Inpatient Rehabilitation Facility
Quality Reporting Program Provider Training

Section J:

Health Conditions (Falls)

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Section J: Objectives

- Demonstrate a working knowledge of the intent of Section J: Health Conditions.

- Interpret the coding options for each new item and when they would be coded.

- Apply coding instructions in order to accurately code practice scenarios and the case study.

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Section J: New Items

All items in Section J are **new.**

Item:	Assessed On:
J1750, History of Falls	Admission
J1800, Any Falls Since Admission	Discharge
J1900, Number of Falls Since Admission	Discharge
J2000, Prior Surgery	Admission

Section J: Intent

- Code a history of falls.

- Code any falls since admission, including level of any fall-related injury.

Definition of a Fall

- Unintentional change in position coming to rest on the ground, floor, or onto the next lower surface.

- May be witnessed, reported by the patient or an observer, or identified when a patient is found on the floor or ground.

- Not a result of an overwhelming external force.
  - E.g., a patient pushes another patient.

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Definition of Intercepted Fall

- **An intercepted fall is considered a fall**.

- An **intercepted fall** occurs when the patient:
  - Would have fallen if he or she had not caught him/herself.
  - Had not been intercepted by another person – **this is still considered a fall.**

J1750

History of Falls

J1750 Item Rationale

- Falls are a leading cause of morbidity and mortality.

- The most important predictors of risk for future falls and injurious falls include:
  - Previous fall
  - Recent fall
  - Falls with significant injury

- Persons with a history of falling may limit activities because of a fear of falling and should be evaluated for contributing factors of falling.

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J1750 Steps for Assessment

1. Indicate if the patient has had:

   o Two or more falls in the past year.

   o Any fall with injury in the past year.

2. Interview the patient if capable of reliably reporting fall history.

3. Speak with family members or significant others to obtain fall history.

J1750 Coding Instructions

- Complete at the time of admission.

J1750 Practice Coding Scenario (1)

- Ms. T reports that she fell 3 months ago and then again 1 month ago while walking outside.

- Ms. T stated she only bruised her arm during the first fall and her knee during the second fall.

- She reported she did not seek medical advice and was able to recover without apparent injury.
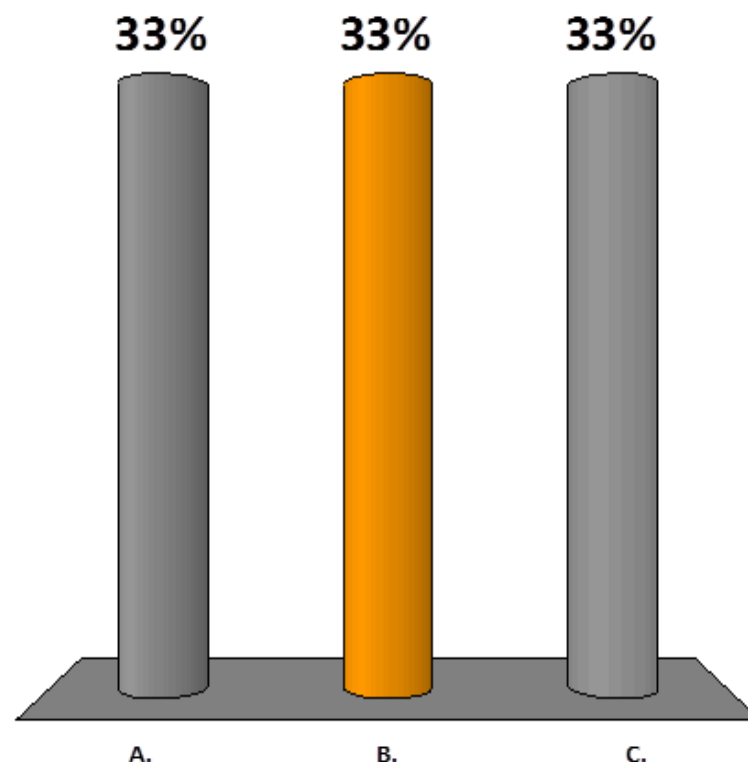
How would you code J1750?

Has the patient had two or more falls **or** any fall with injury in the past year?

A. Code **0,** No

✓ B. Code **1,** Yes

C. Code **8,** Unknown

33%   33%   33%

A.   B.   C.

30

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J1750 Practice Coding Scenario (1)

Coding: J1750. History of Falls would be coded **1, Yes.**

Rationale: Two falls were reported by the patient in the past year.

J1750 Practice Coding Scenario (2)

- Mr. W. is unable to provide information on his fall history, but his wife is able to provide this information.

- Mrs. W. states that her husband fell 8 months ago at home, outside on the driveway.

