PDPM Side of Wound Care

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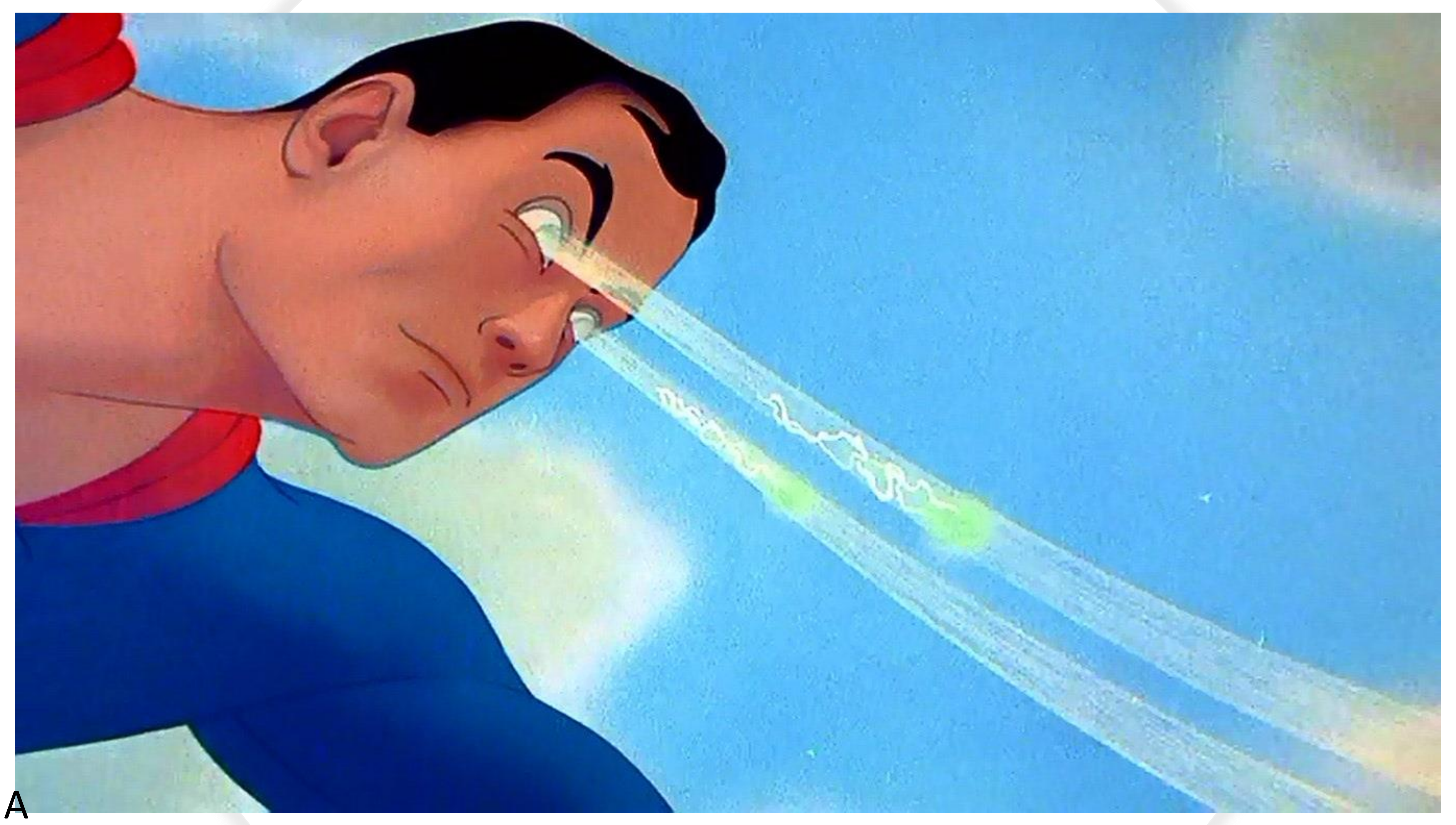
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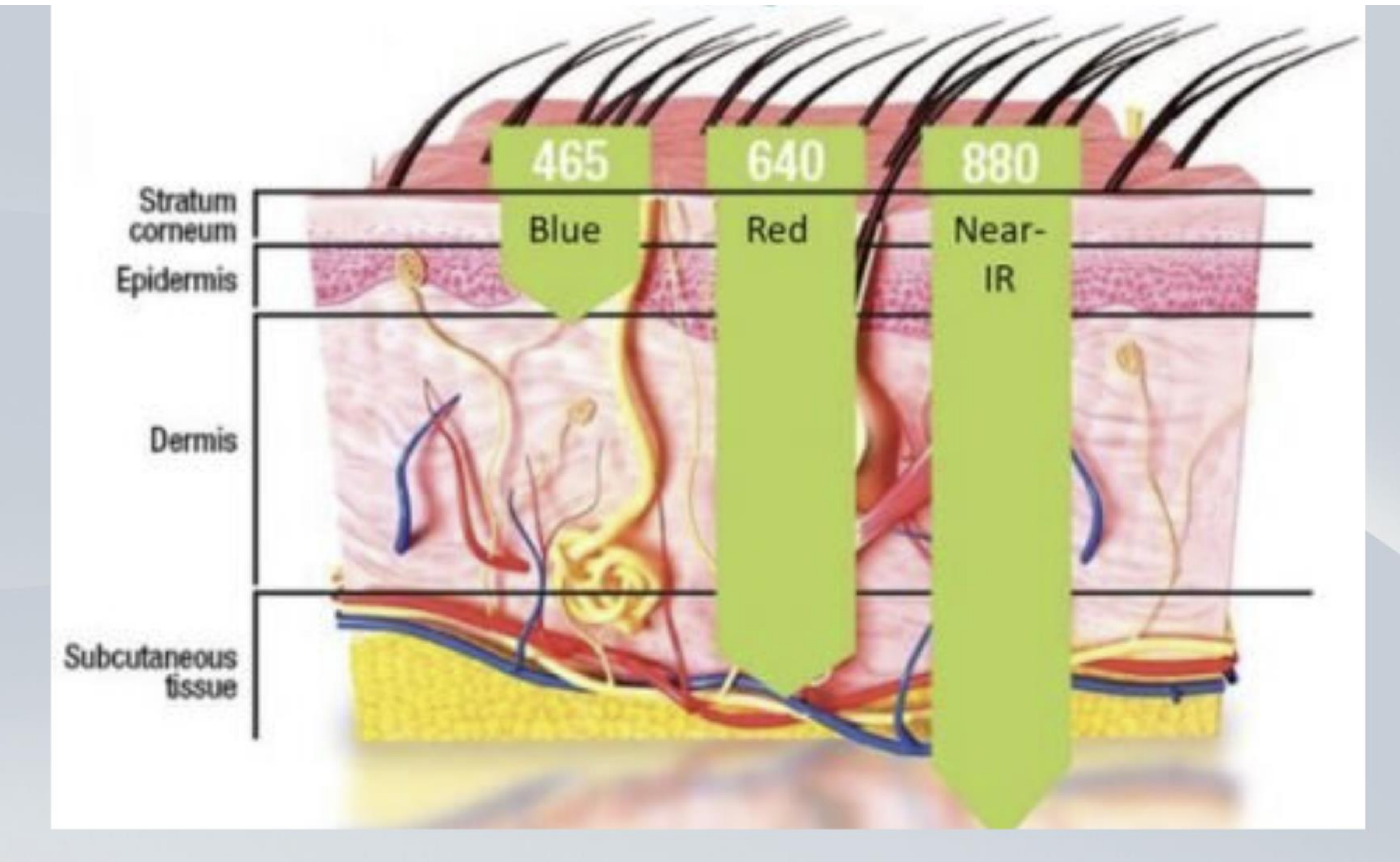

NIR light is very useful in detecting oxygenated and deoxygenated blood, which conveys a comprehensive picture of tissue health and the healing capacity of acute and chronic wounds.

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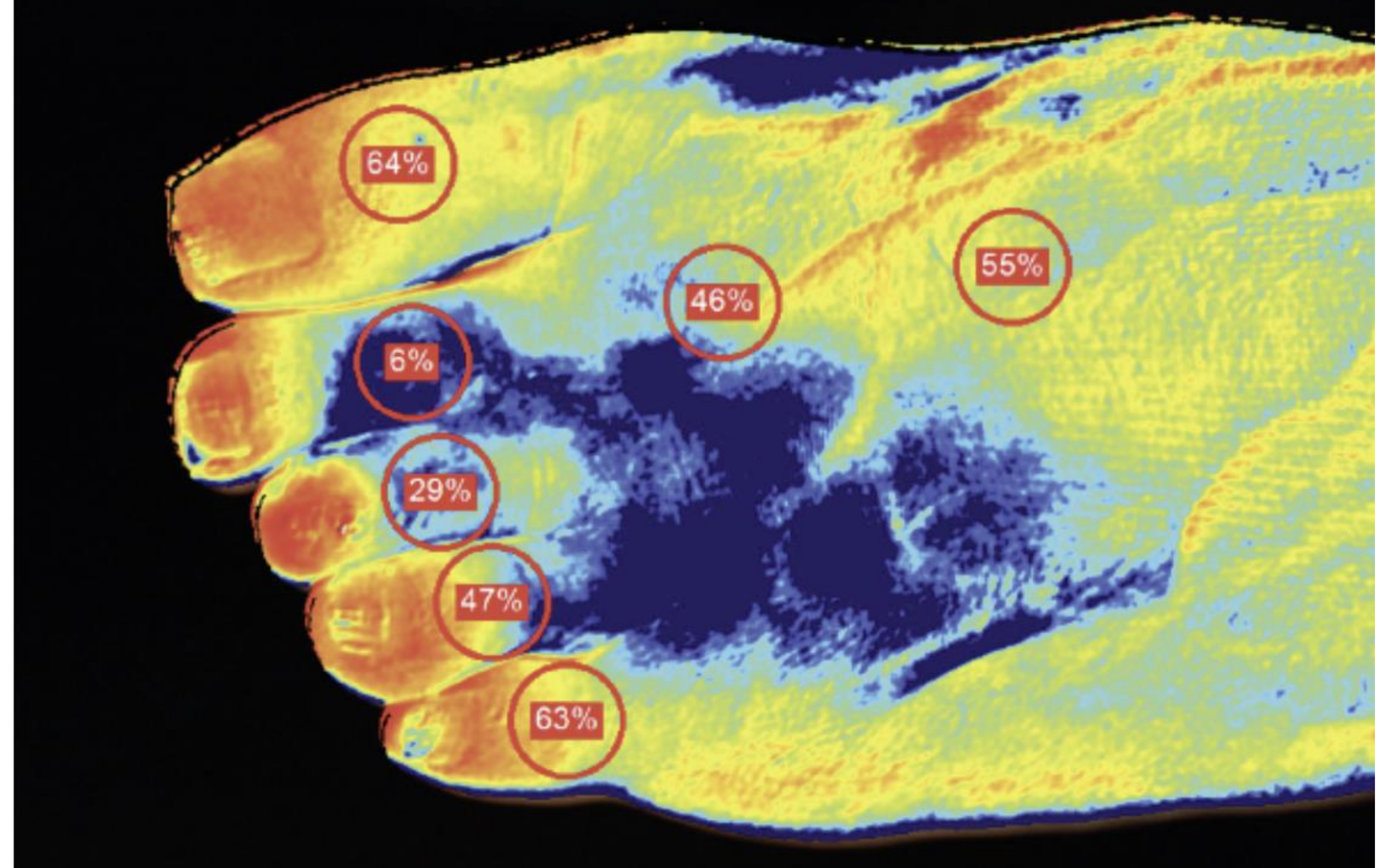

