MDS 3.0 Section M: Skin Conditions: What the Medical Director Needs to Know

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The Centers for Medicare and Medicaid Services has released the new Resident Assessment Instrument version 3.0, which went into effect October 1, 2010. The intention of the revised Resident Assessment Instrument is to improve health-related quality of life and care planning, and incorporate evolving standards of terminology, assessment, and technology. To reach this goal, Section M: Skin Conditions has been greatly expanded and will alter the process of pressure ulcer assessment in all long-term care facilities across America. Details of this assessment instrument include upgraded criteria for risk factors, staging, identification, tracking, and evolution of pressure ulcers. The medical director can and should assume a leadership role in education and collaboration with primary care physicians and wound clinicians to accommodate changes in revised Section M. Integrating the medical director into the facility’s wound care program will improve the quality of care for residents of long-term care facilities. (J Am Med Dir Assoc 2011; 12: 179–183)

Keywords: Quality of care; nursing home regulations; resident assessment; pressure ulcers; medical director

The Centers for Medicare and Medicaid Services (CMS) is making a concerted effort to get the widespread and costly problem of pressure ulcers under control. Section M: Skin Conditions in the revised Minimum Data Set 3.0, which was implemented October 1, 2010, is the latest evidence of this effort.1,2 The new Section M subsection has nearly doubled in size, and is 3 pages long.3 With the revised Resident Assessment Instrument (RAI), CMS intends to improve technical and conceptual flaws present in the prior version.4,5 This article reviews the major changes in this important component of the RAI, highlighting CMS’s intentions with each updated area.6 We emphasize how the medical director and primary physician can collaborate with staff and assist facilities in accurate completion of this assessment tool, while upgrading the quality of care delivered to long-term care residents at risk for skin breakdown with or without pressure ulcers.

Pressure ulcers are now universally considered a quality indicator, and some members of the legal community have attempted to link them directly to elder mistreatment.7,8 As the medical director is required by F-tag 501 to coordinate the quality of care throughout the facility, it is imperative that the medical director be an active participant in the wound care program.9 This includes monitoring statistics of pressure ulcer incidence and prevalence, assisting with risk-detection and prevention programs, education of primary care physicians and monitoring their performance, and assessing the quality of outside consultants.

CMS fully expects the primary care physician to actively collaborate with the wound team. Proper wound care includes timely examination, with staging, diagnosis, testing, obtaining consultants, and prescription of appropriate wound care modalities. The important risk-management implications of pressure ulcer prevention and treatment have been discussed elsewhere.10–12 Because care for pressure ulcers is an interdisciplinary process embedded within many internal systems, quality care for pressure ulcers is synonymous with good risk-management practice.13 These systems include resident assessment, care planning, daily nursing routine, and physician involvement in clinical decision making.

Table 1 gives the subsections of MDS 3.0 Section M: Skin Conditions, all of which will be discussed in this article. Please note that this information is current as of November 15, 2010. The reader is encouraged to check the MDS 3.0...
In the previous tool, MDS 2.0 had an outdated and inaccurate staging system based on National Pressure Ulcer Advisory Panel (NPUAP) recommendations. New staging categories were not in keeping with current National Pressure Ulcer Advisory Panel recommendations. Stage 4 pressure ulcers were classified as Stage 4, which required reverse staging as ulcers heal. Pressure ulcers covered with eschar or slough were classified as Stage 4, which is not in keeping with current National Pressure Ulcer Advisory Panel recommendations. New staging categories were developed by NPUAP that were not recognized in the previous tool. MDS 2.0 had an outdated and inaccurate classification of ulcers other than those related to pressure ulcers, and classified ulcers of arterial and venous origin together in a category designated “stasis ulcers.” With revised MDS 3.0, CMS intended to incorporate current assessment criteria into wound description, classification, and staging.

The purpose was not only to improve pressure ulcer assessment in long-term care, but to make staging concordant with other settings across the health care continuum. The revised RAI Manual encourages careful classification of ulcers that are not attributable to pressure. For example, incontinence dermatitis, yeast infection of the perineum, and moisture-associated skin damage should not be coded as pressure ulcers in M0300. If, however, any of these conditions deteriorates from pressure resulting in disruption in skin integrity over a boney prominence, the wound should be reclassified as a pressure ulcer.