- He hit his head and needed seven sutures to his scalp.
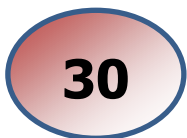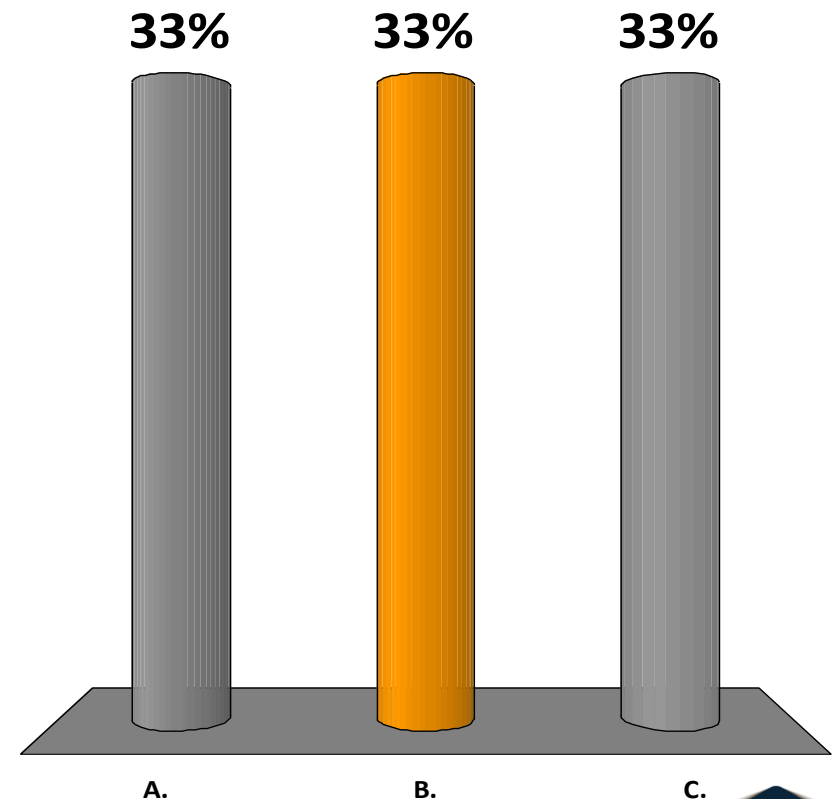
- This was his only fall in the past year.

How would you code J1750?

Has the patient had two or more falls **or** any fall with injury in the past year?

A. Code **0,** No

✓ B. Code **1,** Yes

C. Code **8,** Unknown

33%   33%   33%

A.   B.   C.

30

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J1750 Practice
Coding Scenario (2)

Coding: J1750. History of Falls would be coded **1, Yes.**

Rationale: Mr. W had only one fall in the past year, but that one fall had an injury.

J1800

Any Falls Since Admission

J1800 Item Rationale

- Falls are a leading cause of morbidity and mortality.

- Fear of falling can limit an individual's activity and negatively impact quality of life.

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J1800 Steps for Assessment

- Review inpatient rehabilitation facility (IRF) medical record:

  - Physician, nursing, therapy, and nursing assistant notes

  - Incident reports

  - Fall logs

J1800 Coding Instructions

- Complete only at the time of discharge.

J1800. Any Falls Since Admission

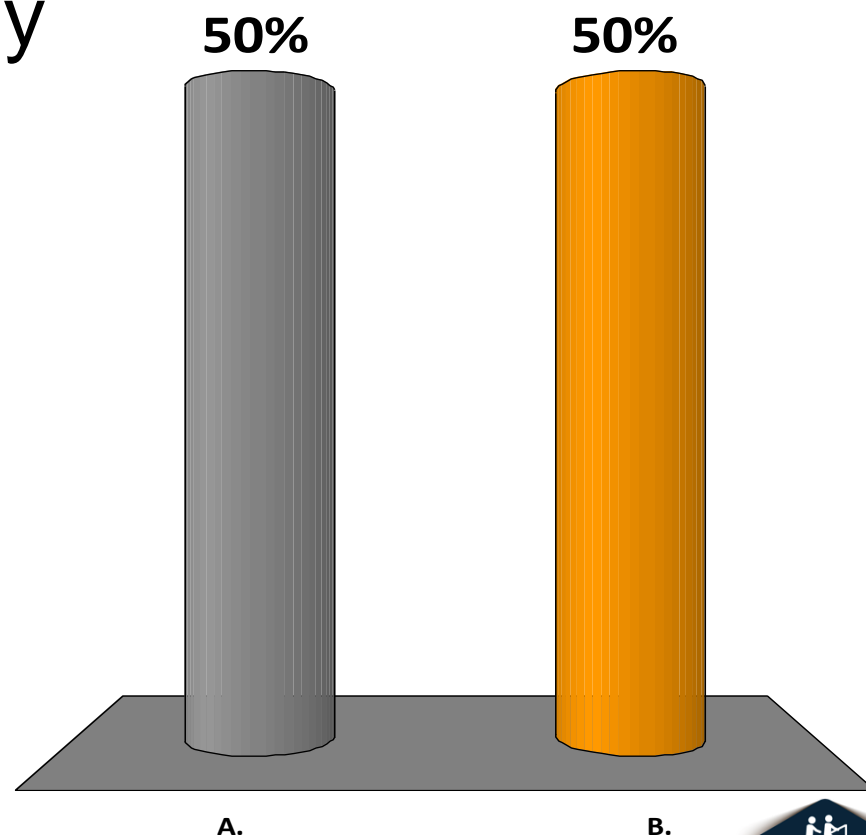| Enter Code	Has the patient **had any falls since admission?**
☐	0. **No** → *Skip to M0210. Unhealed Pressure Ulcer(s)* 1. **Yes** → *Continue to J1900. Number of Falls Since Admission*

