SECTION J: HEALTH CONDITIONS

J0510-J0530. Pain Interview

Intent: The intent of the items in this section is to assess the effect of pain on sleep, pain interference with therapy activities, and pain interference with day-to-day activities.

J0510. Pain Effect on Sleep	
Enter code	*Ask patient: "Over the past 5 days,* ***how much of the time has pain made it hard for you to sleep at night?"*** 0. **Does not apply - I have not had any pain or hurting in the past 5 days** → *Skip to K0200, Height and Weight* 1. **Rarely or not at all** 2. **Occasionally** 3. **Frequently** 4. **Almost constantly** 8. **Unable to answer**
J0520. Pain Interference with Therapy Activities	
Enter code	*Ask patient: Over the past 5 days,* ***how often have you limited your participation in rehabilitation therapy sessions due to pain?"*** 0. **Does not apply - I have not received rehabilitation therapy in the past 5 days** 1. **Rarely or not at all** 2. **Occasionally** 3. **Frequently** 4. **Almost constantly** 8. **Unable to answer**
J0530. Pain Interference with Day-to-Day Activities	
Enter code	*Ask patient: "Over the past 5 days,* ***how often have you limited your day-to-day activities (excluding rehabilitation therapy sessions) because of pain?"*** 1. **Rarely or not at all** 2. **Occasionally** 3. **Frequently** 4. **Almost constantly** 8. **Unable to answer**

Item Rationale

- The effects of unrelieved pain impact the individual in terms of function, complications of immobility, skin breakdown, and infections.
- Pain significantly adversely affects a person's quality of life and is tightly linked to depression, diminished self-confidence, and self-esteem, as well as an increase in behavior problems, particularly for cognitively impaired patients.
- People may limit their activities in order to avoid having pain. Their report of lower pain frequency may reflect their avoidance of activity more than it reflects adequate pain management.

DEFINITION

PAIN

Any type of physical pain or discomfort in any part of the body. It may be localized to one area or may be more generalized. It may be acute or chronic, continuous or intermittent, or occur at rest or with movement. Pain is very subjective; pain is whatever the experiencing person says it is and exists whenever they say it does.

- The assessment of pain is not associated with any particular approach to pain management. Since the use of opioids is associated with serious complications, an array

of successful non-pharmacologic and non-opioid approaches to pain management may be considered. There are a range of pain management strategies that can be utilized, including but not limited to non-narcotic analgesic drugs, transcutaneous electrical nerve stimulation (TENS) therapy, supportive devices, acupuncture, biofeedback, application of heat/cold, massage, physical therapy, nerve block, stretching and strengthening exercises, chiropractic, electric stimulation, radiotherapy, and ultrasound.

Steps for Assessment

1. Directly ask the patient each item in J0510, Pain Effect on Sleep through J0530, Pain Interference with Day-to-Day Activities in the order provided.
   - Use other terms for pain or follow-up discussion if the patient seems unsure or hesitant. Some patients avoid use of the term “pain” but may report that they “hurt.” Patients may use other terms such as “aching” or “burning” to describe pain.
2. If the patient chooses not to answer a particular item, accept their refusal, code 8, Unable to answer, and move on to the next item.
3. If the patient is unsure about whether the pain effect or interference occurred in the 5-day time interval, prompt the patient to think about the most recent episode of pain and try to determine whether it occurred within the look-back period.

J0510. Pain Effect on Sleep

J0510. Pain Effect on Sleep	
Enter code	*Ask patient: "Over the past 5 days,* ***how much of the time has pain made it hard for you to sleep at night?"*** 0. **Does not apply - I have not had any pain or hurting in the past 5 days** → *Skip to K0200, Height and Weight* 1. **Rarely or not at all** 2. **Occasionally** 3. **Frequently** 4. **Almost constantly** 8. **Unable to answer**

Steps for Assessment

1. Read the question and response choices as written.
2. No pre-determined definitions are offered to the patient. The response should be based on the patient's interpretation of frequency response options.
3. If the patient's response does not lead to a clear answer, repeat the patient's response and then try to narrow the focus of the response. For example, if the patient responded to the question, "Over the past 5 days, how much of the time has pain made it hard for you to sleep at night?" by saying, "I always have trouble sleeping," then the assessor might reply, "You always have trouble sleeping. Is it your pain that makes it hard for you to sleep?" The assessor can then narrow down responses with additional follow-up questions about the frequency.