Table 1 shows the designated sections that correspond to each ulcer stage. Within each section, except for Stage 1 pressure ulcers, the wound clinician is required to enter the number of ulcers at each stage and the number of ulcers present on admission or reentry. CMS has specific language adapted from NPUAP describing each pressure ulcer stage, and they are explicit in stating that Stage 2 does not have slough in the wound bed. The presence of slough would reclassify the ulcer to minimally a Stage 3. Only Stage 2 ulcers are required to have “date of oldest” coded. The number of unhealed pressure ulcers should be entered into subsection M0210.

Unstageable ulcers and suspected deep tissue injury (sDTI) were coded differently in MDS 2.0. In the revised version, unstageable ulcers are not only recognized, but divided into 3 types. M0300E codes ulcers that cannot be staged because they are under a device or nonremovable dressing. M0300F codes for ulcers that are unstageable because the base cannot be visualized because of eschar or slough. M0300G codes ulcers that are unstageable because they manifest sDTI. This category is the newest to be recognized by NPUAP, and shows intact skin with purple or maroon areas that may also manifest pain, differences in temperature, or other tissue changes such as firmness or bogginess to palpation. Clinicians are advised to take special care in evaluating persons with darkly pigmented skin, as sDTI and Stage 1 can be overlooked.

Heel blisters are recognized by MDS 3.0, and clinicians are encouraged to carefully examine and describe them before assigning a stage. A clear blister without any damaged peripheral areas are assigned as Stage 2, whereas blisters that are dusky, blood filled, or showing signs of deeper injury are designated unstageable sDTI in M0300G.

Experts agree that as pressure ulcers improve, healed areas consist of tissue that is different from that originally present.

Table 2. Section M Components for Each Pressure Ulcer Stage

<table>
<thead>
<tr>
<th>Code</th>
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<tr>
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<td>Stage 1 pressure ulcers</td>
</tr>
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<tr>
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</tr>
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<td>Stage 4 pressure ulcers</td>
</tr>
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Web site for updates and changes in coding criteria and wording of the RAI Manual.1

**“AT-RISK” CLASSIFICATION**

Section M0100 refers to pressure ulcer risk assessment, and represents a conceptual advance in coding risk status, as it does not rely solely on a numerical risk assessment tool. Focus on such a tool overlooks many medical and physiological conditions that increase risk for pressure ulcers.14 It has been increasingly recognized that patient-specific factors leading to altered tissue perfusion contribute to pressure ulcer formation.15 In contrast with the currently revised Section M, MDS 2.0 did not have a coding section for persons at risk for pressure ulcers.

There are 3 ways of determining at-risk status for pressure ulcers. In M0100A, a resident is considered at risk for pressure ulcers if there is an ulcer present, a scar from a previously healed pressure ulcer, or if the resident has a nonremovable dressing or device. Medical devices account for many pressure ulcers and are increasingly recognized as important contributors to their occurrence.16,17 M0100B codes risk status based on a formal assessment tool such as the Norton or Braden instrument. It is important to note that CMS does not require the use of any formal tool, but does allow for the use of it. Finally M0100C codes risk status based on clinical assessment, which includes decreased mobility, comorbidity conditions, medications such as steroids, or physiologic derangements that cause decreased perfusion. Any or all of the preceding ways of assessing pressure ulcer risk are checked in the M0100 section. Based on the assessment in M0100, residents considered at risk for pressure ulcers are coded in M0150 as either 1 for yes or 0 for no.

**PRESSURE ULCER STAGING AND WOUND CLASSIFICATION**

MDS 2.0 recognized only 4 stages of pressure ulcers and required reverse staging as ulcers heal. Pressure ulcers covered with eschar or slough were classified as Stage 4, which is not in keeping with current National Pressure Ulcer Advisory Panel (NPUAP) recommendations. New staging categories have been developed by NPUAP that were not recognized in the previous tool.18 MDS 2.0 had an outdated and inaccurate classification of ulcers other than those related to pressure ulcers, and classified ulcers of arterial and venous origin together in a category designated “stasis ulcers.” With revised MDS 3.0, CMS intended to incorporate current assessment criteria into wound description, classification, and staging. The purpose was not only to improve pressure ulcer assessment in long-term care, but to make staging concordant with other settings across the health care continuum.