J1800 Practice
Coding Scenario (1)

- An incident report describes an event in which Mr. S was walking down the hall and appeared to slip on a wet spot on the floor.

- He lost his balance and bumped into the wall, but was able to grab onto the hand rail and steady himself.

How would you code J1800?

Has the patient had any falls since admission?

  A. Code **0,** No

✓ B. Code **1,** Yes

50%

50%

A.

B.

30

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J1800 Practice Coding Scenario (1)

Coding: J1800, Any Falls Since Admission, would be coded **1, Yes.**

Rationale: An intercepted fall is considered a fall.
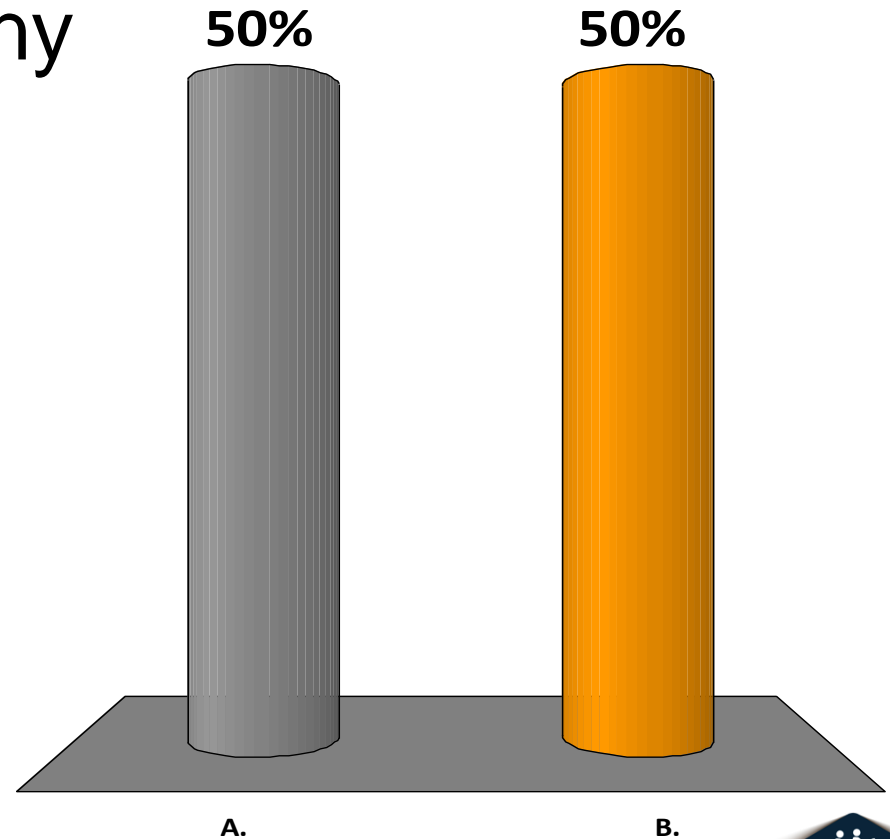
J1800 Practice Coding Scenario (2)

- According to the therapy notes, Mrs. J was walking using parallel bars when she became weak and was assisted to the floor by the therapist.

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How would you code J1800?

Has the patient had any falls since admission?

A. Code **0,** No

✓ B. Code **1,** Yes

50% **50%**

A. B.

30

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J1800 Practice
Coding Scenario (2)

Coding: J1800. Any Falls Since Admission would be coded **1, Yes.**

Rationale: An intercepted fall occurs when the patient would have fallen if he or she had not caught him/herself or had not been intercepted by another person.

J1900

Number of Falls Since Admission

J1900 Steps for Assessment

- Review IRF medical record.

  o Physician, nursing, therapy, and nursing assistant notes

  o Incident reports

  o Fall logs

Definition: Injury Related to a Fall

Injury Related to a Fall:

- Any documented injury that occurred as a result of, or was recognized within a short period of time (e.g., hours to a few days) after the fall and attributed to the fall.