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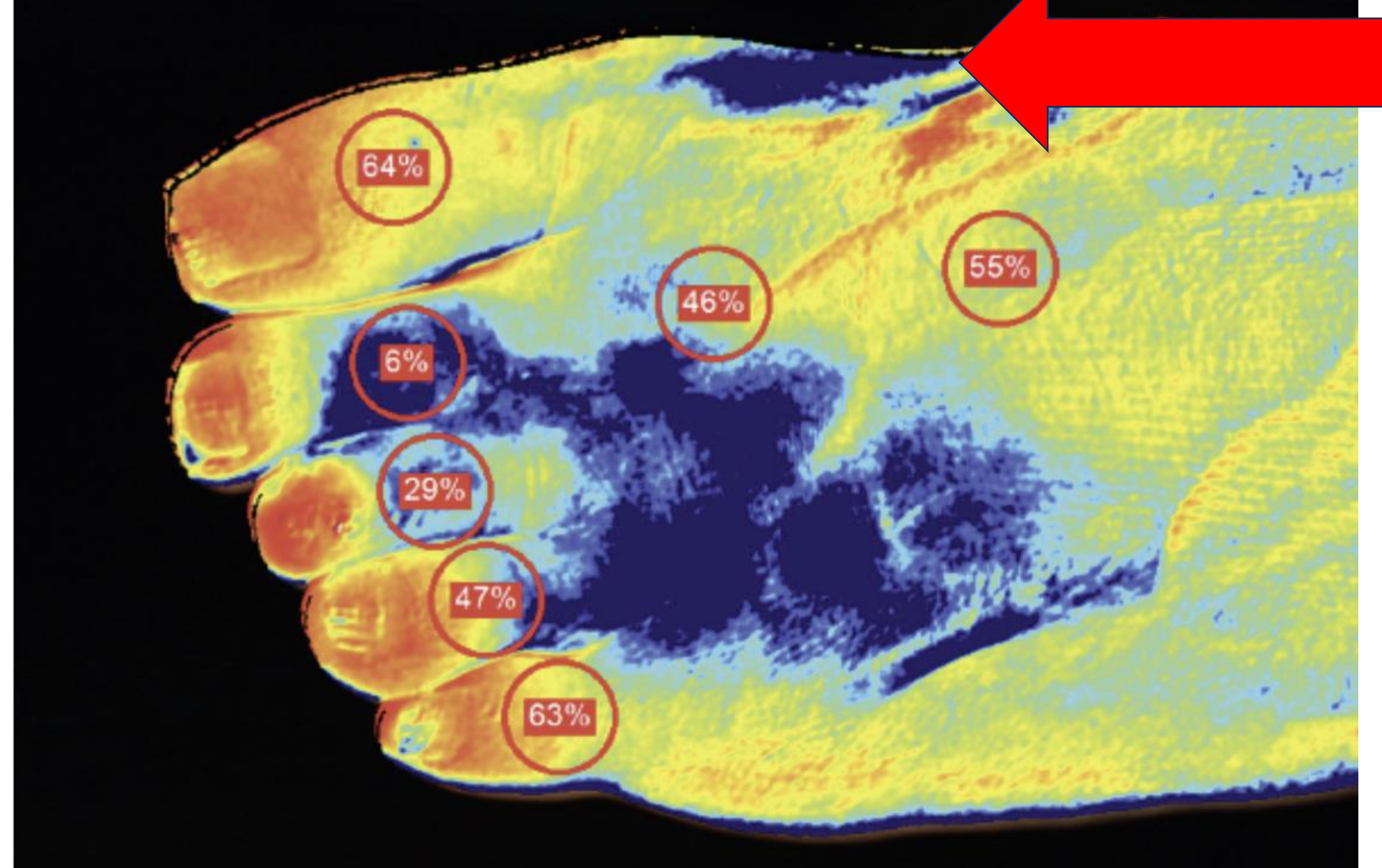

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Pressure Ulcer/Injury Definitions

Acute Care Hospitals	**Non-blanchable erythema of intact skin Intact skin with a localized area of non-blanchable erythema, which may appear differently in darkly pigmented skin. Presence of blanchable erythema or changes in sensation, temperature, or firmness may precede visual changes. Color changes do not include purple or maroon discoloration; these may indicate deep tissue pressure injury.**
Long Term Acute Care Hospitals (LTACH) or Inpatient Rehab Facility (IRF)	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 hues.
Long Term Care (LTC) or Skilled Nursing Facility (SNF)	An observable, pressure related alteration of intact skin whose indicators, as compared to an adjacent or opposite area on the body, may include changes in one or more of the following parameters: skin temperature (warmth or coolness); tissue consistency (firm or boggy); sensation (pain, itching); and/or a defined area of persistent redness in lightly pigmented skin, whereas in darker skin tones, the injury may appear with persistent red, blue, or purple hues.
Home Health	Intact skin with non-blanchable redness of a localized area usually over a bony prominence. The area may be painful, firm, soft, warmer, or cooler as compared to adjacent tissue. Darkly pigmented skin may not have a visible blanching; in dark skin tones only it may appear with persistent blue or purple hues.

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ICD-10 (International Classification of Diseases 10th Revision)

Clinical Information: An ulceration caused by prolonged pressure on the skin and tissues when one stays in one position for a long period of time, such as lying in bed. The bony areas of the body are the most frequently affected sites which become ischemic (ischemia) under sustained and constant pressure.

Death of tissue due to external pressure.

Pressure sores are areas of damaged skin caused by staying in one position for too long. They commonly form where your bones are close to your skin, such as your ankles, back, elbows, heels and hips. You are at risk if you are bedridden, use a wheelchair, or are unable to change your position. Pressure sores can cause serious infections, some of which are life-threatening. They can be a problem for people in nursing homes. You can prevent the sores by keeping skin clean and dry, changing position every two hours, using pillows and products that relieve pressure. Pressure sores have a variety of treatments. Advanced sores are slow to heal, so early treatment is best.

Ulceration caused by prolonged pressure in patients permitted to lie too still for a long period of time; bony prominences of the body are the most frequently affected sites; ulcer is caused by ischemia of the underlying structures of the skin, fat, and muscles as a result of the sustained and constant pressure. (Updated in 2016. No changes since)

Stage 1 Pressure Injury

Acute Care Hospitals	**Non-blanchable erythema of intact skin Intact skin with a localized area of non-blanchable erythema, which may appear differently in darkly pigmented skin. Presence of blanchable erythema or changes in sensation, temperature, or firmness may precede visual changes. Color changes do not include purple or maroon discoloration; these may indicate deep tissue pressure injury.**
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Long Term Care (LTC) or Skilled Nursing Facility (SNF)	An observable, pressure related alteration of intact skin whose indicators, as compared to an adjacent or opposite area on the body, may include changes in one or more of the following parameters: skin temperature (warmth or coolness); tissue consistency (firm or boggy); sensation (pain, itching); and/or a defined area of persistent redness in lightly pigmented skin, whereas in darker skin tones, the injury may appear with persistent red, blue, or purple hues.
Home Health	Intact skin with non-blanchable redness of a localized area usually over a bony prominence. The area may be painful, firm, soft, warmer, or cooler as compared to adjacent tissue. Darkly pigmented skin may not have a visible blanching; in dark skin tones only it may appear with persistent blue or purple hues.

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ICD-10 (International Classification of Diseases 10th Revision)

- Applicable To Healing pressure ulcer of unspecified site, stage 1
- Pressure pre-ulcer skin changes limited to persistent focal edema

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Stage 2 Pressure Ulcer

Acute Care Hospitals	Partial-thickness loss of skin with exposed dermis. The wound bed is viable, pink or red, moist, and may also present as an intact or ruptured serum-filled blister. Adipose (fat) is not visible and deeper tissues are not visible. Granulation tissue, slough and eschar are not present. These injuries commonly result from adverse microclimate and shear in the skin over the pelvis and shear in the heel. This stage should not be used to describe moisture associated skin damage (MASD) including incontinence associated dermatitis (IAD), intertriginous dermatitis (ITD), medical adhesive related skin injury (MARSI), or traumatic wounds (skin tears, burns, abrasions).
Long Term Acute Care Hospitals (LTACH) or Inpatient Rehab Facility (IRF)	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.
Long Term Care (LTC) or Skilled Nursing Facility (SNF)	Partial thickness loss of dermis presenting as a shallow open ulcer with a red-pink wound bed, without slough or bruising. May also present as an intact or open/ ruptured blister.
Home Health	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.

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ICD-10 (International Classification of Diseases 10th Revision)

- Applicable To healing pressure ulcer of unspecified site, stage 2
- Pressure ulcer with abrasion, blister, partial thickness skin loss involving epidermis and/or dermis, unspecified site

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Stage 3 Pressure Ulcer

Acute Care Hospitals	Full-thickness loss of skin, in which adipose (fat) is visible in the ulcer and granulation tissue and epibole (rolled wound edges) are often present. Slough and/or eschar may be visible. The depth of tissue damage varies by anatomical location; areas of significant adiposity can develop deep wounds. Undermining and tunneling may occur. Fascia, muscle, tendon, ligament, cartilage and/or bone are not exposed. If slough or eschar obscures the extent of tissue loss this is an Unstageable Pressure Injury.
Long Term Acute Care Hospitals (LTACH) or Inpatient Rehab Facility (IRF)	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.
Long Term Care (LTC) or Skilled Nursing Facility (SNF)	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
Home Health	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.

A

ICD-10 (International Classification of Diseases 10th Revision)

- Applicable To healing pressure ulcer of other site, stage 3
- Pressure ulcer with full thickness skin loss involving damage or necrosis of subcutaneous tissue, other site

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Stage 4 Pressure Ulcer

Acute Care Hospitals	Full-thickness skin and tissue loss with exposed or directly palpable fascia, muscle, tendon, ligament, cartilage or bone in the ulcer. Slough and/or eschar may be visible. Epibole (rolled edges), undermining and/or tunneling often occur. Depth varies by anatomical location. If slough or eschar obscures the extent of tissue loss this is an Unstageable Pressure Injury.
Long Term Acute Care Hospitals (LTACH) or Inpatient Rehab Facility (IRF)	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.
Long Term Care (LTC) or Skilled Nursing Facility (SNF)	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. The bridge of the nose, ear, occiput, and malleolus do not have subcutaneous tissue, and these ulcers can be shallow.
Home Health	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.

