **Stage II = "present on Admission" = M0300**
- **14-day – PPS done**
  - **Stage II & no worse = "Present on Admission"**
- **30-day PPS**
  - **PU worse -now a Stage III – <u>cannot code as "Present on Admission" anymore</u>**

M0300A: # of Stage 1 Pressure Ulcers

- **Enter the number** of Stage 1 PUs present
- **Enter 0** if no Stage 1 PU present
- A Pressure ulcer with suspected deep tissue injury (sDTI) should **not** be coded as Stage 1 PU
- Code as <u>unstageable pressure ulcers due to suspected deep tissue injury at:</u>
  - **Unstageable - Deep tissue - M0300G**

M0300B: Stage 2 Pressure Ulcers

- **Enter number** of Stage 2 PUs currently present
- **Enter 0** if no Stage 2 PU present & skip to **M0300C**
- **Enter number** of Stage 2 PUs present at Admission, **or** for those readmitted after hospital stay <u>& PU acquired after transfer & during hospitalization</u> (not acquired in NH)
- **Enter 0** if no Stage 2 PU noted at Admission
- **Enter date of oldest Stage 2 PU**

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M0300C: Stage 3 Pressure Ulcers

- **Enter number** of PU present
- **Enter 0** if no Stage 3 PU present - Skip to **M0300D**
- **Enter number** of Stage 3 PUs present on Admission **or** for those readmitted after hospital stay <u>& PU acquired after transfer & during hospitalization</u> (PU not acquired in NH)
- **Enter 0** if no Stage 3 PU at Admission

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M0300D: Stage 4 Pressure Ulcers

- **Enter number** of PUs present
- **Enter 0** if no Stage 4 PU - Skip to **M0300E**
- **Enter number** of Stage 4 PUs on Admission or for those readmitted after hospital stay <u>& PU acquired after transfer & during hospitalization</u> (not acquired in NH)
- **Enter 0** if no Stage 4 PU at Admission

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M0300E: Unstageable PUs Due to Non-removable Dressing/Device

- **Enter number** of PU unstageable d/t to non-removable dressing/device.
- **Enter 0** if no unstageable PU - Skip to **M0300F**
- **Enter #** of unstageable PU d/t non-removable dressing/device at Admission, or for those readmitted after hospital stay <u>& PU acquired after transfer & during hospitalization</u> (not acquired in NH)
- **Enter 0** if no unstageable PU noted at Admission

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M0300F: Unstageable PUs Due to Slough and/or Eschar

- **Enter number of PUs** unstageable d/t slough and/or eschar
- **Enter 0** if no unstageable PU. Skip to **M0300G**
- **Enter #** of unstageable PUs d/t slough and/or eschar at Admission, or for those readmitted after hospital stay <u>& PU acquired after transfer & during hospitalization</u> (not acquired in NH)
- **Enter 0** if no unstageable PU at Admission

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M0300G: Unstageable PUs Due to Suspected Deep Tissue Injury(sDTI)

- **Enter #** of PUs unstageable due to sDTI
- **Enter 0** if no unstageable PUs present. Skip to **Dimensions of Unhealed Stage 3 or Stage 4 PUs or Eschar M0610**
- **Enter #** of unstageable PUs d/t to sDTI at Admission, or for those readmitted after hospital stay <u>& PU acquired after transfer & during hospitalization</u> (not acquired in NH)
- **Enter 0** if no unstageable PU at Admission

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M0610: Dimensions of Unhealed Stage 3 or 4 PUs /Unstageable PUs Due to Slough or Eschar

- If resident has one or more unhealed (non-epithelialized) Stage 3 or 4 PUs or unstageable PU d/t slough or eschar, identify PU with largest surface area (length × width) & record in centimeters
- **Complete only if PU is coded in M0300C1, M0300D1, or M0300F1**
- If 2 PUs occur on same bony prominence & are separated, superficially by skin, count as 2 separate PUs
- Stage & measure each PU separately

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M0700: Most Severe Tissue Type for Any Pressure Ulcer

- **1 = epithelial tissue:** wound superficial
- **2 = granulation tissue:** granulation tissue (no slough or eschar)-clean wound
- **3 = slough:** any amount, but no eschar
- **4 = necrotic tissue (eschar):** any amount necrotic tissue present

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M0700: Most Severe Tissue Type, cont.

