SECTION J:
HEALTH CONDITIONS

Intent: These items are intended to code a history of falls and any falls since admission, including any injury caused by falls.

J1750: History of Falls

J1750. History of Falls	
Enter Code ☐	Has the patient had two or more falls in the past year or any fall with injury in the past year? 0. **No** 1. **Yes** 8. **Unknown**

Item Rationale

- Falls are a leading cause of morbidity and mortality.
- A previous fall, especially a recent fall, recurrent falls, and falls with significant injury are the most important predictors of risk for future falls and injurious falls.
- Persons with a history of falling may limit activities because of a fear of falling and should be evaluated for reversible causes of falling.

Steps for Assessment

1. Indicate if the patient has had two or more falls in the past year or any fall with injury in the past year.
2. Interview the patient if he or she is capable of reliably reporting his or her fall history. Also speak with family members or significant others to obtain the patient's fall history, as appropriate.

Coding Instructions

- Complete during the 3 day admission assessment period. Code 0, No, if the patient has not had two or more falls or any fall with injury in the past year.
- Code 1, Yes, if the patient has had two or more falls or any fall with injury in the past year.
- Code 8, Unknown, if it cannot be determined if the patient has had two or more falls or any fall with injury in the past year.

DEFINITION

FALL

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). The fall may be witnessed, reported by the patient or an observer, or identified when a patient is found on the floor or ground. Falls are 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 or had not been intercepted by another person—this is still considered a fall.

Example

1. Ms. T reports that she fell three months ago and then again one 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.

   Coding: J1750 would be coded 1, Yes.
   Rationale: Two falls were reported by the patient in the past year.

J1800: Any Falls Since Admission

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*

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.

Steps for Assessment

1. Review IRF medical record (physician, nursing, therapy, and nursing assistant notes), incident reports, and fall logs.

Coding Instructions

Complete at the time of discharge.

- Code 0, No, if the patient has not had any fall since the time of admission.
- Code 1, Yes, if the patient has fallen since the time of admission and continue to J1900, Number of Falls Since Admission.

Example

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.

   Coding: J1800 would be coded 1, Yes.
   Rationale: An intercepted fall is considered a fall.

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

Coding: J1800 would be coded 1, Yes.
Rationale: The patient stumbled and the therapist intervened to prevent a fall. An intercepted fall is considered a fall.

J1900: Number of Falls Since Admission

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

Steps for Assessment

1. Review IRF medical record (e.g., physician, nursing, therapy, and nursing assistant notes), incident reports, and fall logs.

Coding Instructions for J1900

Complete at the time of discharge.

Determine the number of falls that occurred since admission and 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.***

DEFINITION

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.

Coding Instructions for J1900A. No injury

- 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.

SECTION J:
HEALTH CONDITIONS

Coding Instructions for J1900B. Injury (except major)

- 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.

DEFINITIONS

INJURY (EXCEPT MAJOR)
Includes skin tears, abrasions, lacerations, superficial bruises, hematomas, and sprains; or any fall-related injury that causes the patient to complain of pain.

MAJOR INJURY
Includes bone fractures, joint dislocations, closed head injuries with altered consciousness, subdural hematoma.

Coding Instructions for J1900C, Major injury

- 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.

Coding Tips

- For item J1900 - Number of Falls Since Admission, include all falls that occur since the time of admission. This would include any falls that occur during a program interruption, including falls that occurred while at home, while out in the community, or in an acute hospital during a program interruption.

Examples

1. A nursing note states that Mrs. K slipped out of her wheelchair onto the floor during a transfer from the bed to the wheelchair. Before being assisted back into her bed, an assessment was completed that indicated no injury.

   Coding: J1900A. No Injury would be coded 1, One.

   Rationale: Slipping onto the floor is a fall. No injury was noted.

2. A nurse's note describes a patient who climbed over his bedrail and fell to the floor. On examination, he had a cut over his left eye and some swelling on his arm. He was sent to the emergency department where x-rays revealed no injury and neurological assessments revealed no changes in mental status. The patient returned to the IRF within 24 hours.

   Coding: J1900B. Injury (except major) would be coded 1, One.

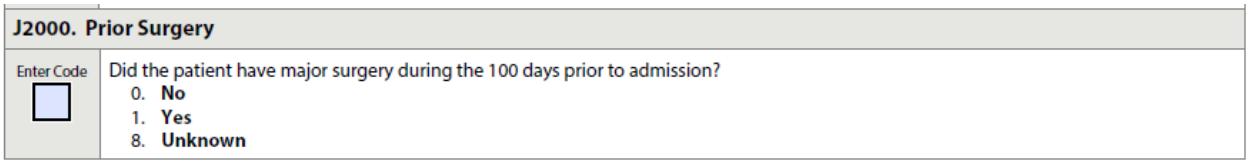
   Rationale: Lacerations and swelling without fracture are classified as injury (except major).

3. A patient fell, lacerated her head, and was sent to the emergency department where a head CT scan revealed a subdural hematoma. The patient received treatment and returned to the IRF after two days.

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

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

J2000: Prior Surgery



J2000. Prior Surgery	
Enter Code ☐	Did the patient have major surgery during the 100 days prior to admission? 0. **No** 1. **Yes** 8. **Unknown**

Item Rationale

- The intent of this item is to identify 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.

Steps for Assessment

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

Coding Instructions

- Complete during the 3 day admission assessment period. 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.

Coding Tips

- 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. A patient would be **required** to stay at least one overnight in an acute care hospital.

Example

1. Mrs. T reported that she required surgical removal of a skin tag from her neck a month and a half ago. She had the procedure in outpatient. Mrs. T reports that no other surgeries in the last 100 days.

   Coding: J2000 would be coded 0, No.

Rationale: Skin tag removal is not major surgery and the patient did not have any other surgeries in the last 100 days.

2. Mr. A's wife informed his nurse that six months ago he was admitted to the hospital for 5 days following a bowel resection (partial colectomy) for diverticulitis. Mr. A's wife reports Mr. A had no other surgeries since the time of his bowel resection.

   Coding: J2000 would be coded 0, No.

   Rationale: Bowel resection is a major surgery requiring general anesthesia and has some degree of risk for death or severe disability. Mr. A required 5 day hospitalization. However, the bowel resection did not occur in the last 100 days, it happened 6 months ago and the patient has not undergone any surgery since that time.