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Table 2 shows the designated sections that correspond to each ulcer stage. Within each section, except for Stage 1 pressure ulcers, the wound clinician is required to enter the number of ulcers at each stage and the number of ulcers present on admission or reentry. CMS has specific language adapted from NPUAP describing each pressure ulcer stage, and they are explicit in stating that Stage 2 does not have slough in the wound bed. The presence of slough would reclassify the ulcer to minimally a Stage 3. Only Stage 2 ulcers are required to have “date of oldest” coded. The number of unhealed pressure ulcers should be entered into subsection M0210.

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and “reverse staging” or “backstaging” should not be used. The RAI Instruction Manual for MDS 3.0 explicitly prohibits reverse staging. Therefore, once a pressure ulcer is Stage 4, it remains a “healing Stage 4” as it improves.

The “present on admission” classification is not as simple as it seems. Pressure ulcers that are present on residents who arrive in the facility are considered present on admission; however, if that ulcer reaches a deeper stage while in the facility it is no longer coded as present on admission. On the other hand, facility-acquired ulcers that deteriorate during a hospital admission are re-coded as present on admission.

Remember that CMS has adapted NPUAP guidelines, and if in doubt with regard to classification, the CMS definition supersedes. For example, NPUAP classification of pressure ulcers uses Roman numerals, whereas CMS requires Arabic numbers for data entry. In addition, CMS recognizes that this tool is only a “minimum” data set, and the wound care clinician is encouraged to enter more detailed narrative wound descriptions elsewhere in the medical record. These narratives should cover additional issues such as specific prevention measures, wound descriptions, resident compliance, advance directives related to wounds, treatments in progress, nutritional status, and response to treatment.

WOUND MEASUREMENTS AND MOST SEVERE TISSUE TYPE

M0610 is the section for measurement of the largest pressure ulcers. Only stages 3, 4, or unstageable owing to slough or eschar are eligible for data entry in M0610. Only the dimensions of the largest pressure ulcer are recorded here, but good practice requires measurements of all ulcers elsewhere in the medical record. Facilities will need a tracking process by which pressure ulcer dimensions can be recorded so that it can be determined which is the largest, so that it can be recorded in this subsection. Measurements are in centimeters to the nearest tenth decimal point, and wounds are measured by length (head to toe of the resident), width (90 degrees perpendicular to length), and depth. If the largest pressure ulcer is covered with eschar, put dashes in the boxes for depth.

M0700 records the most severe tissue type, and the clinician is provided with 4 choices: (1) epithelial tissue, (2) granulation tissue, (3) slough or (4) necrotic tissue. This nomenclature has been adapted from the Pressure Ulcer Staging and Healing tool, which has been advocated by NPUAP for assessment of pressure ulcer changes over time.20,21 When there is a mix of tissue type in an ulcer, the clinician is advised to code the most severe tissue type in M0700 regardless of the percentage of the ulcer covered with the most severe tissue type.

CHANGES IN PRESSURE ULTER STATUS

Sections M0800 and M0900 record pressure ulcers that worsen or heal and are not completed on the admission MDS assessment. Within each of these sections there are data points for Stages 2, 3, and 4. Remember that reverse staging is not accepted when labeling and tracking ulcers. If a pressure ulcer was initially unstageable owing to eschar or slough, then was debrided to reveal a stageable wound, that wound is not considered to have deteriorated. If an ulcer worsens during a hospital admission, that ulcer is coded as worsening.

If a pressure ulcer heals, that resident will remain at risk for new pressure ulcers as per at-risk criteria in M0100A.

NUMBER OF ARTERIAL AND VENOUS ULCERS

The prior MDS version did not allow accurate diagnosis for arterial ulcers, and venous ulcers were designated by outdated terminology. RAI Manual Version 3.0 has detailed instructions regarding bedside diagnosis of arterial and venous ulcers. For purposes of MDS 3.0, the wound clinician needs to count the number of both arterial and venous ulcers and enter that number into M1030. We see this section as another important opportunity for collaboration with the physician to determine the correct etiology of a wound as arterial or venous.