- **Coding Tips:**
- All Stage 2 pressure ulcers should be coded as a "1" for this item
- Stage 2 pressure ulcers should **not** be coded with granulation, slough, or necrotic tissue
- **If the wound bed is covered with a mix of different types of tissue, code for the most severe type**

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M0800: Worsening PU Status Since Prior Assessment (OBRA, PPS, or Discharge)

- M0800 documents whether skin status, overall, has worsened since last assessment
- Complete only if A0310E = 0
- 0 = No new PUs, or none worsened
- Look-back = back to ARD of prior assessment
- If no prior assessment (this is 1st OBRA or PPS), do NOT complete M0800 - **Skip to M1030** –
- Tracking PU -consistent with good clinical care

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Coding Tips – M0800

- **Coding unstageable PUs:**
  - If PU unstageable on Admission, **do not** consider it worse on the 1st assessment in which it is staged after debridement
  - However, if it worsens after that assessment, it should be included in counts
- **If previously staged PU, becomes unstageable & then is debrided sufficiently to be staged:**
  - Compare stage before & after it debridement
  - If stage worsened, code it as such in M0800

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Coding Tips – M0800

- PU acquired during Hospital Admission = Code "present on admission/reentry" & do not include in count of worsening PUs
- If PU worsens to more severe stage during Hospitalization, code "present on admission/reentry" & not included in worsening PU
- **Readmission** -Important to recognize clinically if resident's overall skin status deteriorated in hosp.
- In either case, if PU deteriorates (increases in stage) on subsequent MDS assessments, it would then be included in counts of "worsening Pressure Ulcers"

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M0900A,B,C,D: Healed Pressure Ulcers

- **Complete only if A0310E = 0**
- If no prior assessment (1st OBRA or PPS), **do not complete this item. Skip to M1030**.
- Complete on all residents, even those without a current PU - even if M0210 = 0
- Look-back period ARD of prior assessment
- Review records to identify any PU (on prior MDS assessment) completely closed by ARD (A2300) of current assessment

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Coding Instructions for M0900A

- **See M0900A** – PU present on prior assessment –OBRA, PPS, or Discharge?
- **0 = NO – skip to M1030**
- **1 = Yes – PU on prior assessment**

- Identify deepest stage of each resurfaced or healed pressure ulcer
- Count # of healed PUs for each stage

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Coding Instructions for M0900 B, C, & D

- Identify deepest stage of each resurfaced or healed PU
- Count # of healed PU for each stage present on prior assessment – OBRA, PPS, or Discharge

- **Enter the number** of healed PU since the last assessment for each Stage 2 through 4
- **Enter 0:** if NO PU at a given stage, or NO PU has healed

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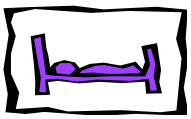
Coding Tips M0900 B, C, & D

- If prior assessment documents a PU healed between MDS assessments, but another PU occurred at the same location, ….
- **do not** consider that 1st PU to have healed, & **do not** record the PU as healed



68

M1030: Number of Venous & Arterial Ulcers- past 7 days

- **Check all that apply**
- Pressure ulcers coded in M0210 through M0900 should NOT be coded here.
- **Enter the number** of venous & arterial ulcers present.
- **Enter 0:** if no venous or arterial ulcers present

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M1040: Other Ulcers, Wounds & Skin Problems – past 7 days

- Review medical record, including skin care flow sheets or other skin tracking forms
- Interview direct care staff & tx. nurse
- Examine resident & document any ulcers, wounds, or skin problems are present.
- Pressure ulcers coded in M0200 through M0900 should NOT be coded here

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M1040: Other Ulcers, Wounds & Skin Problems, cont.

