Home Health Quality Reporting Program

PRACTICE CODING SCENARIOS DAY 1

March 5 and 6, 2019
The Lord Baltimore Hotel
Baltimore, MD 21201

Section J: Health Conditions

J1800 Practice Coding Scenario 1

- The discharging registered nurse (RN) reviews the clinical record and interviews the patient and caregiver, Mrs. K and her daughter Susan, determining that a single fall occurred since the most recent SOC/ROC.
- The fall is documented on a clinical note from an RN home visit in which Susan reported her mother slipped from her wheelchair to the floor the previous day.

J1800 Practice Coding Scenario 2

- An incident report describes an event in which Mr. S appeared to slip on a wet spot on the floor during a home health aide bath visit.
- He lost his balance and bumped into the wall, but was able to steady himself and remain standing.

J1800 Practice Coding Scenario 3

- A patient is participating in balance retraining activities during a therapy visit.
- The therapist is intentionally challenging patient's balance, anticipating a loss of balance.
- The patient has a loss of balance to the left due to hemiplegia, and the physical therapist provides minimal assistance to allow the patient to maintain standing.

J1800 Practice Coding Scenario 4

- A patient is ambulating with a walker with the help of the physical therapist.
- The patient stumbles and the therapist has to bear some of the patient's weight in order to prevent a fall.

J1900 Practice Coding Scenario 5

- Review of the clinical record and incident reports and patient and caregiver report identify that a single fall occurred since the most recent SOC/ROC.
- The fall is documented on a clinical note from an RN home visit that describes the patient Mr. R's report of a fall that occurred between visits, in which he tripped on the dog, fell against the wall, and banged his elbow, sustaining a skin tear that he treated himself.
- Documentation of the RN assessment during the home visit details the healing skin tear and no other injury or symptom identified related to the fall.

J1900.	**Number of Falls Since SOC/ROC,** whichever is more recent	
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

J1900 Practice Coding Scenario 6

- Review of the patient record, incident reports and patient and caregiver report identify that two falls occurred since the most recent SOC/ROC. The falls are documented on clinical notes.
- The first describes an event during which Mr. G tripped on the bathroom rug and almost fell, but caught himself against the sink. The RN assessment identified no injury.
- The second describes an event during which Mr. G, while coming up the basement stairs with the laundry, fell against the stair and sustained a bruise and laceration on his left knee.

J1900.	**Number of Falls Since SOC/ROC,** whichever is more recent	
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

J1900 Practice Coding Scenario 7

- Review of the patient record, incident reports and patient and caregiver report identify that a single fall occurred since the most recent SOC/ROC.
- The fall is documented on an incident report, which describes an event during which Mrs. J fell while walking from her bedroom to the bathroom and was transported to the emergency room via ambulance.
- Examination and testing revealed a skin tear on Mrs. J's left hand, bruising on both knees, and a fractured left hip.

J1900.	**Number of Falls Since SOC/ROC,** whichever is more recent	
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

Changes in Skin Integrity Post-Acute Care: Pressure Ulcer/Injury (M1311)

M1311 Practice Coding Scenario 1

- A patient is admitted to home health with a Stage 3 pressure ulcer on her coccyx. No other pressure ulcers are present.
- At discharge, it is entirely covered with eschar and the wound bed cannot be assessed. No additional pressure ulcers arise during this episode.
- The patient is discharged from home health services with an unstageable pressure ulcer due to slough/eschar.

M1311 Practice Coding Scenario 2

- A patient is admitted to home health with referral documentation indicating the presence of a Stage 3 sacral pressure ulcer. This ulcer is covered with a non-removable dressing; and therefore, this pressure ulcer/injury is unstageable at SOC. No other pressure ulcers/injuries are present.
- An order is obtained to change the dressing on Day 4 of the quality episode, and assessment reveals a Stage 3 pressure ulcer.
- On Day 9 of the quality episode, the pressure ulcer is covered with eschar and is assessed as unstageable. The eschar-covered ulcer is unchanged at the time of discharge. No other pressure ulcers/injuries develop during this quality episode.

M1311 Practice Coding Scenario 3

- The RN completes a skin assessment during the SOC visit for Mrs. K, and identifies a right hip DTI with intact skin.
- This DTI is first numerically stageable 10 days later as a Stage 3 pressure ulcer and increases in numerical stage five days after that, to a Stage 4 pressure ulcer.
- The pressure ulcer remains a Stage 4 at discharge.

Changes in Skin Integrity Post-Acute Care: Pressure Ulcer/Injury (M1311) continued

Coding Activity

Instructions: Review the following scenarios and complete the M1311 Coding Tables. The presenter will reconvene the group and discuss the correct responses for each scenario.

M1311 Practice Coding Scenario 4

- The RN assesses Mr. L's skin during the assessment timeframe for the SOC, and identifies a DTI with intact skin on his right heel.
- This DTI first becomes numerically stageable at the third home visit, as a Stage 3 pressure ulcer.
- At the Discharge skin assessment, this pressure ulcer is unstageable due to slough and eschar.