J1900 Coding Instructions

- Complete at the time of discharge.

- Determine the number of falls that occurred since admission.

- Code the level of fall-related injury for each.

- Code each fall only once. If the patient has multiple injuries in a single fall, code the fall for the highest level of injury.

CODING:
0. None
1. One
2. Two or more

J1900. Number of Falls Since Ad...

CODING:
0. None
1. One
2. Two or more

...ysical assessment by the nurse or primary care clinician; ...ange in the patient's behavior is noted after the fall

B. Injury (except major): skin tears, abrasions, lacerations, superficial bruises, hematomas and sprains; or any fall-related injury that causes the patient to complain of pain

C. **Major injury:** Bone fractures, joint dislocations, closed head injuries with altered consciousness, subdural hematoma

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J1900A Coding Instructions

- **Code 0, None,** if the patient had no injurious fall since admission.

- **Code 1, One,** if the patient had one non-injurious fall since admission.

- **Code 2, Two or more,** if the patient had two or more non-injurious falls since admission.

A. No injury: No

J1900. Number of Falls Since Admission

CODING:	↓ Enter Codes in Boxes
0. None 1. One 2. Two or more	☐ **A. No injury:** No evidence of any injury is noted on physical assessment by the nurse or primary care clinician; no complaints of pain or injury by the patient; no change in the patient's behavior is noted after the fall
	☐ **B. Injury (except major):** Skin tears, abrasions, lacerations, superficial bruises, hematomas and sprains; or any fall-related injury that causes the patient to complain of pain
	☐ **C. Major injury:** Bone fractures, joint dislocations, closed head injuries with altered consciousness, subdural hematoma

J1900B Coding Instructions

- **Code 0, None,** if the patient had no injurious fall (except major) since admission.

- **Code 1, One,** if the patient had one injurious fall (except major) since admission.

- **Code 2, Two or more,** if the patient had two or more injurious falls (except major) since admission.

J1900. Number of Falls Since Admission

B. Injury (except major):

CODING:		Enter Codes in Boxes
0. None 1. One 2. Two or more	☐	A. **No injury:** No evidence of any injury is noted on physical assessment by the nurse or primary care clinician; no complaints of pain or injury by the patient; no change in the patient's behavior is noted after the fall
	☐	B. **Injury (except major):** Skin tears, abrasions, lacerations, superficial bruises, hematomas and sprains; or any fall-related injury that causes the patient to complain of pain
	☐	C. **Major injury:** Bone fractures, joint dislocations, closed head injuries with altered consciousness, subdural hematoma

Definition: Injury (Except Major)

Examples of Injury (except major) include:

- Skin tears

- Abrasions

- Lacerations

- Superficial bruises

- Hematomas

- Sprains

- Any fall-related injury that causes the patient to complain of pain

J1900C Coding Instructions

- **Code 0, None,** if the patient had no major injurious fall since admission.

- **Code 1, One,** if the patient had one major injurious fall since admission.

- **Code 2, Two or more,** if the patient had two or more major injurious falls since admission.

C. Major injury:

J1900. Number of Falls Since Admission		
CODING: 0. None 1. One 2. Two or more	↓ **Enter Codes in Boxes**	
	☐	**A. No injury:** No evidence of any injury is noted on physical assessment by the nurse or primary care clinician; no complaints of pain or injury by the patient; no change in the patient's behavior is noted after the fall
	☐	**B. Injury (except major):** Skin tears, abrasions, lacerations, superficial bruises, hematomas and sprains; or any fall-related injury that causes the patient to complain of pain
	☐	**C. Major injury:** Bone fractures, joint dislocations, closed head injuries with altered consciousness, subdural hematoma

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Definition: Major Injury

Examples of Major Injury include:

- Bone fractures

- Joint dislocations

- Closed head injuries with altered consciousness

- Subdural hematoma

J1900 Coding Scenario (1)

- Mr. J reported he was ambulating to the bathroom with his walker when he stumbled at the bathroom door and fell.

- On assessment, the nurse found two large skin tears on the patient's right arm, bruising to his right lower leg, and a laceration above his right eye. All wounds were cleaned and dressed.

- Two days later, Mr. J complained of pain in his right fourth finger, which was noted to have slight swelling and some bruising. An x ray revealed a non-displaced fracture of the finger.

How would you code J1900?