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ICD-10 (International Classification of Diseases 10th Revision)

- Applicable To healing pressure ulcer of other site, stage 4
- Pressure ulcer with necrosis of soft tissues through to underlying muscle, tendon, or bone, other site

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Unstageable (Due to Slough/Eschar) Pressure Ulcer

Setting	Definition
Acute Care Hospitals	Full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because it is obscured by slough or eschar. If slough or eschar is removed, a Stage 3 or Stage 4 pressure injury will be revealed. Stable eschar (i.e. dry, adherent, intact without erythema or fluctuance) on the heel or ischemic limb should not be softened or removed.
Long Term Acute Care Hospitals (LTACH) or Inpatient Rehab Facility (IRF)	Known but not stageable due to coverage of wound bed by slough and/or eschar.
Long Term Care (LTC) or Skilled Nursing Facility (SNF)	If, after careful cleansing of the pressure ulcer/injury, a pressure ulcer's/injury's anatomical tissues remain obscured such that the extent of soft tissue damage cannot be observed or palpated, the pressure ulcer/injury is considered unstageable.
Home Health	Known but not stageable due to coverage of wound bed by slough and/or eschar.

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Unstageable due to Non-removable Medical Device/Dressing Pressure Ulcer

Acute Care Hospitals	N/A
Long Term Acute Care Hospitals (LTACH) or Inpatient Rehab Facility (IRF)	Known but not stageable due to coverage of wound bed by slough and/or eschar.
Long Term Care (LTC) or Skilled Nursing Facility (SNF)	Known but not stageable due to non-removal dressing/device. Includes, for example, a primary surgical dressing that cannot be removed, an orthopedic device, or cast.
Home Health	Known but not stageable due to non-removable dressing/device.

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Unstageable Pressure Injuries Related to Deep Tissue Injury

Acute Care Hospitals	N/A
Long Term Acute Care Hospitals (LTACH) or Inpatient Rehab Facility (IRF)	Unstageable pressure injuries presenting as deep tissue injury
Long Term Care (LTC) or Skilled Nursing Facility (SNF)	Purple or maroon area of discolored intact skin due to damage of underlying soft tissue. The area may be preceded by tissue that is painful, firm, mushy, boggy, warmer or cooler as compared to adjacent tissue.
Home Health	Unstageable pressure injuries presenting as deep tissue injury

M

ICD-10 (International Classification of Diseases 10th Revision)

Approximate Synonyms:

- Nonstageable pressure ulcer
- Pressure ulcer, unstageable

Medical Device Related Pressure Injury

Acute Care Hospitals	Medical device related pressure injuries result from the use of devices designed and applied for diagnostic or therapeutic purposes. The resultant pressure injury generally conforms to the pattern or shape of the device. The injury should be staged using the staging system.
Long Term Acute Care Hospitals (LTACH) or Inpatient Rehab Facility (IRF)	N/A
Long Term Care (LTC) or Skilled Nursing Facility (SNF)	N/A
Home Health	N/A

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Deep Tissue Pressure Injury

Acute Care Hospitals	Intact or non-intact skin with localized area of persistent non-blanchable deep red, maroon, purple discoloration or epidermal separation revealing a dark wound bed or blood filled blister. Pain and temperature change often precede skin color changes. Discoloration may appear differently in darkly pigmented skin. This injury results from intense and/or prolonged pressure and shear forces at the bone-muscle interface. The wound may evolve rapidly to reveal the actual extent of tissue injury, or may resolve without tissue loss. If necrotic tissue, subcutaneous tissue, granulation tissue, fascia, muscle or other underlying structures are visible, this indicates a full thickness pressure injury (Unstageable, Stage 3 or Stage 4). Do not use DTPI to describe vascular, traumatic, neuropathic, or dermatologic conditions.
Long Term Acute Care Hospitals (LTACH) or Inpatient Rehab Facility (IRF)	N/A
Long Term Care (LTC) or Skilled Nursing Facility (SNF)	N/A
Home Health	N/A

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ICD-10 (International Classification of Diseases 10th Revision)

Pressure-induced deep tissue damage

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Mucosal Membrane Pressure Injury

Acute Care Hospitals	Mucosal membrane pressure injury is found on mucous membranes with a history of a medical device in use at the location of the injury. Due to the anatomy of the tissue these ulcers cannot be staged.
Long Term Acute Care Hospitals (LTACH) or Inpatient Rehab Facility (IRF)	Mucosal pressure ulcers are not staged using the skin pressure ulcer/injury staging system because anatomical tissue comparisons cannot be made. Therefore, mucosal ulcers (e.g., those related to nasogastric tubes, oxygen tubing, endotracheal tubes, urinary catheters, mucosal ulcers in the oral cavity) should not be coded on the LTCH CARE Data Set or IRF-PAI.
Long Term Care (LTC) or Skilled Nursing Facility (SNF)	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.
Home Health M	Not mentioned in the Oasis-D.

ICD-10 (International Classification of Diseases 10th Revision)

Not mentioned in ICD-10

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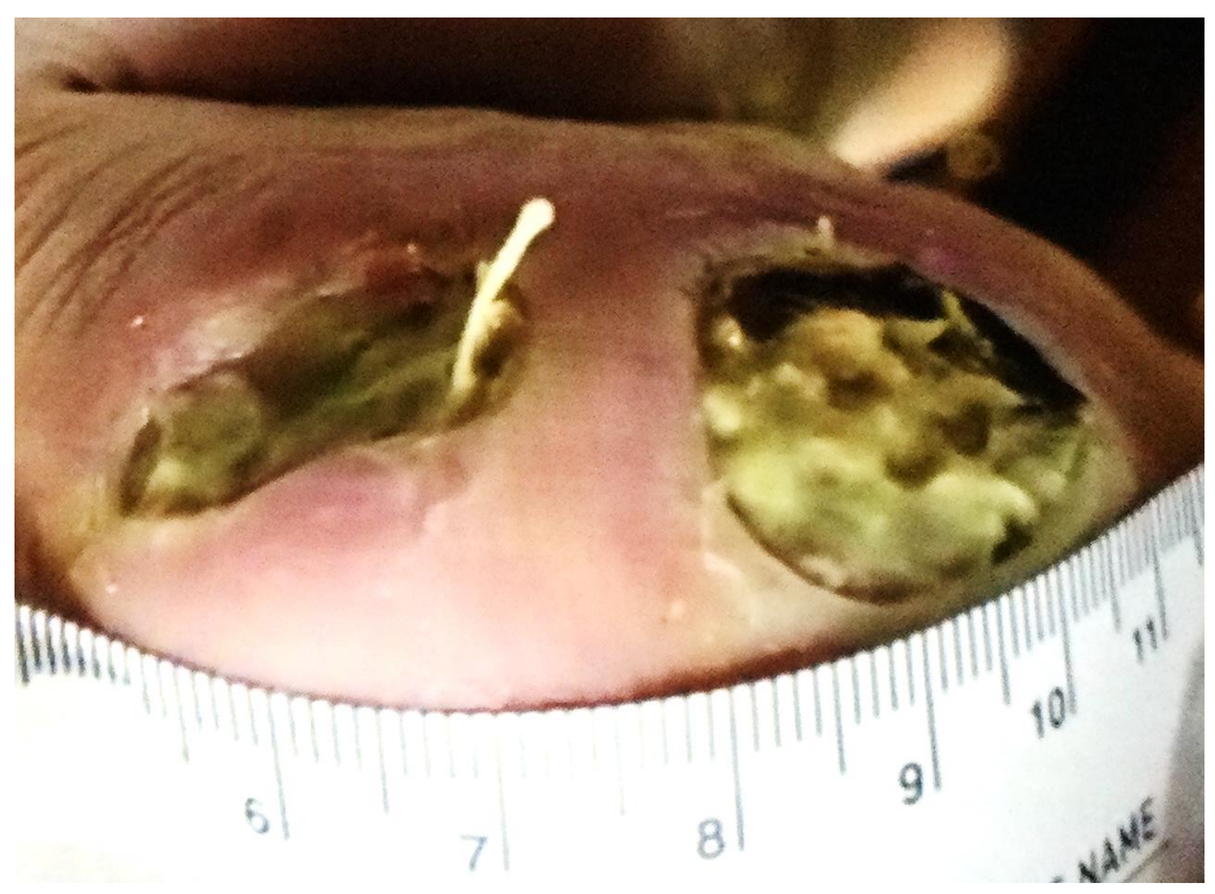
74-year-old female with dementia, history of hypoglycemia and numerous abdominal surgeries. Arterial studies reveal “trickle” blood flow. Wounds are painful. Resident is non-ambulatory. Lives in a rural care setting. Previous attempts at vascular surgery were declined by surgeon due to resident not being a surgical candidate. Family agrees to do everything possible short of surgery and causing unnecessary pain. Family has visited and personally observed wounds and gangrene with advanced wound care specialist.



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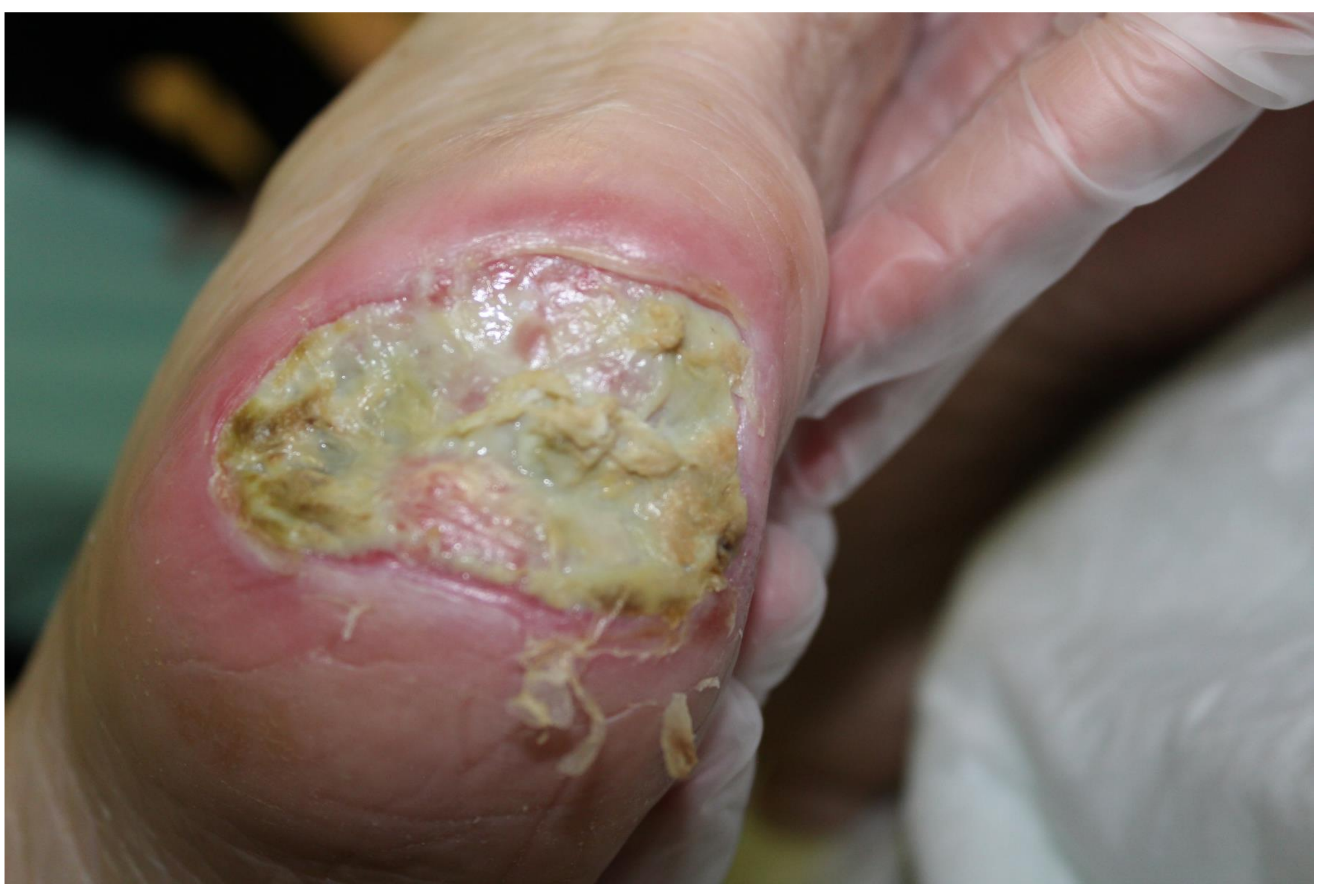