M1311. Current Number of Unhealed Pressure Ulcers/Injuries	SOC Assessment	Discharge Assessment
M1311A1. Number of Stage 2 pressure ulcers		
M1311A2. Number of these Stage 2 pressure ulcers that were present at most recent SOC/ROC		
M1311B1. Number of Stage 3 pressure ulcers		
M1311B2. Number of these Stage 3 pressure ulcers that were present at most recent SOC/ROC		
M1311C1. Number of Stage 4 pressure ulcers		
M1311C2. Number of these Stage 4 pressure ulcers that were present at most recent SOC/ROC		
M1311D1. Number of unstageable pressure ulcers/ injuries due to non-removable dressing/device		
M1311D2. Number of these unstageable pressure ulcers/ injuries that were present at most recent SOC/ROC		
M1311E1. Number of unstageable pressure ulcers due to slough and/or eschar		
M1311E2. Number of these unstageable pressure ulcers that were present at most recent SOC/ROC		
M1311F1. Number of unstageable pressure injuries presenting as deep tissue injury		
M1311F2. Number of these unstageable pressure injuries that were present at most recent SOC/ROC		

Changes in Skin Integrity Post-Acute Care: Pressure Ulcer/Injury (M1311) continued

Coding Activity

M1311 Practice Coding Scenario 5

- A patient is admitted to home health with a Stage 2 pressure ulcer on the right lateral knee.
- The skin assessment on Day 6 of the quality episode identifies that this ulcer has evolved to a Stage 3 pressure ulcer, which remains at this stage at the time of discharge.

M1311. Current Number of Unhealed Pressure Ulcers/Injuries	SOC Assessment	Discharge Assessment
M1311A1. Number of Stage 2 pressure ulcers		
M1311A2. Number of these Stage 2 pressure ulcers that were present at most recent SOC/ROC		
M1311B1. Number of Stage 3 pressure ulcers		
M1311B2. Number of these Stage 3 pressure ulcers that were present at most recent SOC/ROC		
M1311C1. Number of Stage 4 pressure ulcers		
M1311C2. Number of these Stage 4 pressure ulcers that were present at most recent SOC/ROC		
M1311D1. Number of unstageable pressure ulcers/ injuries due to non-removable dressing/device		
M1311D2. Number of these unstageable pressure ulcers/ injuries that were present at most recent SOC/ROC		
M1311E1. Number of unstageable pressure ulcers due to slough and/or eschar		
M1311E2. Number of these unstageable pressure ulcers that were present at most recent SOC/ROC		
M1311F1. Number of unstageable pressure injuries presenting as deep tissue injury		
M1311F2. Number of these unstageable pressure injuries that were present at most recent SOC/ROC		

Changes in Skin Integrity Post-Acute Care: Pressure Ulcer/Injury (M1311) continued

Coding Activity

M1311 Practice Coding Scenario 6

- At SOC, the patient's skin assessment reveals two Stage 2 pressure ulcers on the right elbow.
- On Day 5, while conducting a skin assessment, both pressure ulcers were identified to be a Stage 3.
- On discharge, the patient's skin assessment reveals two healing Stage 3 pressure ulcers on the right elbow.

M1311. Current Number of Unhealed Pressure Ulcers/Injuries	SOC Assessment	Discharge Assessment
M1311A1. Number of Stage 2 pressure ulcers		
M1311A2. Number of these Stage 2 pressure ulcers that were present at most recent SOC/ROC		
M1311B1. Number of Stage 3 pressure ulcers		
M1311B2. Number of these Stage 3 pressure ulcers that were present at most recent SOC/ROC		
M1311C1. Number of Stage 4 pressure ulcers		
M1311C2. Number of these Stage 4 pressure ulcers that were present at most recent SOC/ROC		
M1311D1. Number of unstageable pressure ulcers/ injuries due to non-removable dressing/device		
M1311D2. Number of these unstageable pressure ulcers/ injuries that were present at most recent SOC/ROC		
M1311E1. Number of unstageable pressure ulcers due to slough and/or eschar		
M1311E2. Number of these unstageable pressure ulcers that were present at most recent SOC/ROC		
M1311F1. Number of unstageable pressure injuries presenting as deep tissue injury		
M1311F2. Number of these unstageable pressure injuries that were present at most recent SOC/ROC		

Changes in Skin Integrity Post-Acute Care: Pressure Ulcer/Injury (M1311) continued

Coding Activity

M1311 Practice Coding Scenario 7

- A patient is admitted to home health with a right ankle foot orthosis (AFO) to compensate for weakness and foot drop.
- On the first skin assessment, the clinician notes a Stage 2 pressure ulcer on the right upper ankle, that conforms to the shape of the AFO. The orthotist is consulted and the AFO is adjusted.
- At discharge, the ulcer is assessed as a Stage 2 and no other pressure ulcers/injuries are noted.

M1311. Current Number of Unhealed Pressure Ulcers/Injuries	SOC Assessment	Discharge Assessment
M1311A1. Number of Stage 2 pressure ulcers		
M1311A2. Number of these Stage 2 pressure ulcers that were present at most recent SOC/ROC		
M1311B1. Number of Stage 3 pressure ulcers		
M1311B2. Number of these Stage 3 pressure ulcers that were present at most recent SOC/ROC		
M1311C1. Number of Stage 4 pressure ulcers		
M1311C2. Number of these Stage 4 pressure ulcers that were present at most recent SOC/ROC		
M1311D1. Number of unstageable pressure ulcers/ injuries due to non-removable dressing/device		
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M1311E2. Number of these unstageable pressure ulcers that were present at most recent SOC/ROC		
M1311F1. Number of unstageable pressure injuries presenting as deep tissue injury		
M1311F2. Number of these unstageable pressure injuries that were present at most recent SOC/ROC		