When there is ambiguity as to whether the ulcer was caused by pressure or some other cause, CMS has added language that narrows the clinician’s choices. In other words, even in the presence of severe underlying arterial or venous disease, if pressure was the major factor in wound etiology, it is designated a pressure ulcer and not coded in M1030. The same applies for new lower extremity wounds in persons with diabetes mellitus.

OTHER ULCERS, WOUNDS, AND SKIN PROBLEMS

Section M1040 codes for wound, skin, or foot problems other than pressure ulcers. M1040B is where diabetic foot ulcers are coded, keeping in mind the CMS restriction that if a wound has a predominant pressure-related etiology it is designated as a pressure ulcer in M0300. Surgical wounds, burns, and other open lesions, such as those related to malignancy, are coded in this section. Skin tears and cuts related to trauma should not be coded in M1040 or anywhere else in Section M. Skin tears as a result of a fall are coded in section J1900B.

If a pressure ulcer is debrided surgically it is not recoded as a surgical wound. However, if a pressure ulcer is closed with a myocutaneous flap it is recoded as a surgical wound in M1040E.

SKIN AND ULCER TREATMENTS

Except for the addition of “application of dressings to feet,” section M1200 is largely unchanged from MDS 2.0. Pressure-reducing devices for the chair and bed are coded here, as well as turning and repositioning and nutrition/hydration programs. Egg crate mattresses and inflatable or cushioned doughnuts are not allowed as pressure relief devices. Note that CMS prevention language is slightly different from NPUAP, as CMS uses the term “pressure reducing” while NPUAP uses “pressure redistribution.” These terms are assumed to be synonymous in the RAI Manual.6

The RAI Manual is strict in what is allowed for coding in pressure ulcer prevention sections M1200A, B, and C. Any coding for pressure ulcer prevention must be preceded and accompanied by an individualized assessment and care plan elsewhere in the medical record, and not simply a matter of automatic triggers or facility policy.

Any pressure ulcer treatment should be coded in M1200E. Actively treated wounds or skin problems that are not entered in Section M, such as skin tears, require coding in
M1200G: Application of nonsurgical dressings other than to the feet. Treatment of moisture-associated skin damage is coded in M1200H: Application of ointments/medications other than to feet. If a resident is being treated for diabetic ulcers on the foot, this is coded in M1200I.

**IMPLICATIONS FOR THE MEDICAL DIRECTOR AND PRIMARY CARE PHYSICIAN**

Revised Section M: Skin Conditions will certainly engender controversy. The detail required for classification of pressure ulcers is based on a staging system that has undergone numerous revisions and reclassifications over the years. Expert opinion continues to shift as the natural history of pressure ulcers is redefined. Negative attitudes have been expressed regarding prior versions of the MDS, with doubts expressed regarding its usefulness in care planning and quality improvement. However, laws and regulations continue to impact all aspects of long-term care, reflecting public expectations and impacting on key aspects of health care delivery. Despite its flaws and limitations, Section M: Skin Conditions represents a major attempt to encourage facilities to improve processes of care, which will ultimately have an impact on outcomes related to pressure ulcers and skin care.

Instructions for MDS 3.0 are very specific regarding coding of pressure ulcers, including any wound whose etiology is caused by pressure and excluding wounds that are not pressure related such as incontinence dermatitis. Lower extremity wounds in persons with arterial or venous disease, or microvascular disease owing to diabetes mellitus, could potentially be overcoded as pressure ulcers. For example, the RAI Manual 3.0 directs the clinician to code an ulcer on the planter aspect of the foot in a resident with diabetes as a diabetic ulcer in M1040B. However, if the same resident develops an ulcer on the dorsum of the toe from a tight shoe, that wound will be coded as a pressure ulcer. Clinically, however, many clinicians would prefer this wound be designated as a diabetic ulcer.

