

Home Health Quality Reporting Program

PRACTICE CODING SCENARIOS DAY 1



November 6 and 7, 2018
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.

Section J: Health Conditions continued

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:	↓ Enter Codes in Boxes	
0. None	<input type="checkbox"/>	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. One	<input type="checkbox"/>	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
2. Two or more	<input type="checkbox"/>	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:	↓ Enter Codes in Boxes	
0. None	<input type="checkbox"/>	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. One	<input type="checkbox"/>	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
2. Two or more	<input type="checkbox"/>	C. Major injury: Bone fractures , joint dislocations, closed head injuries with altered consciousness, subdural hematoma

Section J: Health Conditions continued

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:	↓ Enter Codes in Boxes
0. None	<input type="checkbox"/>
1. One	<input type="checkbox"/>
2. Two or more	<input type="checkbox"/>
	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. 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)

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. 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)

M1311 Practice Coding Scenario 3

- The Registered Nurse (RN) assesses Mr. J's skin at SOC and identifies a DTI with intact skin on his left heel.
- This DTI remains unchanged until the RN skin assessment 10 days later, which reveals open skin presenting as a Stage 3 pressure ulcer. The pressure ulcer does not change for the remainder of the episode.
- At the discharge skin assessment, the ulcer remains a Stage 3. There are no other pressure ulcers/injuries at the SOC assessment, during the quality episode or at 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)

M1311 Practice Coding Scenario 4

- 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.

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)

M1311 Practice Coding Scenario 5

- 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)

M1311 Practice Coding Scenario 6

- 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)

M1311 Practice Coding Scenario 7

- 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)

M1311 Practice Coding Scenario 8

- 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		
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		