- **Check all that apply**
- **M1040A -** infection of the foot (e.g., cellulitis, purulent drainage)
- **M1040B -** diabetic foot ulcers)
- **M1040C -** other open lesion(s) on the foot
- **M1040D -** open lesion(s) other than ulcers, rashes, cuts (e.g., cancer lesion)
- **M1040E -** surgical wound(s)
- **M1040F -** burn(s) -second or third degree
- **M1040Z - None** of the above were present

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M1200: Skin & Ulcer Treatments in past 7 days

- Appropriate prevention & tx of skin changes & ulcers reduce complications & promote healing.
- General skin tx include basic PU prevention & skin health interventions - good clinical practice
- General tx.s should guide more individualized & specific interventions in the care plan.
- If skin changes not improving, or worsening, this information may be helpful in determining more appropriate care

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M1200: Coding Skin & Ulcer Treatments in past 7 days

- Review medical record, tx. records, & health care provider orders for documented skin tx.
- Some skin tx's part of routine standard care - check NH policies & procedures
- Interview direct care staff & tx. RN
- Observe - observation of resident's wheelchair & bed will reveal if pressure-reducing devices for the bed or wheelchair in place
- **Check all that apply**
- **Check Z - None of the above were provided**

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M1200: Coding Skin & Ulcer Treatments

- **M1200A-** pressure reducing device for chair
- **M1200B-** pressure reducing device for bed
- **M1200C-** turning/repositioning program
- **M1200D-** nutrition /hydration interventions
- **M1200E-** ulcer care
- **M1200F-** surgical wound care
- **M1200G-** application of non-surgical dressings (with /without topical medications) other than to feet
- **M1200H-** application - ointments/meds other than to feet
- **M1200I-** application of dressings to feet (with/ without topical medications)
- **M1200Z- none of the above provided**

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Section N - Medications

- **Intent: Record number of days that any type of:**
  - **Injection**
  - **Insulin, and/or**
  - **Selected medications received by resident**
  - **ER, Dr's office, etc.**

Additional info on medications found in: The Orange Book, National Drug Code Directory, and the FDA Website Consumer Information for Food & Dietary Supplements

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N0300 Injections

- Document # of days resident received injections
- Look-back period is **7 days** or **since admission/ reentry** if less than 7 days
- Includes any type of medication, antigen, or vaccine (**including insulin injections**)
- May be administered by subcutaneous, intramuscular, or intradermal injection
- **Do not record the number of injections**

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N0350A & N0350B - Insulin

- **N0350A Insulin injections:** Number of days insulin injections were received by resident
- **N0350B Order for Insulin:** Number of days insulin orders were changed for resident
- Review resident's medication administration records & determine if resident received insulin injections, or if insulin orders were changed

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N0400 Medications Received

- Documents these medications listed & received by resident – **Check all that apply**

A - Antipsychotic *
B - Antianxiety *
C - Antidepressant *
D - Hypnotic *
E - Anticoagulant
F - Antibiotic
G - Diuretic
Z - None of the above were received

*** Only items A, B, C, & D are captured on the Quarterly and PPS forms**

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N0400 Guidelines

- Look-back period is **7 days** or **since admission/ reentry** if less than 7 days
- Code medications according to a drug's pharmacological classification, **not** how it is used.
- Include any of these medications given to the resident by **any route**, in any setting
- Code a medication even if given only once during the look-back period

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N0400 Guidelines, cont.

- Count long-acting medications that are given every few weeks or monthly **only** if given during past 7 days
- **Combination** medications should be coded in **all categories** that constitute the combination
- Over-the-counter sleeping medications are not coded as hypnotics - they are not classified as hypnotic drugs

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CMS Updates since August

- Updates to Section N – Medications
  - New coding tips for herbal and alternative medicine products (chamomile, valerian root, etc.)
  - Important to document & monitor them

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