Coding Instructions

Complete only if A0250 = 01 Admission or A0250 = 10 Planned Discharge.
Complete based on assessments that occur within the 3-day admission assessment time period or the 3-day discharge assessment time period.

- **Code 0, Does not apply,** if the patient responds that they did not have any pain or hurting in the past 5 days.
- **Code 1, Rarely or not at all,** if the patient responds that pain has been present and the pain rarely or not at all made it hard to sleep in the past 5 days.
- **Code 2, Occasionally,** if the patient responds that pain has occasionally made it hard to sleep in the past 5 days.
- **Code 3, Frequently,** if the patient responds that pain has frequently made it hard to sleep in the past 5 days.
- **Code 4, Almost constantly,** if the patient responds that pain has almost constantly made it hard to sleep in the past 5 days.
- **Code 8, Unable to answer,** if the patient is unable to answer the question, does not respond, or gives a nonsensical response.

Coding Tips

- This item should be coded based on the patient's interpretation of the provided response options for frequency. If the patient is unable to decide between two options, then the assessor should code for the option with the higher frequency.
- The key difference between code 0, Does not apply and code 1, Rarely or not at all is that for code 0, the patient reports no pain/hurting in the past 5 days, and for code 1, the patient reports pain/hurting HAS been present in the past 5 days, but has rarely or not at all impacted sleep.
- If the patient reports they had pain in the past 5 days and the pain does not interfere with the patient's sleep (e.g., because the patient is using pain management strategies successfully), code 1, Rarely or not at all.

Examples

1. Assessor: "Over the past 5 days, how much of the time has pain made it hard for you to sleep at night?"

   Patient: "I've had a little back pain from being in the wheelchair all day, but it's felt so much better when I go to bed. The pain hasn't kept me from sleeping at all."

   Coding: J0510, Pain Effect on Sleep would be **coded 1, Rarely or not at all.**

   Rationale: The patient reports pain has been present, but no sleep problems related to pain.

2. Assessor: "Over the past 5 days, how much of the time has pain made it hard for you to sleep at night?"

   Patient: "All the time. It's been hard for me to sleep all the time. I have to ask for extra pain medicine, and I still wake up several times during the night because my back hurts so much."

   Coding: J0510, Pain Effect on Sleep would be **coded 4, Almost constantly.**

   Rationale: The patient reports pain-related sleep problems "all the time," so the most applicable response is "Almost constantly."

J0520. Pain Interference with Therapy Activities

J0520. Pain Interference with Therapy Activities	
Enter code	*Ask patient: "Over the past 5 days,* ***how often have you limited your participation in rehabilitation therapy sessions due to pain?"*** 0. **Does not apply - I have not received rehabilitation therapy in the past 5 days** 1. **Rarely or not at all** 2. **Occasionally** 3. **Frequently** 4. **Almost constantly** 8. **Unable to answer**

Steps for Assessment

1. Read the question and response choices as written.
2. Confirm that the patient has been offered rehabilitation therapies during the reference timeframe.

Coding Instructions

Complete only if A0250 = 01 Admission or A0250 = 10 Planned Discharge.
Complete based on assessments that occur within the 3-day admission assessment time period or the 3-day discharge assessment time period.

- **Code 0, Does not apply,** if the patient responds that they did not participate in rehabilitation therapy for reasons unrelated to pain (e.g., therapy not needed, unable to schedule) in the past 5 days.
- **Code 1, Rarely or not at all,** if the patient responds that pain has rarely or not at all limited participation in rehabilitation therapy sessions in the past 5 days.
- **Code 2, Occasionally,** if the patient responds that pain has occasionally limited participation in rehabilitation therapy sessions in the past 5 days.
- **Code 3, Frequently,** if the patient responds that pain has frequently limited participation in rehabilitation therapy sessions in the past 5 days.
- **Code 4, Almost constantly,** if the patient responds that pain has almost constantly limited participation in rehabilitation therapy sessions in the past 5 days.
- **Code 8, Unable to answer,** if the patient is unable to answer the question, does not respond, or gives a nonsensical response.

