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MDS Alert

Pressure Ulcers: Are You Completing The Pressure Ulcer Risk Determination Correctly?

If you're missing these elements, you're getting M0100 & M0150 all wrong.

As you first embark on your arduous journey through the MDS 3.0's massive Section M, you're first greeted with M0100 (Determination of Pressure Ulcer Risk) and M0150 (Risk of Pressure Ulcers). These two areas are probably among the easiest in Section M, but if you miss any of these risk factors you'll ruin your coding of M0100 and M0150.

Review Those Risk Factors

"Pressure ulcer risk factors include immobility and decreased functional status," noted **Jeff Levine, MD**, clinical assistant professor for the department of medicine (geriatrics) at the **Albert Einstein College of Medicine**, in a recent **Centers for Medicare & Medicaid Services** (CMS) instructional session. "Co-morbid conditions, such as renal disease, thyroid disease, diabetes, congestive heart failure ... medications such as steroids thin the skin and make the skin more susceptible to damage."

Blood flow problems can also increase a resident's risk for pressure ulcers. "Anemia with severely low hemoglobin hematocrit is another pressure ulcer risk," Levine said. And severe lung disease with hypoxia is another risk factor.

"Other pressure ulcer risk factors include cognitive impairment, and exposure of skin to urinary and fecal incontinence," Levine pointed out. Malnutrition and dehydration are "long recognized as pressure ulcer risk factors,"

And if a resident has a healed pressure sore, he's automatically at risk according to M0100A, Levine instructed. "The tissue that heals over a pressure sore is not normal. And it's always going to be weaker than normal tissue."

Don't Forget About Refusal of Care

Section M also recognizes that refusal of care is a risk factor for pressure ulcers. "Does that mean that if a patient refuses care that you can just say, okay, document 'refused care' and walk away? No," Levine stated. "Because what you need to do is ... care plan it."

"Make sure the patient is and the caregivers are educated," Levine suggested. "Maybe get a psych consult if you question [the resident's] competency. But pay attention to it, and just don't let it go."

Also, interestingly "devices account for 10 percent of all pressure sores," according to Levine. "Ears are the number-one device-related site." This is usually from oxygen tubing either placed in the hospital or in the nursing home. "They put the tubing behind your ear and nobody checks. And the patient comes to your facility, and [he] can have awful pressure sores behind [his] ear."

Heed These Tips for the Clinical Assessment

So for the clinical assessment item, "you want to determine the etiology of all wounds and lesions," Levine said. And you can use a handy mnemonic developed by **Elizabeth Ayello, PhD, RN, CWOCN**, president of **Ayello, Harris and**

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Associates, Inc. and an internationally known wound-care expert, called "HALT:"

- **H**istory of pressure ulcer or patient events, including immobility, decreased functional status and nutrition issues.
- **A**ssociated diagnoses and co-morbidities, including advancing age and medications.
- **L**ook at the skin.
- **T**ouch the skin.

"You want to always give the patient a head-to-toe assessment whenever there is a new pressure sore or a worsening of a pressure sore, and that includes looking and touching," Levine noted.

And then for M0150, you code "1" for yes or "0" for no answering whether the resident is at risk for developing pressure ulcers. The answer to M0150 "is gleaned from the information that you've gotten in M0100," Levine said.

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