



TIP SHEET - MDS SKIN CONDITION CODING

DEFINITION: According the RAI Manual "A skin ulcer can be defined as a local loss of epidermis and variable levels of dermis and subcutaneous tissue, or in the case of Stage 1 pressure ulcers, persistent area of skin redness (without a break in the skin) that does not disappear when pressure is relieved." (RAI Manual, Pg 3-159)

CODING:

1. M1 - recording of all skin ulcers if caused by pressure or circulatory problems.
2. M2 - differentiates between pressure or venous stasis ulcers only; records highest level of each.
3. M3 - history of resolved/cured ulcers. Definition same as for M1.
4. M4 - records skin problems or lesions not caused by pressure or circulatory problems.
5. M5 - records any specific or generic skin treatments.
6. M6 - records specific foot problems and care.

PROCESS:

1. Review the record and check with appropriate nursing staff for the presence of any skin problems.
2. Examine the resident for condition (stage, number) of any skin problems. Coding will be based on what is seen (i.e. visible tissue) during the look back period. NPUAP standards cannot be used for coding on the MDS. MDS defined staging is used for M1 and M2 only.
3. Determine the cause of the skin ulcer. If it is caused from pressure or circulation (venous or arterial) then it is coded in M1. All remaining skin ulcers then are documented in M4. (See pg 3/159) Record the number of skin ulcers caused by either pressure or circulatory problems according to stage for M1. M2 is for coding the highest stage of pressure or venous stasis ulcers only.
4. Include in M4 all skin problems not caused by pressure, venous stasis, circulatory problems or not coded anywhere else in Section M.
5. Code all skin treatments in M5.
6. Code all foot problems and care in M6.

CLARIFICATION:

1. Necrotic eschar prohibits accurate staging. Code the skin ulcer with eschar as Stage 4 until debrided.
2. Good clinical practice dictates that the ulcer be re-examined and re-staged after debridement.
3. If a skin ulcer is repaired with a flap graft, is coded as a surgical wound and not as a skin ulcer.
4. Skin ulcers should be coded in either M1, with further clarification in M2, or in M4. Pressure or stasis ulcers coded in M2 should not be coded in M4.
5. If skin ulcers are captured in M1 or M4, good clinical practice would also have something documented in M5 under treatment.
6. For MDs coding, ankle problems are not considered foot problems.

DOCUMENTATION:

1. For clinical practice facilities need to follow the NPUAP standards in regards to pressure ulcer documentation (i.e. Healing stage 4 that has the appearance of tissue size and depth of a stage 2- the clinical record will state a healing stage 4, but the MDS would have Stage 2 in M1.)
2. Document weekly assessments of the wound healing progress or lack of. Documentation should include a thorough description of size, drainage, etc.
3. Care planning should identify risk factors and interventions based on the identified level of risk, as well as interventions to facilitate healing of existing skin problems.

EXAMPLES:

1. Mrs. B has impaired arterial circulation to her right foot. She has a Stage 3 in appearance on the top of her foot. She also has a superficial skin tear on her right forearm. M1 would be coded as a Stage 3 ulcer, M2 would be coded with 0 (zeros) and M4a would be checked for the skin tear. M5d, e and g may be checked, depending on specified interventions. M6c would be checked.

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