DEFINITION

REHABILITATION THERAPY
Includes, but is not limited to, special healthcare services or programs that help a person regain physical, mental, and/or cognitive (thinking and learning) abilities that have been lost or impaired as a result of disease, injury or treatment. Can include, for example, any services provided by physical therapy (PT), occupational therapy (OT), speech-language pathology (SLP) therapy, and cardiac and pulmonary therapies.

Coding Tips

- This item should be coded based on the patient's interpretation of the provided response options for frequency. If the patient is unable to decide between two options, then the assessor should code for the option with the higher frequency.
- Rehabilitation therapies may include treatment supervised in person by a therapist or nurse or other staff, or the patient/family/caregivers carrying out a prescribed therapy program without agency staff present, regardless of the rehabilitation focus or goal(s).

Example

1. Assessor: "Over the past 5 days, how often have you limited your participation in rehabilitation therapy sessions due to pain?"

   Patient: "Since the surgery a week ago, the pain has made it hard to even get out of bed. I try to push myself, but the pain frequently limits how much I can do with my therapist."

   Coding: J0520, Pain Interference with Therapy Activities would be **coded 3, Frequently.**

   Rationale: The patient reports that pain frequently limits participation in therapies.

J0530. Pain Interference with Day-to-Day Activities

J0530. Pain Interference with Day-to-Day Activities	
Enter Code	*Ask patient: "Over the past 5 days,* ***how often have you limited your day-to-day activities (excluding rehabilitation therapy sessions) because of pain?"*** 1. **Rarely or not at all** 2. **Occasionally** 3. **Frequently** 4. **Almost constantly** 8. **Unable to answer**

Steps for Assessment

1. Read the question and response choices as written.

Coding Instructions

Complete only if A0250 = 01 Admission or A0250 = 10 Planned Discharge.
Complete based on assessments that occur within the 3-day admission assessment time period or the 3-day discharge assessment time period.

- **Code 1, Rarely or not at all,** if the patient responds that pain has rarely or not at all limited day-to-day activities (excluding rehabilitation therapy sessions) in the past 5 days.
- **Code 2, Occasionally,** if the patient responds that pain has occasionally limited day-to-day activities (excluding rehabilitation therapy sessions) in the past 5 days.
- **Code 3, Frequently,** if the patient responds that pain has frequently limited day-to-day activities (excluding rehabilitation therapy sessions) in the past 5 days.
- **Code 4, Almost constantly,** if the patient responds that pain has almost constantly limited day-to-day activities (excluding rehabilitation therapy sessions) in the past 5 days.
- **Code 8, Unable to answer,** if the patient is unable to answer the question, does not respond, or gives a nonsensical response.

Coding Tips

- This item should be coded based on the patient's interpretation of the provided response options for frequency. If the patient is unable to decide between two options, then the assessor should code for the option with the higher frequency.

Examples

1. Assessor: "Over the past 5 days, how often have you limited your day-to-day activities (excluding rehabilitation therapy sessions) because of pain?"

   Patient: "Although I have some pain in my back, I'm still able to read, eat my meals, and take walks like I usually do."

   Coding: J0530, Pain Interference with Day-to-Day Activities would be **coded 1, Rarely or not at all.**

Rationale: The patient reports that pain has not limited participation in day-to-day activities.

2. Assessor: "Over the past 5 days, how often have you limited your day-to-day activities (excluding rehabilitation therapy sessions) because of pain?"

   Patient: "The pain has made it hard to do pretty much anything. Even getting out of bed to brush my teeth has been hard. I haven't been able to talk to my family because the pain is so bad. It's just constant. I'd say it constantly limits what I do."

   Coding: J0530, Pain Interference with Day-to-Day Activities would be **coded 4, Almost constantly.**

   Rationale: The patient reports that pain has constantly limited participation in other activities.

J1800. Any Falls Since Admission

Intent: These falls items (J1800 and J1900) are intended to code any falls since admission, including any injury caused by falls.

J1800. Any Falls Since Admission	
Enter Code	Has the patient **had any falls since admission?** 0. **No** → *Skip to K0520, Nutritional Approaches* 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 LTCH medical record (physician, nursing, therapy, and nursing assistant notes), incident reports, and fall logs.