CMS acknowledges that this tool is a “minimum” data set, and each medical chart should contain narrative documentation detailing pressure relief modalities, descriptions of the wound(s), treatments in progress, and response to such. For example, there are numerous types of pressure-reducing devices for bed and chair, and the medical chart should contain information on the specific type of device, ie, brand name and model, powered or nonpowered, type of device, and so forth. F-tag 314 acknowledges that pressure ulcers can be avoidable or unavoidable, a topic that is not part of the RAI instruction manual or MDS 3.0 Section M. The issue of unavoidability should be addressed by a physician or medical director who is knowledgeable about the patient’s condition and documented in a narrative note elsewhere in the medical record. In addition, there is no recognition in the F-tag, RAI Manual, or Section M regarding skin changes at life’s end or the Kennedy Terminal Ulcer. If the wound clinician wishes to incorporate this terminology as part of the ulcer assessment, it should be done in the narrative portion of the medical record.

Section M does not have data entry for pain, an extremely important component of wound care, although this topic is addressed elsewhere in MDS 3.0. Treatment of pressure ulcers has only limited presence in MDS 3.0 Section M. This is found in M1200 A and B for pressure reduction, M1200 C for turning and repositioning, M1200D for nutrition and hydration, and M1200E for ulcer care. It is imperative that nutritional assessments on all patients at risk for or who have pressure ulcers to be thorough and timely.

In addition, clinicians need to document specific wound care modalities. Because of the numerous treatment choices available, it is best to justify each order with a rationale (eg, enzymatic debridement, moisturize a dry wound, encourage granulation).

To meet the challenge of revised MDS 3.0 Section M: Skin Condition, facilities need to completely reevaluate policies, procedures, and guidelines for wound care in their facilities. There is no doubt that the requirements of Section M will require facilities to upgrade staff knowledge and skills with regard to staging, reporting, description, and treatment.

Outsourcing wounds to professionals whose work processes are outside the loop of the facility will not satisfy requirements for revised Section M, as internal communication is a critical component of care. CMS encourages each facility to look carefully at the clinical-administrative interface, upgrading prevention awareness, documentation, and data flow. The medical director should have a critical leadership role in this process.

The medical director can begin by upgrading his or her knowledge base regarding wound care and pertinent regulations, and a good place to start is reviewing the detailed instructions in F-tag 314, RAI Manual, and other sources such as the American Medical Directors Association Clinical Practice Guidelines. The medical director should then take an active role teaching primary care physicians who work in the facility, providing leadership and collaborating with the clinical team regarding critical issues such as determining at-risk status and staging and classification of wounds. Although the literature is limited regarding physician knowledge of pressure ulcers, data has shown that skills in this area are limited.

Medical charts should have internal and external consistency in wound diagnosis, staging, and designation of location. All primary care physicians should be educated in this process, as well as the process of collaboration with the facility’s wound care clinician. Evidence-based care is a key to clinical decision making and problem solving in the nursing home. However, given the numerous wound care modalities available and the limited data supporting many of them, physicians should be prepared to justify their therapeutic modalities. CMS encourages critical thinking and informed decision making with the revised RAI and the authors encourage discarding “standing orders” for wounds. These tools of convenience substitute informed decision making with an inappropriate cookbook approach to wound care. However, standardized protocols that allow for individualized clinical decision making have been shown to have good care outcomes.

Given the attention directed to quality indicators by CMS, as well as the heightened risk-management atmosphere in
nursing homes, particularly around pressure ulcers, there should be little tolerance for physicians who do not comply with facility standards. These standards should include timely assessment for pressure ulcer risk, examination of wounds, inclusion of wound descriptions in medical charting, and informed decision making on treatment choices.

CMS intended the revised MDS 3.0 to be in tune with health-related quality of life and care planning, as well as evolving standards of medical care including terminology and technology. The new Section M: Skin Conditions goes a long way in reaching these goals. To comply with the new regulatory standards, facilities must completely reevaluate their wound care programs, staffing expertise, and manpower requirements. The medical director is a critical member of the team who can assist long-term care facilities in upgrading the quality of care for wounds, but this effort will certainly require investment in learning, teaching, and collaboration, which should ideally extend across care settings.

REFERENCES