J1900. Number of Falls Since Admission

CODING:	↓ Enter Codes in Boxes
0. None 1. One 2. Two or more	**A. No injury:** No evidence of any injury is noted on physical assessment by the nurse or primary care clinician; no complaints of pain or injury by the patient; no change in the patient's behavior is noted after the fall
	B. Injury (except major): Skin tears, abrasions, lacerations, superficial bruises, hematomas and sprains; or any fall-related injury that causes the patient to complain of pain
	C. Major injury: Bone fractures, joint dislocations, closed head injuries with altered consciousness, subdural hematoma

J1900A Coding

J1900. Number of Falls Since Admission		
CODING: 0. None 1. One 2. Two or more	↓ **Enter Codes in Boxes**	
	`0`	**A. No injury:** No evidence of any injury is noted on physical assessment by the nurse or primary care clinician; no complaints of pain or injury by the patient; no change in the patient's behavior is noted after the fall
	☐	**B. Injury (except major):** Skin tears, abrasions, lacerations, superficial bruises, hematomas and sprains; or any fall-related injury that causes the patient to complain of pain
	☐	**C. Major injury:** Bone fractures, joint dislocations, closed head injuries with altered consciousness, subdural hematoma

J1900B Coding

J1900. Number of Falls Since Admission		
CODING: 0. None 1. One 2. Two or more	**↓ Enter Codes in Boxes**	
	`0`	**A. No injury:** No evidence of any injury is noted on physical assessment by the nurse or primary care clinician; no complaints of pain or injury by the patient; no change in the patient's behavior is noted after the fall
	`0`	**B. Injury (except major):** Skin tears, abrasions, lacerations, superficial bruises, hematomas and sprains; or any fall-related injury that causes the patient to complain of pain
		C. Major injury: Bone fractures, joint dislocations, closed head injuries with altered consciousness, subdural hematoma

J1900C Coding

J1900. Number of Falls Since Admission		
CODING: 0. None 1. One 2. Two or more	↓ **Enter Codes in Boxes**	
	`0`	**A. No injury:** No evidence of any injury is noted on physical assessment by the nurse or primary care clinician; no complaints of pain or injury by the patient; no change in the patient's behavior is noted after the fall
	`0`	**B. Injury (except major):** Skin tears, abrasions, lacerations, superficial bruises, hematomas and sprains; or any fall-related injury that causes the patient to complain of pain
	`1`	**C. Major injury:** Bone fractures, joint dislocations, closed head injuries with altered consciousness, subdural hematoma

J1900 Coding Scenario (1)

Coding: J1900C. Major injury would be coded **1, One.**

Rationale:

- Mr. J fractured his finger as a result of a fall.
- Although he suffered multiple injuries as a result of the fall, the highest level of injury should be coded.

J1900 Coding Scenario (2)

- Mrs. K was found on the floor in front of her wheelchair. Upon exam, no obvious injuries were noted.

- Four days later, Mrs. K was again found on the floor in front of her wheelchair. No injuries were noted.

- Seven days after the first fall, Mrs. K's roommate called for help after witnessing Mrs. K get out of her wheelchair and fall on the way to the bathroom.

- When staff arrived, Mrs. K was on the floor bleeding from a large scalp laceration. She was sent to the ED and returned with 12 staples.

How would you code J1900?

J1900. Number of Falls Since Admission

CODING:
0. None
1. One
2. Two or more

↓ Enter Codes in Boxes

☐	**A. No injury:** No evidence of any injury is noted on physical assessment by the nurse or primary care clinician; no complaints of pain or injury by the patient; no change in the patient's behavior is noted after the fall
☐	**B. Injury (except major):** Skin tears, abrasions, lacerations, superficial bruises, hematomas and sprains; or any fall-related injury that causes the patient to complain of pain
☐	**C. Major injury:** Bone fractures, joint dislocations, closed head injuries with altered consciousness, subdural hematoma

J1900A Coding

J1900. Number of Falls Since Admission		
CODING:	↓ **Enter Codes in Boxes**	
0. None 1. One 2. Two or more	[2]	**A. No injury:** No evidence of any injury is noted on physical assessment by the nurse or primary care clinician; no complaints of pain or injury by the patient; no change in the patient's behavior is noted after the fall
	[ ]	**B. Injury (except major):** Skin tears, abrasions, lacerations, superficial bruises, hematomas and sprains; or any fall-related injury that causes the patient to complain of pain
	[ ]	**C. Major injury:** Bone fractures, joint dislocations, closed head injuries with altered consciousness, subdural hematoma

J1900B Coding

J1900. Number of Falls Since Admission		
CODING: 0. None 1. One 2. Two or more	↓ **Enter Codes in Boxes**	
	2	**A. No injury:** No evidence of any injury is noted on physical assessment by the nurse or primary care clinician; no complaints of pain or injury by the patient; no change in the patient's behavior is noted after the fall
	1	**B. Injury (except major):** Skin tears, abrasions, lacerations, superficial bruises, hematomas and sprains; or any fall-related injury that causes the patient to complain of pain
	☐	**C. Major injury:** Bone fractures, joint dislocations, closed head injuries with altered consciousness, subdural hematoma

