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3	—	M-1	CMS is aware of the array of terms used to describe alterations in skin integrity due to pressure. Some of these terms include: pressure ulcer, pressure injury, pressure sore, decubitus ulcer, and bed sore. Acknowledging that clinicians may use and documentation may reflect any of these terms, it is acceptable to code pressure-related skin conditions in Section M if different terminology is recorded in the clinical record, as long as the primary cause of the skin alteration is related to pressure. For example, if the medical record reflects the presence of a Stage 2 pressure injury, it should be coded on the MDS as a Stage 2 pressure ulcer.
3	M0100–M1200	M-1–M-54	Page length changed due to revised content.
3	M0210	M-5–M-6	• Oral Mucosal ulcers caused by pressure should not be coded in Section M. These ulcers are captured in item **L0200C, Abnormal mouth tissue**. • Mucosal pressure ulcers are not staged using the skin pressure ulcer staging system because anatomical tissue comparisons cannot be made. Therefore, mucosal ulcers (for example, those related to nasogastric tubes, nasal oxygen tubing, endotracheal tubes, urinary catheters, etc.) should not be coded here. • If a pressure ulcer is surgically closed with a flap or graft, it should be coded as a surgical wound and not as a pressure ulcer. If the flap or graft fails, continue to code it as a surgical wound until healed. • Residents with diabetes mellitus (DM) can have a pressure, venous, arterial, or diabetic neuropathic ulcer. The primary etiology should be considered when coding whether a resident with DM~~the diabetic~~ has an ulcer that is caused by pressure or other factors. • If a resident with DM has a heel ulcer from pressure and the ulcer is present in the 7-day look-back period, **code 1** and proceed to code items M0300–M0900 as appropriate for the pressure ulcer. • If a resident with DM has an ulcer on the plantar (bottom) surface of the foot closer to the metatarsals and the ulcer is present in the 7-day look-back period, **code 0** and proceed to M1040 to code the ulcer as a diabetic foot ulcer. It is not likely that pressure is the primary cause of the resident's ulcer when the ulcer is in this location.

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3	M0300	M-7	Added bold formatting to the following highlighted text. 4. If the pressure ulcer was unstageable on admission/entry or reentry, but becomes numerically stageable later, **it should be considered as "present on admission" at the stage at which it first becomes numerically stageable**. If it subsequently increases in numerical stage, that higher stage **should not be considered "present on admission."**
3	M0300A	M-9	3. Reliance on only one descriptor is inadequate to determine the staging of the pressure ulcer between Stage 1 and suspected deep tissue ulcers (see definition of suspected deep tissue injury on page M-21). The descriptors are similar for these two types of ulcers (e.g., temperature ~~(~~[warmth or coolness~~)~~]; tissue consistency ~~(~~[firm or boggy]).
3	M0300C	M-12	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-16).
3	M0300C	M-13	**Coding Tips** • The depth of a Stage 3 pressure ulcer varies by anatomical location. Stage 3 pressure ulcers can be shallow, particularly on areas that do not have subcutaneous tissue, such as the bridge of the nose, ear, occiput, and malleolus. • In contrast, areas of significant adiposity can develop extremely deep Stage 3 pressure ulcers. Therefore, observation and assessment of skin folds should be part of overall skin assessment. Do **not** code moisture-associated skin damage or excoriation here.