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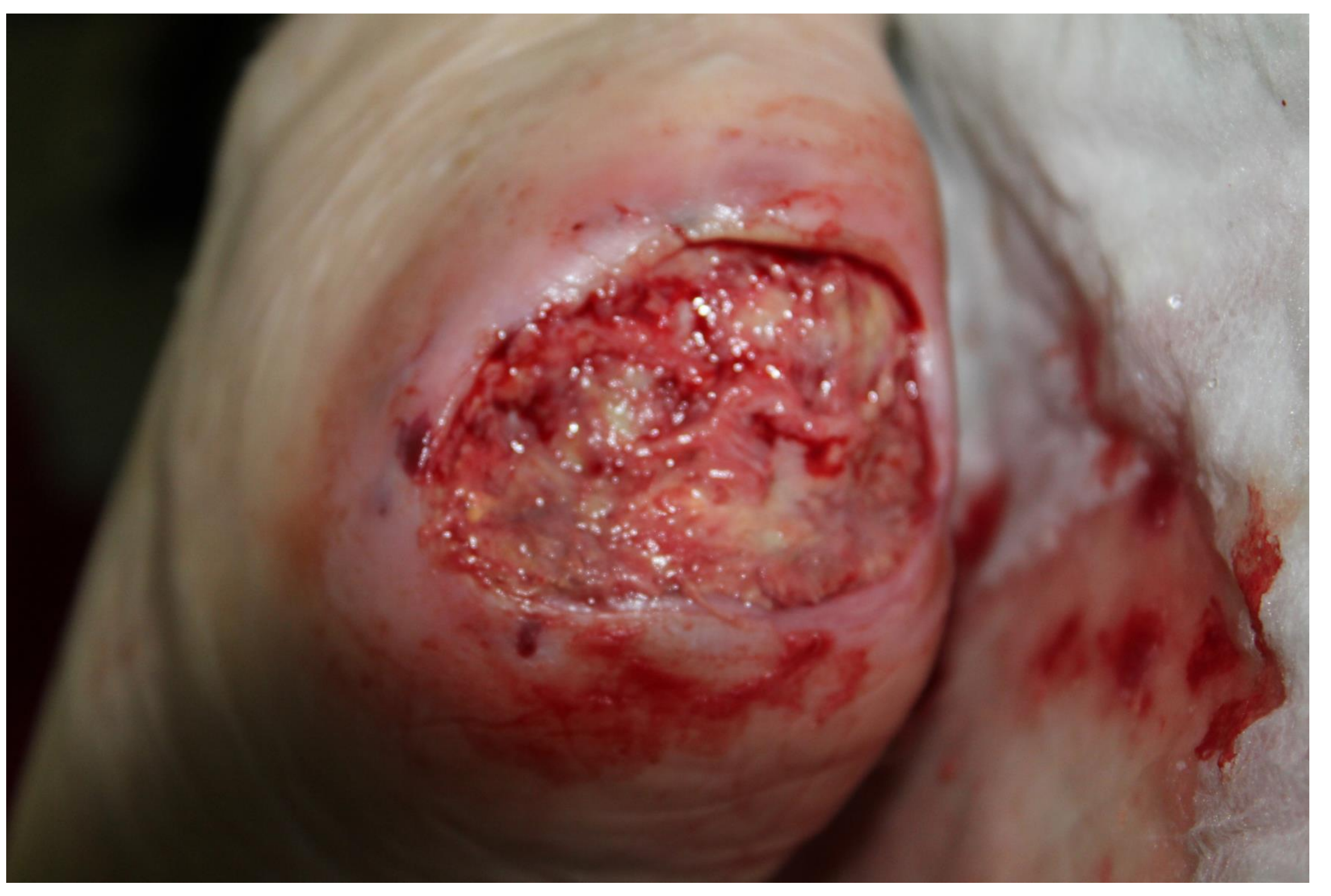

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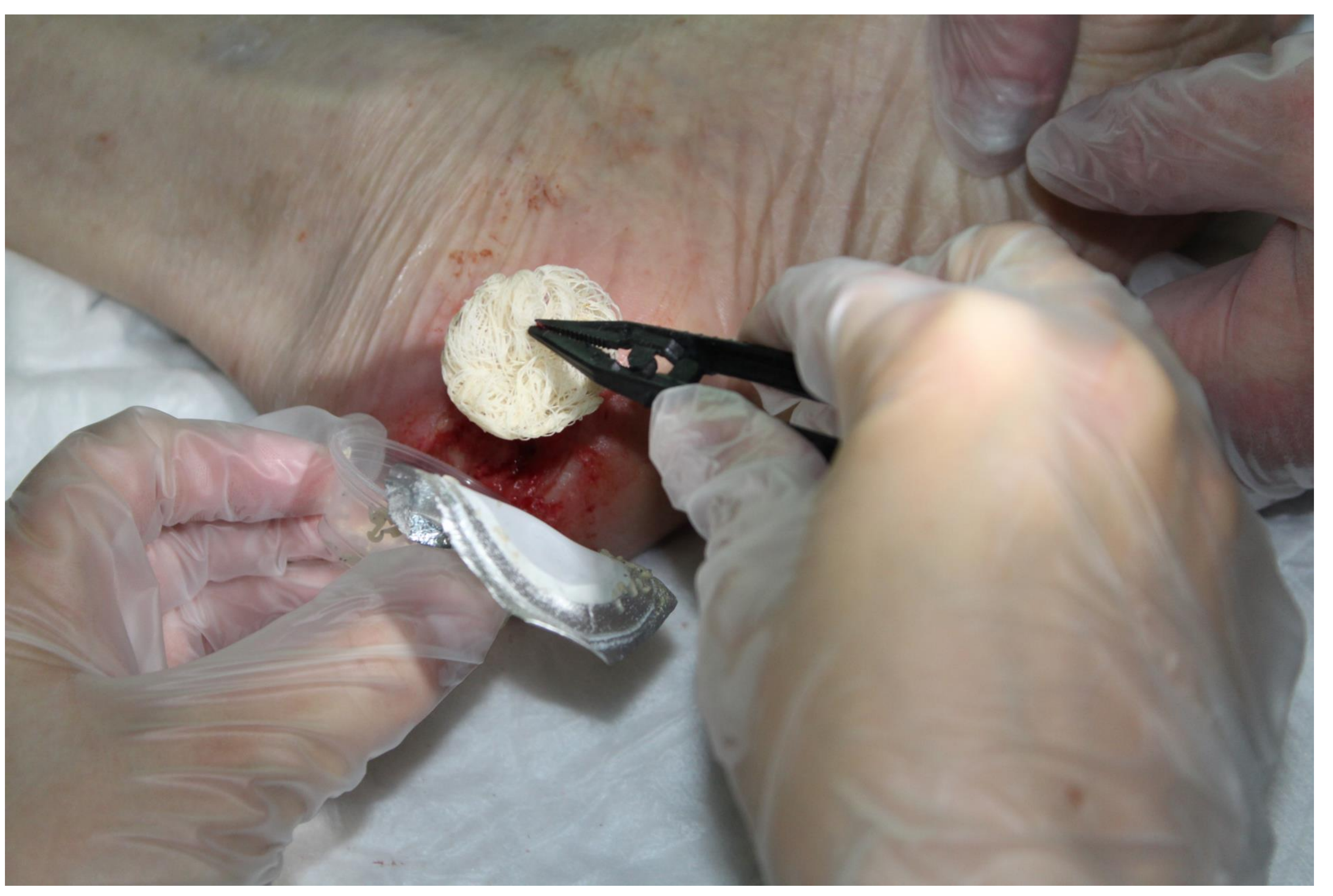

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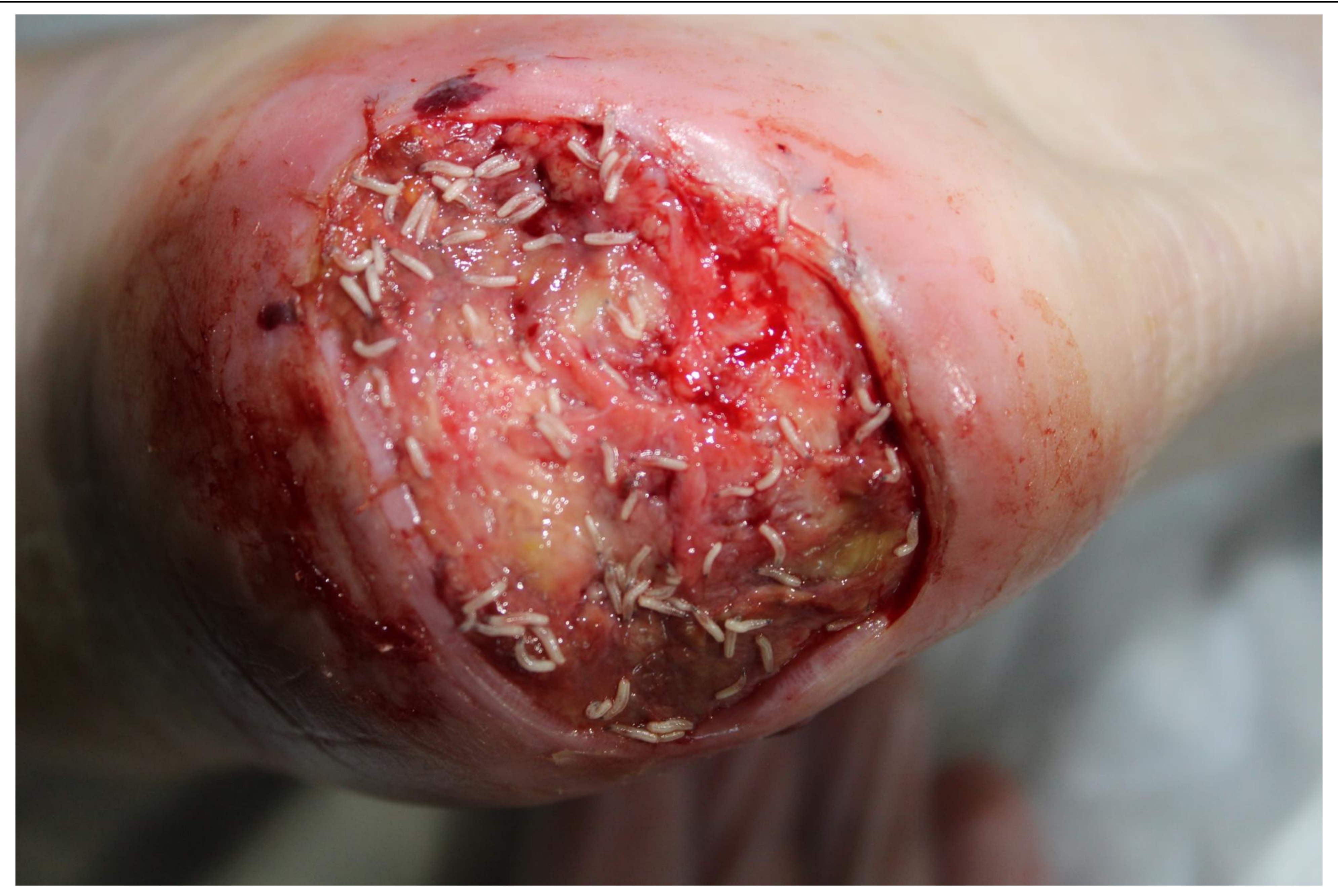