J1900C Coding

J1900. Number of Falls Since Admission

CODING:

0. None
1. One
2. Two or more

↓ **Enter Codes in Boxes**

Code	Description
2	**A. No injury:** No evidence of any injury is noted on physical assessment by the nurse or primary care clinician; no complaints of pain or injury by the patient; no change in the patient's behavior is noted after the fall
1	**B. Injury (except major):** Skin tears, abrasions, lacerations, superficial bruises, hematomas and sprains; or any fall-related injury that causes the patient to complain of pain
0	**C. Major injury:** Bone fractures, joint dislocations, closed head injuries with altered consciousness, subdural hematoma

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J1900 Coding Scenario (2)

Coding:

- **J1900A.** No injury would be coded **2, Two or more.**

- **J1900B.** Injury (except major) would be coded **1, One.**

- **J1900C.** Major injury, would be coded **0, None.**

Rationale: Mrs. K had two falls with no injury and one fall with a injury except major (requiring staples).

J1900 Coding Scenario (3)

- Ms. A was ambulating in the hallway when she stumbled and started to fall. She grabbed the railing but hit her head on the wall. The incident was witnessed by the nurse, who immediately assessed Ms. A.

- Ms. A was noted to have tenderness in her right temporal region. Vital signs were stable, and neuro exam was normal.

- A few hours later, Ms. A complained of a headache and nausea. Since she was on warfarin, she was sent to the ED for evaluation. A head CT scan revealed a subdural hematoma.

- She received treatment and returned to the IRF after 2 days.

How would you code J1900?

J1900. Number of Falls Since Admission

CODING: 0. None 1. One 2. Two or more	↓ **Enter Codes in Boxes**	
	☐	**A. No injury:** No evidence of any injury is noted on physical assessment by the nurse or primary care clinician; no complaints of pain or injury by the patient; no change in the patient's behavior is noted after the fall
	☐	**B. Injury (except major):** Skin tears, abrasions, lacerations, superficial bruises, hematomas and sprains; or any fall-related injury that causes the patient to complain of pain
	☐	**C. Major injury:** Bone fractures, joint dislocations, closed head injuries with altered consciousness, subdural hematoma

J1900A Coding

J1900. Number of Falls Since Admission		
CODING: 0. None 1. One 2. Two or more	↓ **Enter Codes in Boxes**	
	0	**A. No injury:** No evidence of any injury is noted on physical assessment by the nurse or primary care clinician; no complaints of pain or injury by the patient; no change in the patient's behavior is noted after the fall
		B. Injury (except major): Skin tears, abrasions, lacerations, superficial bruises, hematomas and sprains; or any fall-related injury that causes the patient to complain of pain
		C. Major injury: Bone fractures, joint dislocations, closed head injuries with altered consciousness, subdural hematoma

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J1900B Coding

J1900. Number of Falls Since Admission		
CODING: 0. None 1. One 2. Two or more	↓ **Enter Codes in Boxes**	
	`0`	**A. No injury:** No evidence of any injury is noted on physical assessment by the nurse or primary care clinician; no complaints of pain or injury by the patient; no change in the patient's behavior is noted after the fall
	`0`	**B. Injury (except major):** Skin tears, abrasions, lacerations, superficial bruises, hematomas and sprains; or any fall-related injury that causes the patient to complain of pain
		C. Major injury: Bone fractures, joint dislocations, closed head injuries with altered consciousness, subdural hematoma

J1900C Coding

J1900. Number of Falls Since Admission		
CODING: 0. None 1. One 2. Two or more	↓ **Enter Codes in Boxes**	
	`0`	**A. No injury:** No evidence of any injury is noted on physical assessment by the nurse or primary care clinician; no complaints of pain or injury by the patient; no change in the patient's behavior is noted after the fall
	`0`	**B. Injury (except major):** Skin tears, abrasions, lacerations, superficial bruises, hematomas and sprains; or any fall-related injury that causes the patient to complain of pain
	`1`	**C. Major injury:** Bone fractures, joint dislocations, closed head injuries with altered consciousness, subdural hematoma

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J1900 Coding Scenario (3)

Coding: J1900C, Major Injury, would be coded **1, One.**

Rationale: Subdural hematoma is a major injury, and it occurred as a result of an intercepted fall.

J2000

Prior Surgery

J2000 Item Rationale

- Identifies whether the patient had major surgery during the 100 days prior to admission.

- A recent history of major surgery can affect a patient's recovery.

J2000 Steps for Assessment

- Interview the patient.

- Ask family or a significant other if the patient is unable to report.

- Review the patient's medical record to determine whether the patient had major surgery during the 100 days prior to admission.

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J2000 Coding Instructions

- Complete only at the time of admission.

- **Code 0, No,** if the patient did not have major surgery during the 100 days prior to admission.