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3	M0300C	M-14	1. A pressure ulcer described as a Stage 2 was noted and documented in the resident's medical record on admission. On a later assessment, the wound is noted to be a full thickness ulcer without exposed bone, tendon, or muscle, thus it is now a Stage 3 pressure ulcer. Coding: The current Stage 3 pressure ulcer would be coded at M0300C1 as Code 1, and at M0300C2 as 0, not present on admission/entry or reentry. Rationale: The designation of "present on admission" requires that the pressure ulcer be at the same location and not have increased in numerical stage. This pressure ulcer worsened from a Stage 2 to a Stage 3 after admission. M0300C1 is coded as 1 and M0300C2 is coded as 0 on the current assessment because the ulcer was not a Stage 3 pressure ulcer on admission. This pressure ulcer would also be coded in M0800B as worsened.
3	M0300C	M-14	3. On admission, the resident has three small Stage 2 pressure ulcers on her coccyx. Two weeks later, the coccyx is assessed. Two of the Stage 2 pressure ulcers have merged and the third has increased in numerical stage to a Stage 3 pressure ulcer. Coding: The two merged pressure ulcers would be coded at M0300B1 as 1, and at M0300B2 as 1, present on admission/entry or reentry. The Stage 3 pressure ulcer would be coded at M0300C1 as 1, and at M0300C2 as 0, not present on admission/entry or reentry. Rationale: Two of the pressure ulcers on the coccyx have merged, but have remained at the same stage as they were at the time of admission; therefore, M0300B1 and M0300B2 would be coded as 1; the pressure ulcer~~one~~ that increased in numerical stage to a Stage 3 is coded in M0300C1 as 1 and in ~~cannot be coded in~~ M0300C2 as 0, not present on admission/entry or reentry since the Stage 3 ulcer was not present on admission/entry or reentry and developed a deeper level of tissue damage in the time since admission.

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3	M0300G	M-22	**Coding Tips** • Once suspected deep tissue injury has opened to an ulcer, reclassify the ulcer into the appropriate stage. Then code the ulcer for the reclassified stage. • Deep tissue injury may be difficult to detect in individuals with dark skin tones. • Evolution may be rapid, exposing additional layers of tissue even with optimal treatment. • When a lesion due to pressure presents with an intact blister AND the surrounding or adjacent soft tissue does NOT have the characteristics of deep tissue injury, do **not** code here (see definition of Stage 2 pressure ulcer on page M-10).
3	M0800	M-27	**Health-related Quality of Life** • This item documents whether skin status, overall, has worsened since the last assessment. To track increasing skin damage, this item documents the number of new pressure ulcers and whether any pressure ulcers have increased in numerical stage (~~"~~worsened~~"~~) since the last assessment. Such tracking of pressure ulcers is consistent with good clinical care.
3	M0800	M-27	DEFINITION WORSENING IN PRESSURE ULCER STATUS~~"WORSENING"~~ Pressure ulcer "worsening" is defined as a pressure ulcer that has progressed to a deeper level of tissue damage and is therefore staged at a higher number using a numerical scale of 1-4 (using the staging assessment system classifications assigned to each stage; starting at stage 1, and increasing in severity to stage 4) on an assessment as compared to the previous assessment. For the purposes of identifying the absence of a pressure ulcer, zero pressure ulcers is used when there is no skin breakdown or evidence of damage.

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3	M0800	M-28	**Coding Tips** • Coding this item will be easier for nursing homes that document and follow pressure ulcer status on a routine basis. • If a numerically staged pressure ulcer increases in numerical staging it is considered worsened. • Specific guidance regarding c~~C~~oding worsening of ~~unstageable~~ pressure ulcers: — If an unstageable pressure ulcer that was ~~unstageable~~ present on admission/entry or reentry~~,~~ is subsequently able to be numerically staged, do not consider it to be worsened because this would be ~~on~~ the first time ~~assessment~~ that the pressure ulcer was ~~it is~~ able to be numerically staged. However, if subsequent to this numerical staging, the pressure ulcer further deteriorates~~subsequently~~ and increases in numerical stage ~~after that assessment~~, the ulcer ~~it sh~~would be considered worsened.
3	M1040	M-36	M1040D, Open lesion(s) other than ulcers, rashes, cuts (e.g., ~~cancer lesion~~bullous pemphigoid)
3	M1040	M-36	• Do **not** code rashes or cuts/lacerations here. Although not recorded on the MDS assessment, these skin conditions should be considered in the plan of care. • Do **not** code pressure ulcers, venous or arterial ulcers, diabetic foot ulcers or skin tears here. These conditions are coded in other items on the MDS.