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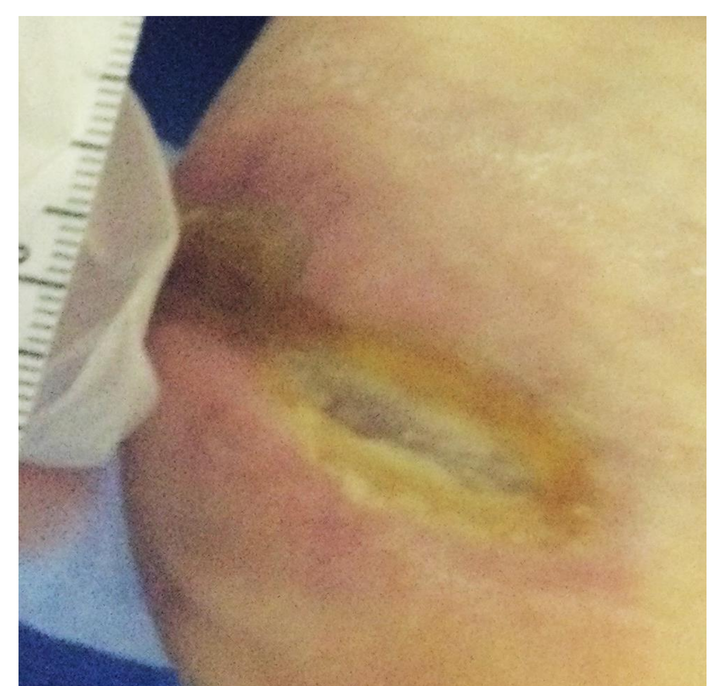
Wounds were first present in November 2020. This is the most recent photo from August 2021 visit.



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Conditions and Extensive Services Used for NTA Classification

Specific to Wound Care (20 potential categories)

- Special Treatments/Programs: Intravenous Medication Post-admit Code
- Opportunistic Infections
- Bone/Joint/Muscle Infections/Necrosis-Except Aseptic Necrosis of Bone
- Wound Infection Code
- Active Diagnoses: Diabetes Mellitus (DM) Code
- Immune Disorders
- Other Foot Skin Problems: Diabetic Foot Ulcer Code
- Active Diagnoses: Multi-Drug Resistant Organism (MDRO) Code
- Special Treatments/Programs: Isolation Post-admit Code

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Conditions and Extensive Services Used for NTA Classification

Specific to Wound Care (20 potential categories)

- Specified Hereditary Metabolic/Immune Disorders
- Morbid Obesity
- Highest Stage of Unhealed Pressure Ulcer-Stage 4
- Other Foot Skin Problems: Foot Infection Code, Other Open Lesion on Foot Code, Except Diabetic Foot Ulcer Code
- Complications of Specified Implanted Device or Graft
- Aseptic Necrosis of Bone
- Systemic Lupus Erythematosus, Other Connective Tissue Disorders, and Inflammatory Spondylopathies

Active Diagnoses: Diabetes Mellitus (DM) Code (I2900)

Pre-diabetes still acts like diabetes in a wound care world and lower extremity. Irreversible damage to blood vessels and nerves occurs even with pre-diabetes.

Other Foot Skin Problems: Diabetic Foot Ulcer Code (M1040B)

Wagner Scale for Diabetic Foot Ulcers[71]	
Grade	**Description**
Grade 0	Pre-ulcerous lesion, healed ulcer, bony deformity
Grade 1	Superficial ulcer without subcutaneous tissues involvement
Grade 2	Deep ulcer, penetration through the subcutaneous tissue; may have exposed bone, tendon or ligament or joint capsule
Grade 3	Deep ulcer with cellulitis, abscess formation, or osteomyelitis
Grade 4	Localized gangrene of digit
Grade 5	Extensive gangrene involving whole foot

*****Wagner scale is based on level of infection/gangrene, not level of tissue destruction like the pressure ulcer scale*****

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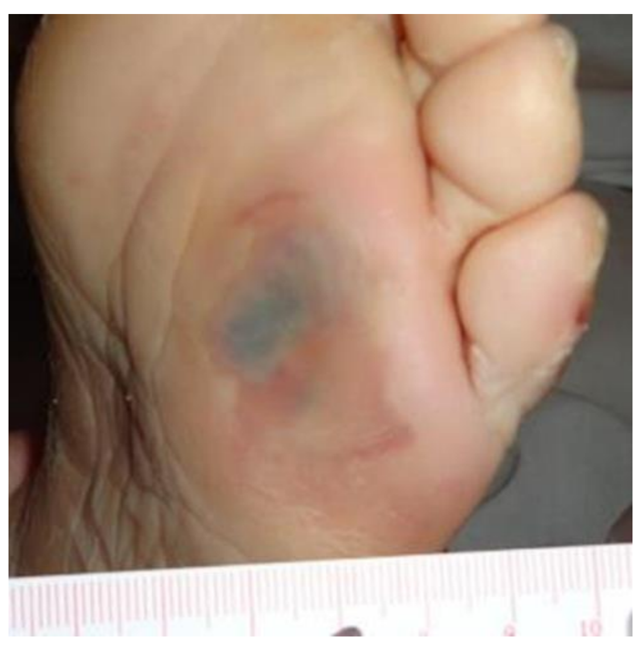
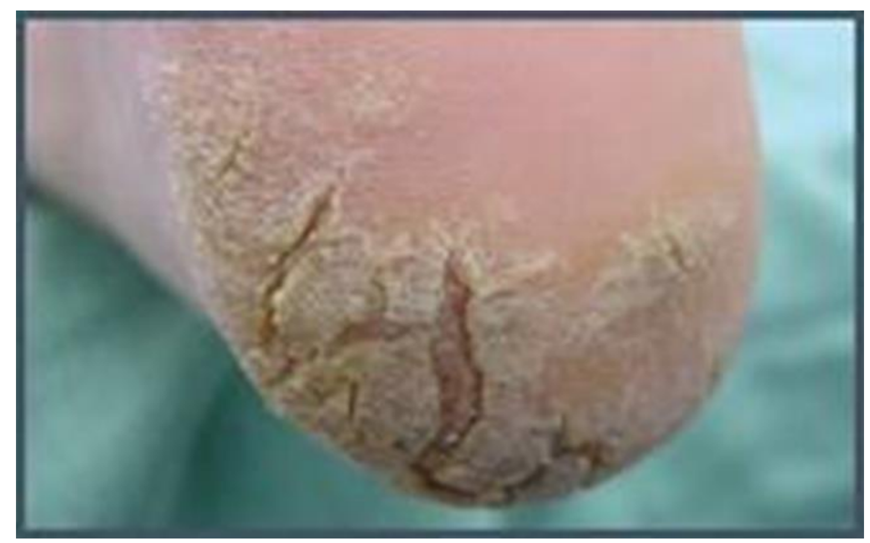
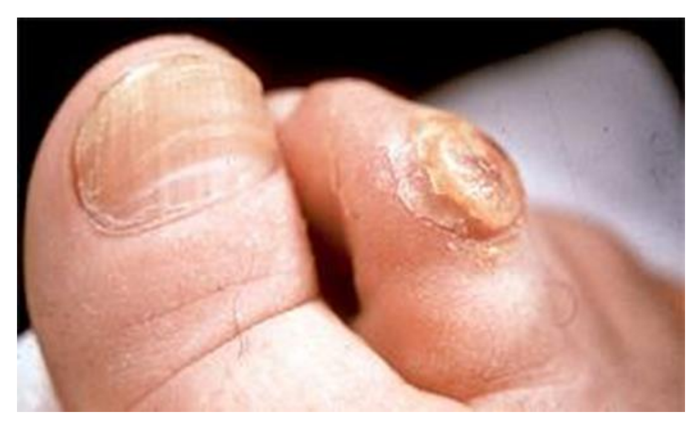
Other Foot Skin Problems: Diabetic Foot Ulcer Code (M1040B)

Wagner Grade 0: Pre-ulcerative. Will have a wound if we don't fix the issue. Ex: Corns, calluses, fissures, dark purple areas, callous







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Other Foot Skin Problems: Diabetic Foot Ulcer Code (M1040B)

Wagner Grade 1: ***Partial thickness wounds in a diabetic foot***

Superficial: No slough, no eschar, no granulation tissue. Top layer or two of skin only. Not deeper than skin deep. Epithelial tissue only.

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Other Foot Skin Problems: Diabetic Foot Ulcer Code (M1040B)

Wagner Grade 2: Full thickness wounds in a diabetic foot

Deep ulcer penetrating down to ligaments, muscle, or bone but no presence of obvious infection.