- **Code 1, Yes,** if the patient did have major surgery during the 100 days prior to admission.

0.	**No**
1.	**Yes**
8.	**Unknown**

J2000. Prior Surgery

Enter Code	Did the patient have major surgery during the 100 days prior to admission?
	0. No
	1. Yes
	8. Unknown

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Definition: Major Surgery

- Generally, major surgery refers to a procedure requiring general anesthesia.

- In addition, major surgery usually carries some degree of risk to the patient's life, or the potential for severe disability if something goes wrong during the surgery.

- An overnight stay in an acute care hospital **is required** for a procedure to be classified as "Major Surgery."

J2000 Coding Scenario

Mr. B's medical record indicates that he underwent a total hip replacement two months prior to his current IRF stay.

- How would you code J2000?

- What is your rationale?

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J2000 Coding Scenario

Coding: J2000. Prior Surgery, would be coded **1, Yes.**

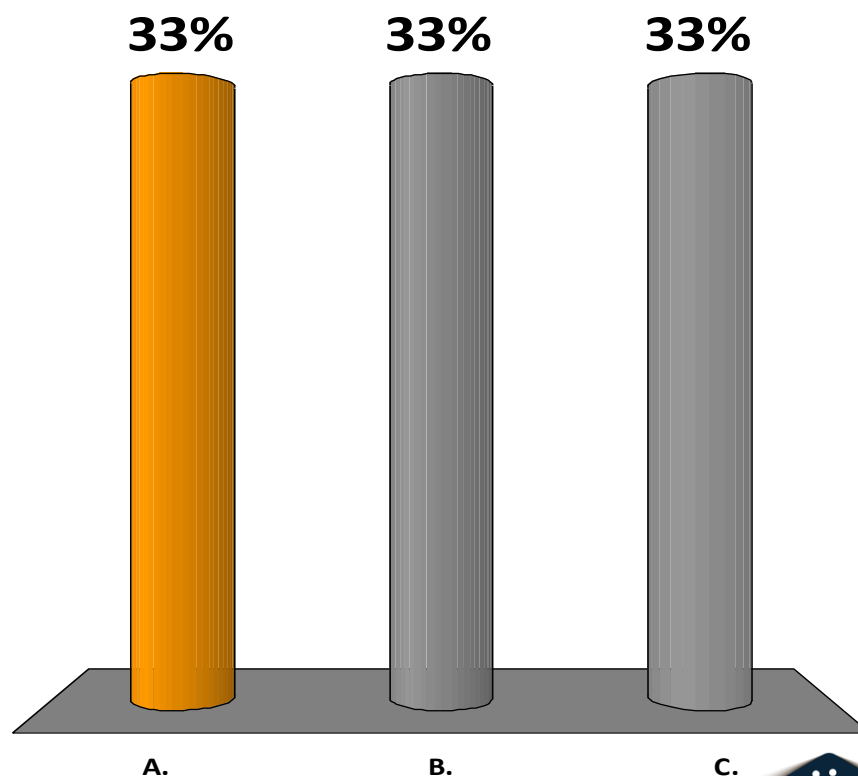**Rationale:** Hip replacement meets the definition of major surgery.

J2000 Practice
Coding Scenario (1)

- A review of Mrs. K's medical record indicates a surgical history of a colon resection nine months prior to the IRF admission for removal of a large, benign intestinal polyp. Mrs. K was hospitalized for four days.

- Mrs. K was also noted to have wisdom tooth extraction two months prior to the IRF admission.

How would you code J2000?

Did the patient have major surgery during the 100 days prior to admission?

✓ A. Code **0,** No

B. Code **1,** Yes

C. Code **8,** Unknown

33%   **33%**   **33%**

A.   B.   C.

30

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J2000 Practice
Coding Scenario (1)

Coding: J2000. Prior Surgery, would be coded **0, No.**

Rationale:

- A colon resection is major surgery, but it was done more than 100 days prior to admission.

- The wisdom tooth extraction was within the 100 day timeframe, but does not meet the definition of major surgery.

