A facility’s performance in the quality measures is determined by the MDS coding of a variety of data elements directly related to the residents’ condition and what has occurred with the resident during the “look back” period. The tables below identify the specific components of the MDS that populate both the numerator (the top number) and the denominator (the bottom number) of the High-risk Pressure Ulcer rate/percentage that will ultimately be publicly reported on Nursing Home Compare at [www.medicare.gov](http://www.medicare.gov).

On the reverse side of this sheet you’ll find special considerations for each of the MDS sections identified below that directly impact the facility’s performance in the High-risk Pressure Ulcer Quality Measure and helps to ensure the accurate and reliable reporting of the MDS.

### NUMERATOR
(who has it)

In order for the resident to be placed in the numerator they must meet **both** of the following conditions:

- #1: At high-risk for pressure ulcers (defined below)
- #2: Have a stage II, III, or IV pressure ulcer(s)

### Coding of MDS

Who has it - All residents who meet the denominator definition for high risk **AND** any of the following:

- Has a Stage II, or Stage III, or Stage IV pressure ulcer (coded in M0300B1, M0300C1, M0300D1) **or**
- An active diagnosis of ICD-9 (I8000 = Stage II 707.22, or Stage III 707.23, or Stage IV 707.24)

### DENOMINATOR
(who could have it)

In order for the resident to be placed in the denominator they must meet the definition of high-risk (except those with exclusions as noted below). High risk is defined when **one or more** of the 3 criteria are met:

- #1: impaired bed mobility or transfer
- #2: Comatose
- #3: Malnutrition **OR** at risk for malnutrition

### Coding of MDS

Who could have it due to conditions that meet the definition of high risk on the selected target assessment of:

- Impaired bed mobility: $G0110A1 = 3, 4, 7, 8$ **or**
- Impaired transfer: $G0110B1 = 3, 4, 7, 8$ **or**
- Comatose: $B0100 = 1$ **or**
- Malnutrition or at risk of malnutrition: $I5600 = checked$

**Note:** Section G coding for the purposes of the denominator include:

- $3 =$ extensive assistance: resident involved in activity but staff provided weight bearing support during the look-back
- $4 =$ full staff performance every time during the look-back
- $7 =$ activity happened only once or twice during the look-back
- $8 =$ activity did not occur during the look-back

### EXCLUSIONS:

- Admission assessment: A0310A – 01, or
- Five-Day PPS Assessment: A0301B – 01, or
- Readmission/Return Assessment: A0310B = 06 or
- Resident does not have a Stage II, III, IV pressure ulcer.
Quality Measure Specifications
Percentage of Long-stay High-risk Residents with Pressure Ulcers

SPECIAL CONSIDERATIONS

Section I:
• For a malnutrition: the physician will need to document the diagnosis related to malnutrition such as a depletion of protein, as long as it’s documented within the past 60 days (30 days for a UTI is the only exception) and the treatment occurred within the last 7 days (during the look back period). Lab work will help to support this (ie, low albumin).

Section G:
• Extensive assistance: in order to code as ‘extensive’ only 3 instances needed to occur within the look back period.
• Are you certain the ADL’s for all of your residents are documented correctly for the MDS Coordinator to report them accurately and reliably? Remember you are not coding what the resident can do but rather what occurred during the look back period.

Section M:
• Classification of wounds: It is especially important to be absolutely certain that anything that is coded in Section M is due to a wound that is a direct result of pressure. Too often wounds are classified as pressure when in reality the root cause of the ulcer is from something other than pressure, such as a diabetic ulcer, a venous ulcer or a failed flap that should now be coded as surgical.

Significant Change:
• Are you taking credit for healed pressure ulcers? If/when a resident becomes free of pressure ulcers that were once present, AND if there is a 2nd significant change in the residents’ condition, then a “significant change” MDS should be initiated.

Active Diagnosis:
• Physician-documented diagnoses in the last 60 days that have a direct relationship to the resident’s functional status, cognitive status, mood or behavior, medical treatments, nursing monitoring, or risk of death during the 7-day look-back period.

Process to code as an active diagnosis:
Step 1: Identify diagnoses: The disease conditions in this section require a physician-documented diagnosis (or by a nurse practitioner, physician assistant, or clinical nurse specialist if allowable under state licensure laws) in the last 60 days. Medical record sources for physician diagnoses include progress notes, the most recent history and physical, transfer documents, discharge summaries, diagnosis/problem list, and other resources as available. If a diagnosis/problem list is used, only diagnoses confirmed by the physician should be entered.
• Although open communication regarding diagnostic information between the physician and other members of the interdisciplinary team is important, it is also essential that diagnoses communicated verbally be documented in the medical record by the physician to ensure follow-up.
• Diagnostic information, including past history obtained from family members and close contacts, must also be documented in the medical record by the physician to ensure validity and follow-up.
Step 2: Determine whether diagnosis is active: Once a diagnosis is identified, it must be determined if the diagnosis is active. Do not include conditions that have been resolved or have no longer affected the resident’s functioning or plan of care, or that the resident has adjusted to as their “new normal,” during the last 7 days. Use the following information sources to determine if a diagnosis is active: transfer documents, physician progress notes, recent history and physical, discharge summary, nursing assessments, nursing care plans, medication sheets, doctor’s orders, consults, official diagnostic reports and any other sources.