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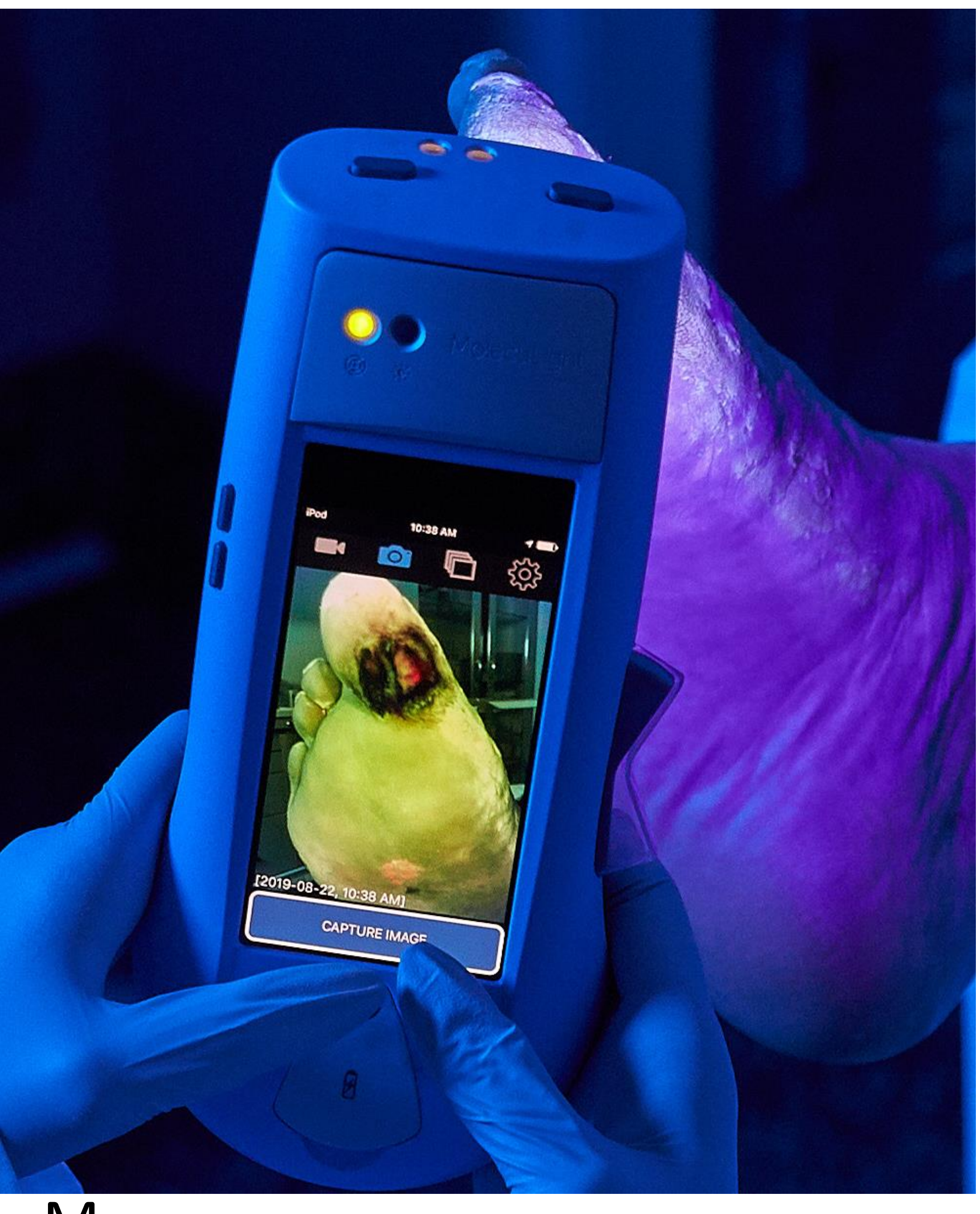
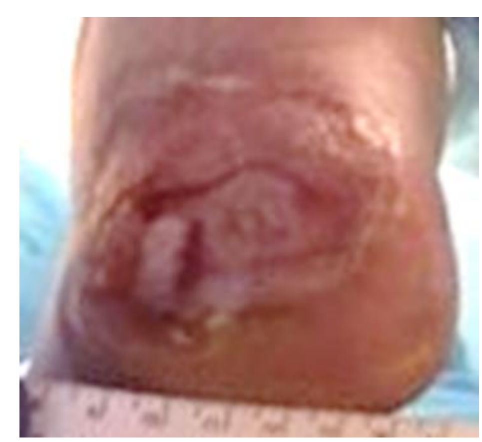


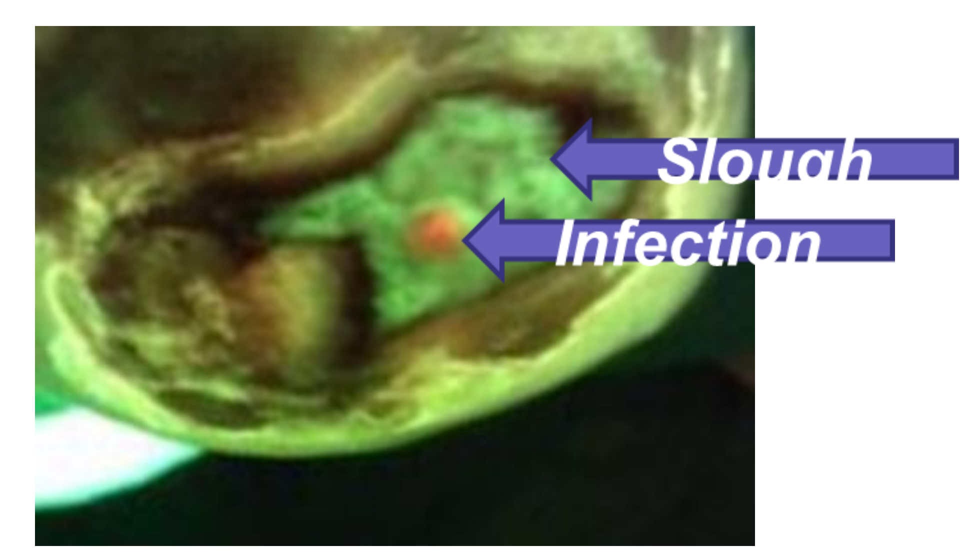
- Point-of-care fluorescence imaging device to:
    1. Detect bacteria (>10^4 CFU/g) in wounds*
    2. Digitally measure wound area
- Supports point-of-care wound assessment and documentation
- Handheld, portable, touch-screen
- No contrast agents and no patient contact required

Other Foot Skin Problems: Diabetic Foot Ulcer Code (M1040B)

Wagner Grade 3: Presence of obvious infection



- Osteomyelitis
- Purulent drainage
- Foul smell
- Obvious cellulitis
- Positive culture



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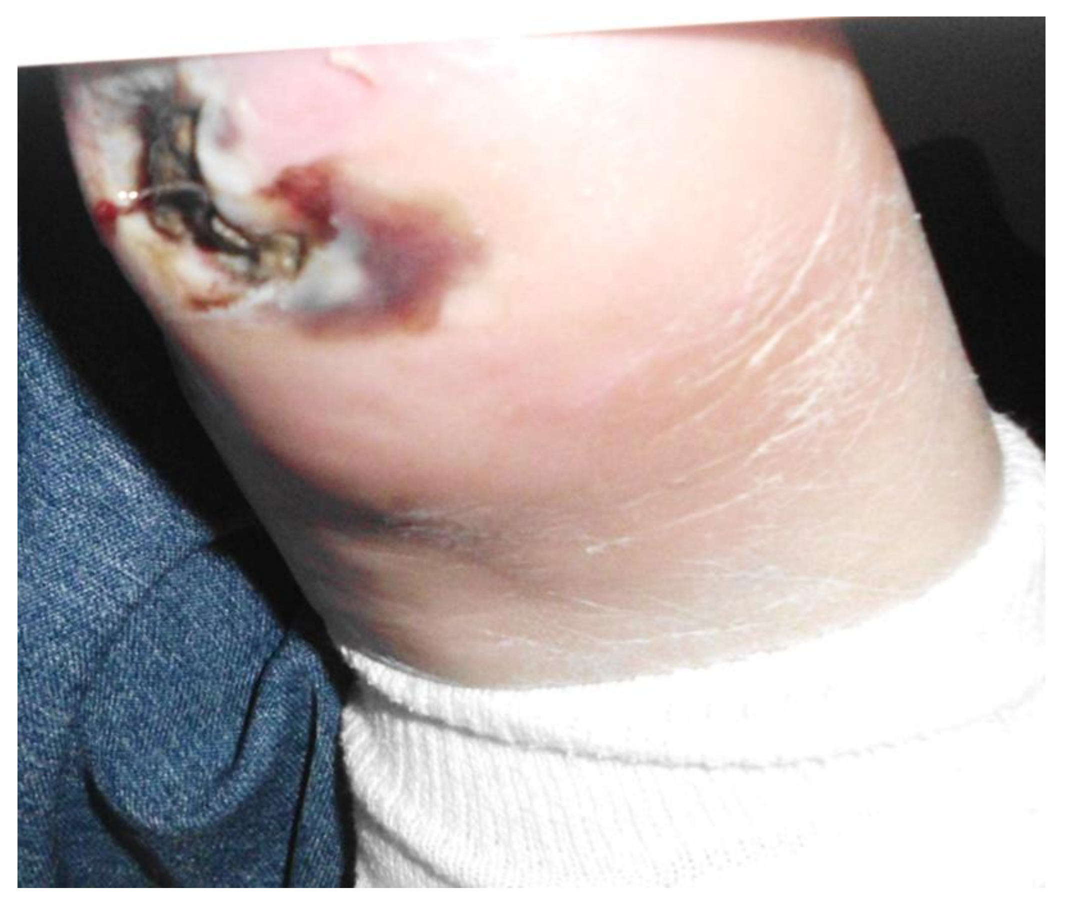
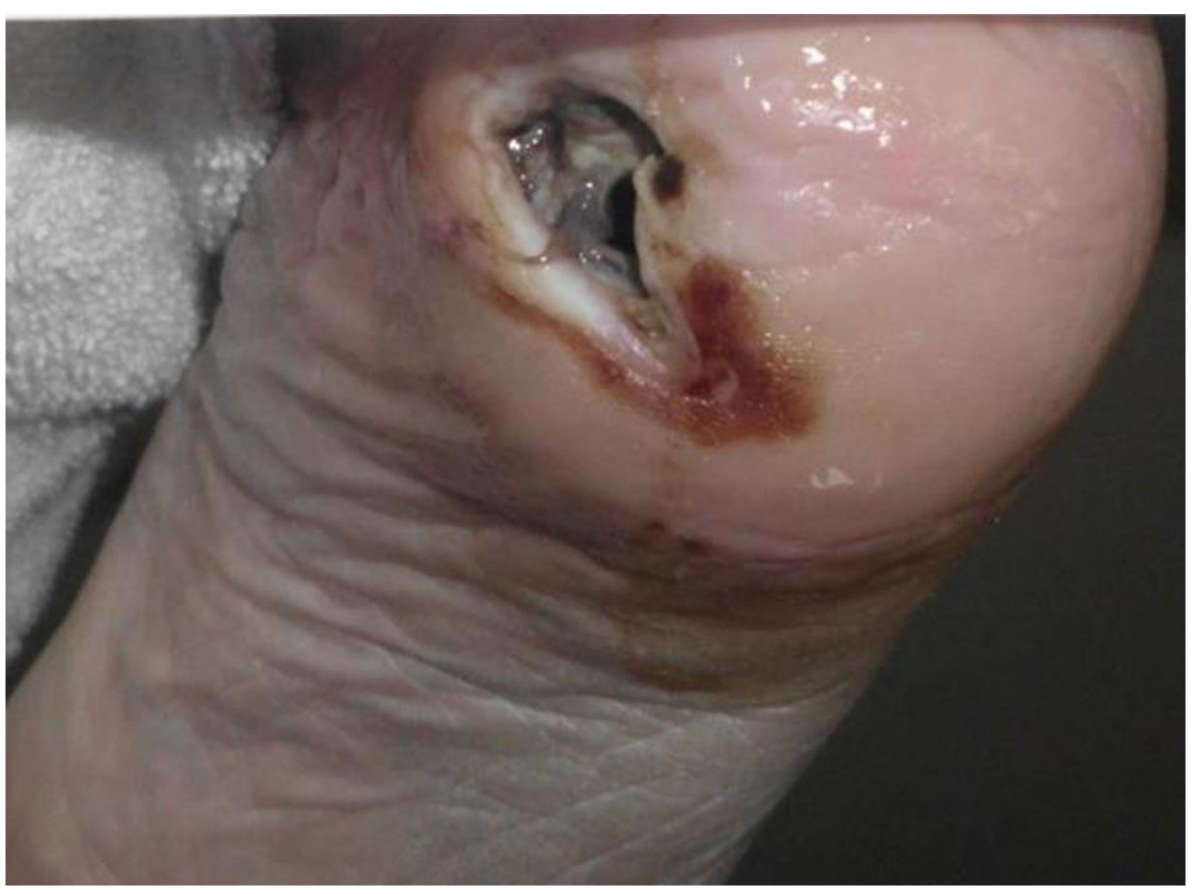
Other Foot Skin Problems: Diabetic Foot Ulcer Code (M1040B)