J2000 Practice Coding Scenario (2)
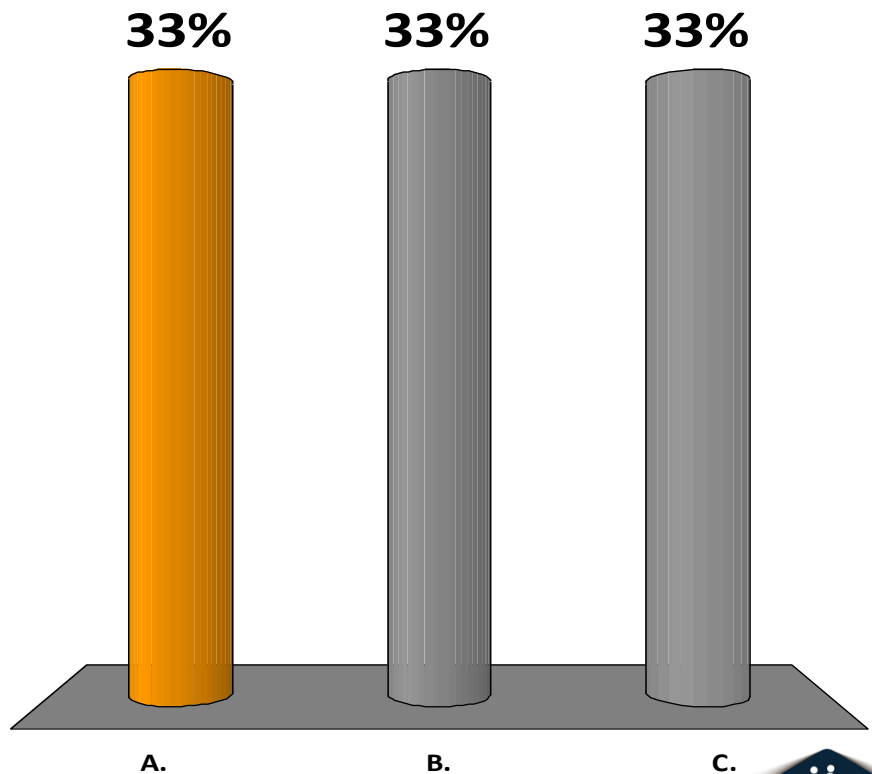
- In reviewing the medical record, it was noted that Mr. Z had a PEG tube inserted 20 days prior to admission to the IRF.

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How would you code J2000?

Did the patient have major surgery during the 100 days prior to admission?

✓ A. Code **0,** No

B. Code **1,** Yes

C. Code **8,** Unknown

33% 33% 33%

A. B. C.

30

J2000 Practice Coding Scenario (2)

Coding: J2000. Prior Surgery, would be coded **0, No.**

Rationale: Insertion of the PEG tube is a day procedure in the endoscopy department and does not require general anesthesia.

J2000. Prior Surgery

Enter Code [0]

Did the patient have major surgery during the 100 days prior to admission?
0. **No**
1. **Yes**
8. **Unknown**

Case Study: Mrs. G

Please work in groups at your table to determine how you would code:

- J1750 and J2000 on Mrs. G's admission assessment

- J1800 and J1900 for Mrs. G's Discharge Assessment.

We will debrief in 10 minutes.

Case Study: J1750 Answers and Discussion

J1750. History of Falls

- **Admission Coding:** 1, Yes.

- **Rationale:** According to Mrs. G's daughter, Mrs. G sustained no other falls this past year except the fall due to her stroke. In the ED, it was noted she had multiple skin tears and bruising on her arms.

Case Study: J1800 Answers and Discussion

J1800. Any Falls Since Admission

- **Discharge Coding:** 1, Yes.

- **Rationale:** Mrs. G sustained a fall on July 9 when transferring back to bed with the aide.

Case Study: J1900 Answers and Discussion

J1900: Number of Falls since Admission (Discharge)

- **Discharge Coding:**

    o **J1900A. No Injury:** 0, None

    o **J1900B. Injury (Except Major):** 1, One

    o **J1900C. Major Injury:** 0, None

- **Rationale:** When Mrs. G fell with the aide, she moaned in pain when her right ankle was palpated. An x ray was taken, and it was negative for fracture. She was diagnosed with a sprained right ankle. An acetaminophen was ordered for her pain, as well as an air splint for comfort.

Case Study: J2000 Answers and Discussion

J2000: Prior Surgery

- **Admission Coding:** 1, Yes.

- **Rationale:** Mrs. G had a colon resection on May 26, 2016.

Section J: Summary

- Items **J1750,** History of Falls, and **J2000,** Prior Surgery, are completed on admission only.

- Items **J1800,** Any Falls Since Admission, and **J1900,** Number of Falls Since Admission, are completed at discharge only.

- It is important to remember the definition of a fall.

Section J: Summary

Fall Definition:

- Unintentional change in position coming to rest on the ground, floor, or onto the next lower surface (e.g., onto a bed, chair, or bedside mat).

- May be witnessed, reported by the patient or an observer, or identified when a patient is found on the floor or ground.

- Not a result of an overwhelming external force (e.g., a patient pushes another patient.

- An **intercepted fall** occurs when the patient:

  - Would have fallen if he or she had not caught him/herself.
  - Had not been intercepted by another person—this is still considered a fall.

Section J: Action Plan

- Educate staff about new items in Section J.

- Evaluate current documentation to ensure terminology aligns with items in the IRF-PAI v1.4.

- Practice coding a variety of scenarios and case studies with staff.