Wagner Grade 4: Presence of local gangrene





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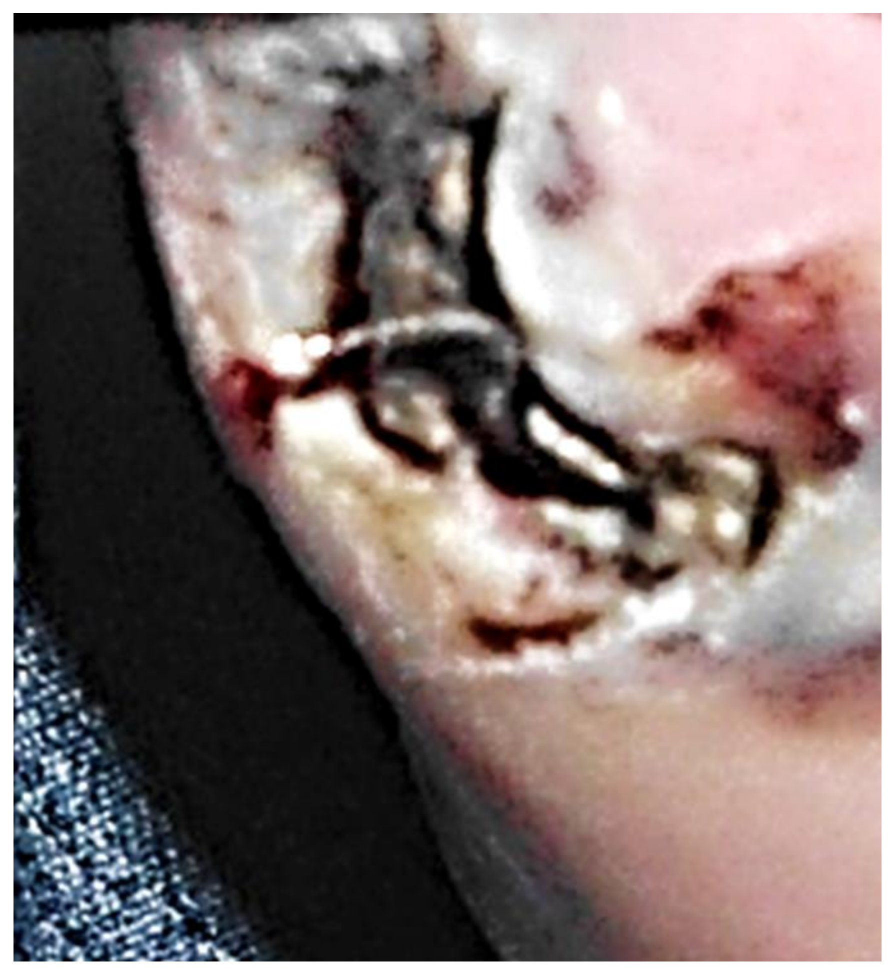
Other Foot Skin Problems: Diabetic Foot Ulcer Code (M1040B)



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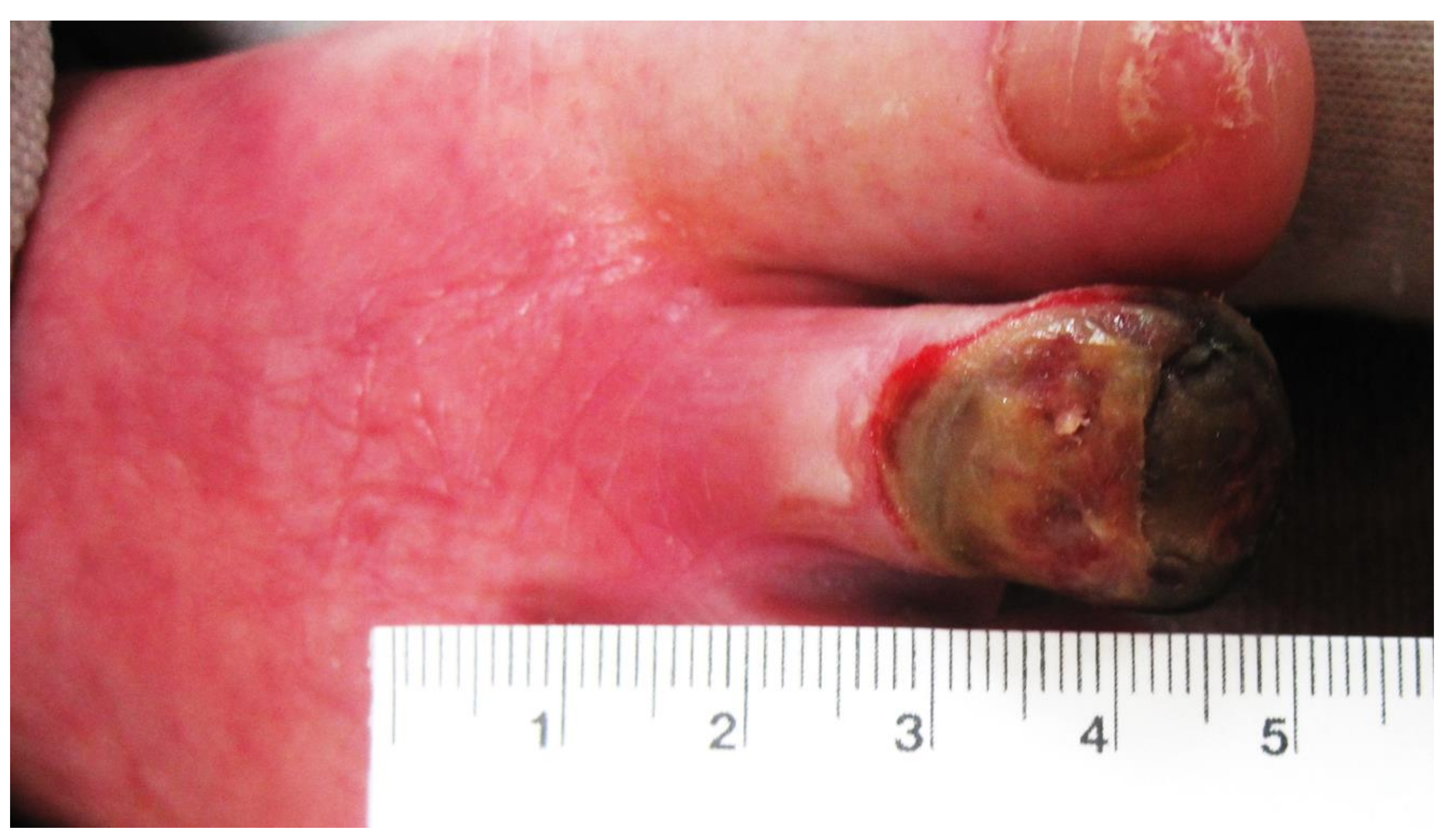
Other Foot Skin Problems: Diabetic Foot Ulcer Code (M1040B)

Wagner Grade 5: Presence of extensive gangrene



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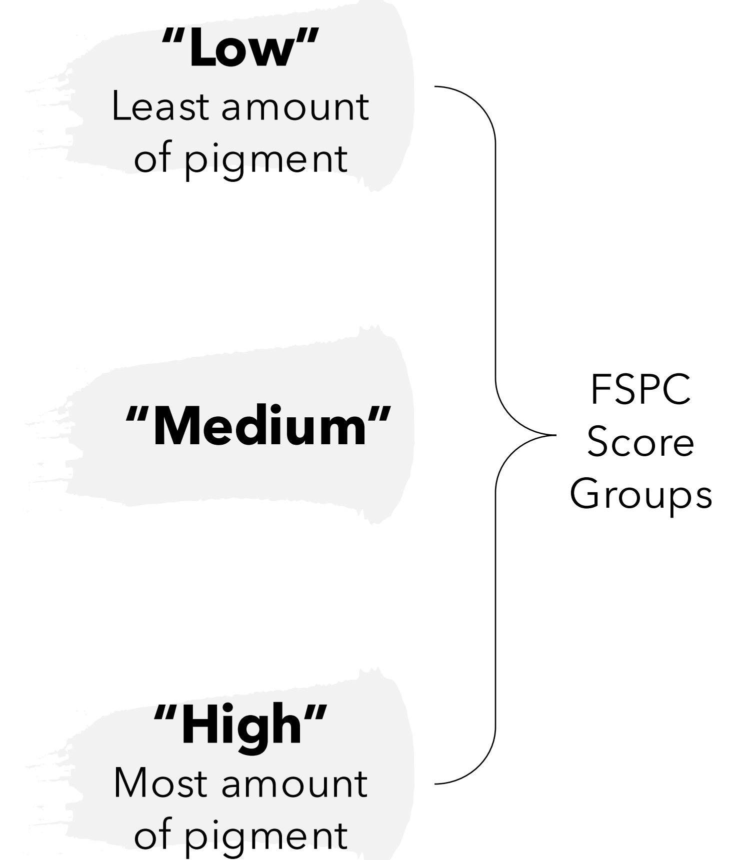
Fitzpatrick Skin Classification Score[1] (FSPC)

	Skin colour	Reaction to sun
I	**Skin colour:** light, pale white	**Reaction to sun:** always burns, never tans
II	**Skin colour:** fair, beige	**Reaction to sun:** usually burns, tans with difficulty
III	**Skin colour:** olive, light brown	**Reaction to sun:** sometimes burns, tans gradually
IV	**Skin colour:** light to med brown	**Reaction to sun:** rarely burns, tans easily
V	**Skin colour:** med to dark brown	**Reaction to sun:** never burn, tans easily
VI	**Skin colour:** deep brown, black	**Reaction to sun:** never burn, tans easily



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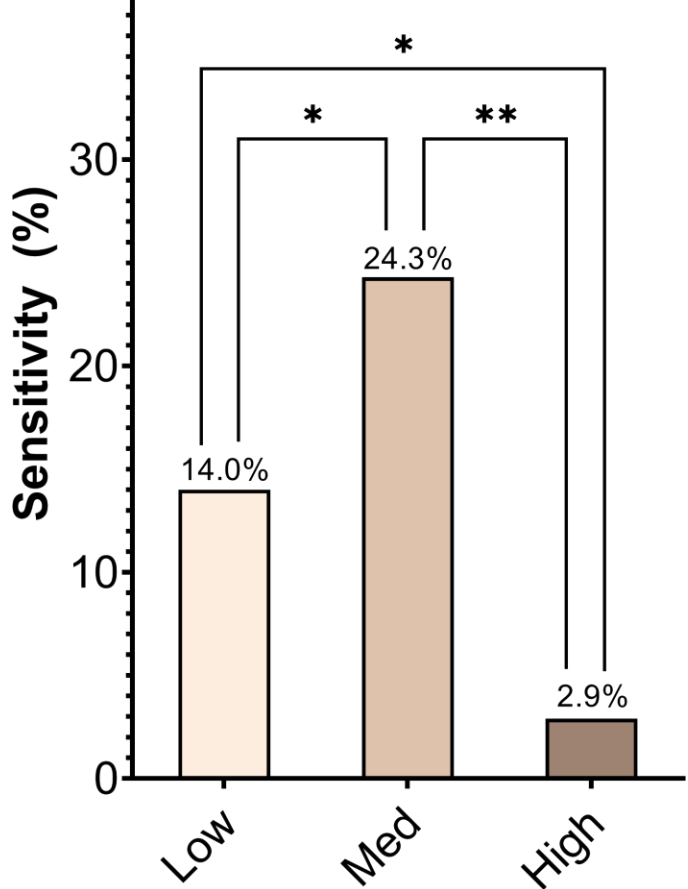
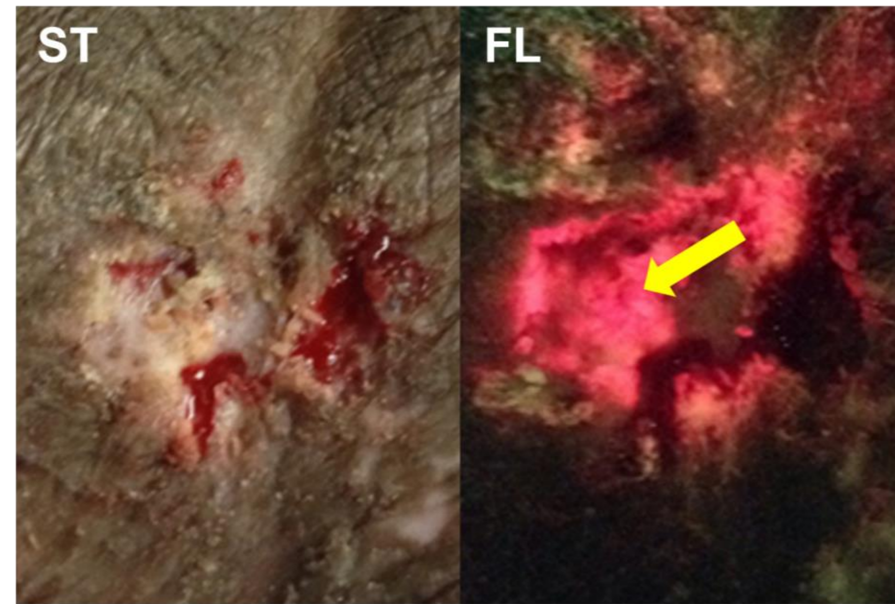
[1]Fitzpatrick TB (1960) *Archives of Dermatology*

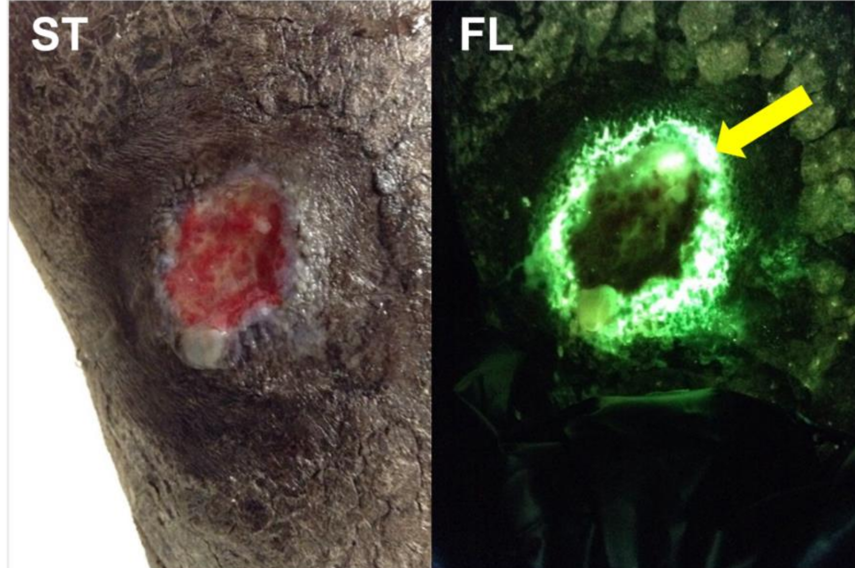
Infection detected less often on higher skin pigmentation



High skin pigment (FSPC V & VI)



Standard of care sensitivity to detect bacterial loads through clinical observation was **just 3% on high skin pigmentation patients**



M Statistically significant at p ≤ 0.05 (*) or p ≤ 0.01 (**)

Other Foot Skin Problems: Diabetic Foot Ulcer Code (M1040B)

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Grade 3	Deep ulcer with cellulitis, abscess formation, or osteomyelitis
Grade 4	Localized gangrene of digit
Grade 5	Extensive gangrene involving whole foot

*****Wagner scale is based on level of infection/gangrene, not level of tissue destruction like the pressure ulcer scale*****

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Active Diagnoses: Multi-Drug Resistant Organism (MDRO) Code: MDS Item I1700

The following is provided by the Centers for Disease Control and Prevention (CDC):

- ☐ ESBLs-Extended-spectrum beta-lactamase producing Enterobacteriaceae
- ☐ MRSA-Methicillin/oxacillin-resistant Staphylococcus aureus
- ☐ Mutli-drug resistant Tuberculosis (MDR) TB
- ☐ VRE-Vancomycin-resistant enterococci
- ☐ Resistant Acinetobacter
- ☐ Clostridioides difficile
- ☐ (CRE) Carbapenem-resistant Enterobacteriaceae
- ☐ Drug-resistant Neisseria gonorrhoeae
- ☐ Multidrug resistant Acinetobacter
- ☐ Drug-resistant Campylobacter
- ☐ Fluconazole-resistant Candida
- ☐ Multidrug-resistant Pseudomonas aeruginosa
- ☐ Drug-resistant non-typhoidal Salmonella
- ☐ Drug-resistant Salmonella Serotype Typhi
- ☐ Drug-resistant Shigella
- ☐ Drug-resistant Streptococcus pneumoniae
- ☐ Drug-resistant Tuberculosis

Wound Infection Code: MDS Item I2500

Active wound infection (Do not include wounds colonized with bacteria)

○ Yes ○ No

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Morbid Obesity: MDS Item I8000

Patient is 100 pounds over ideal body weight or has a BMI of 40 or more or BMI of 35 with obesity related health conditions

○ Yes ○ No

Immune Disorders: MDS Item I8000

List immune disorder:

Aseptic Necrosis of Bone: MDS Item I8000

Aseptic necrosis of the bone, avascular necrosis, or osteonecrosis of the bone

○ Yes ○ No

Severe Skin Burn or Condition: MDS Item I8000

Thermal burn

- ☐ Burn(s) caused by flame or fire
- ☐ Burn(s) caused by hot or molten liquid or steam
- ☐ Burn(s) caused by hot objects like cooking pans or irons or heated appliances

Chemical Burn

- ☐ Chlorine
- ☐ Ammonia
- ☐ Bleach
- ☐ Battery acid
- ☐ Strong or harsh cleaners

Electrical burns

- ☐ Body comes in contact with electric current

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Morbid Obesity (I8000)

Patient is 100 pounds over ideal body weight

has a BMI of 40

BMI of 35 with obesity related health conditions

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Highest Stage of Unhealed Pressure Ulcer-Stage 4

DEFINITION

STAGE 4 PRESSURE ULCER

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.

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Pressure ulcer/injury staging is an assessment system that provides a description and classification based on visual appearance and/or anatomic depth of soft tissue damage. This tissue damage can be visible or palpable in the ulcer bed. Pressure ulcer/injury staging also informs expectations for healing times.

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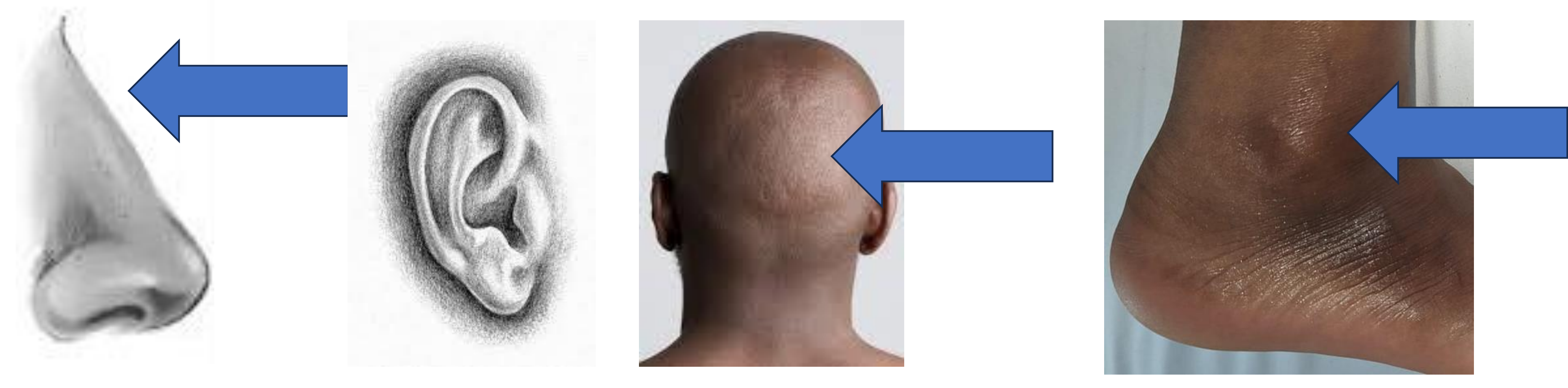
Highest Stage of Unhealed Pressure Ulcer-Stage 4

Coding Tips

- The depth of a Stage 4 pressure ulcer varies by anatomical location. The bridge of the nose, ear, occiput, and malleolus do not have subcutaneous tissue, and these ulcers can be shallow.
- Stage 4 pressure ulcers can extend into muscle and/or supporting structures (e.g., fascia, tendon, or joint capsule) making osteomyelitis possible.
- Exposed bone/tendon/muscle is visible or directly palpable.
- Cartilage serves the same anatomical function as bone. Therefore, pressure ulcers that have exposed cartilage should be classified as a Stage 4.

The depth of a Stage 4 pressure ulcer varies by anatomical location. The bridge of the nose, ear, occiput, and malleolus do not have subcutaneous tissue, and these ulcers can be shallow.



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Exposed bone/tendon/muscle is visible or directly palpable.

Special Treatments/Programs: Radiation Post-admit Code	MDS Item O0100B2	1
Highest Stage of Unhealed Pressure Ulcer - Stage 4	MDS Item M0300D1	1
Psoriatic Arthropathy and Systemic Sclerosis	MDS Item I8000	1

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Long Term Acute Care Hospitals (LTACH)

- Puts Med A Skilled Days on pause
- No readmission penalty
- Interrupted Stay Policy would go into effect upon re-entry to the SNF

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Questions?

WOUND CARE + PLUS

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