Coding Instructions

Complete only if A0250 = 10 Planned Discharge, A0250 = 11 Unplanned Discharge, or A0250 = 12 Expired. Complete at the time of discharge.

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

Coding Tips

- Include all falls that occurred since the time of admission. This would include any falls that occurred outside of the LTCH facility during a program interruption.

Examples

1. An incident report describes an event in which the patient was walking down the hall and appeared to slip on a wet spot on the floor. The patient lost their balance and bumped into the wall, but was able to grab onto the handrail and steady themself.

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

   Rationale: An intercepted fall is considered a fall. An intercepted fall occurs when the patient would have fallen if they had not caught themself or had not been intercepted by another person.

2. A patient is participating in balance training during a therapy session. The therapist is intentionally challenging the patient's balance, anticipating a loss of balance. The patient has

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 is considered a fall. An intercepted fall occurs when the patient would have fallen if they had not caught themself or had not been intercepted by another person. However, an anticipated loss of balance resulting from a supervised therapeutic intervention where the patient's balance is being intentionally challenged during balance training is not considered an intercepted fall.
  - An exception would be if a major injury results from a fall or intercepted fall that occurs when a clinician is intentionally challenging a patient's balance during balance training, it would be reported as both a fall and a major injury in J1800 - Any Falls Since Admission and J1900 – Number of Falls Since Admission.

a loss of balance to the left due to hemiplegia and the physical therapist provides steadying/contact guard assistance to allow the patient to maintain standing.

Coding: J1800, Any Falls Since Admission would be **coded 0, No.**

Rationale: The patient's balance was intentionally being challenged, so a loss of balance is anticipated by the physical therapist. ~~When assistance is provided to a patient to allow them to maintain standing during an anticipated loss of balance, this is not considered a fall or "intercepted fall."~~ When the patient experiences an anticipated loss of balance resulting from a supervised therapeutic intervention where the patient's balance is being intentionally challenged during balance training, unless there was a fall or "intercepted" fall that resulted in a major injury, it would not be coded as a fall in J1800.

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

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

Rationale: The patient unexpectedly stumbled, which was not anticipated by the therapist, and the therapist intervened to prevent a fall. An intercepted fall is considered a fall if it is not an anticipated loss of balance resulting from a supervised therapeutic intervention where the patient's balance is being intentionally challenged during balance training.

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

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

Coding Instructions

Complete only if A0250 = 10 Planned Discharge, A0250 = 11 Unplanned Discharge, or A0250 = 12 Expired.
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.

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.

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, include all falls that occurred since the time of admission. This would include any falls that occurred outside of the LTCH facility during a program interruption.
- Fractures confirmed to be pathologic (vs traumatic) are not to be considered a major injury resulting from a fall
- Facilities are encouraged to utilize accurate and/or new information regarding fall-related injuries as information becomes known. For example, injuries can present themselves later than the time of the fall. The facility may not learn of the level of injury until after the LCDS assessment is completed or the patient has left the facility (e.g., because the patient was transported to an emergency room and admitted to an inpatient facility post-fall). Errors should be corrected following the facility's correction policy and in accordance with guidance from Chapter 4: Submission and Correction of the LTCH Care Data Set (LCDS) Assessment Records in this manual.

DEFINITIONS

~~**NO INJURY**~~

~~No evidence of any injury noted on assessment; no complaints of pain or injury by the patient; no change in the patient's behavior is noted after the fall.~~

INJURY (EXCEPT MAJOR)

Includes, but is not limited to, 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, but is not limited to, traumatic bone fractures, joint dislocations/subluxations, ~~closed head injuries~~ internal organ injuries, amputations, traumatic spinal cord injuries, head injuries, and crush injuries. ~~with altered consciousness, and subdural hematoma.~~

Examples

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

   Coding: J1900A, No injury, would be **coded 1, One,** if no other falls without injury occurred.

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

2. A nurse's note describes a patient who climbed over their bedrail and fell to the floor. On examination, the patient had a cut over their left eye and some swelling on their arm. The patient was sent to the emergency room, where x-rays revealed no injury and neurological checks revealed no changes in mental status. The patient returned to the LTCH 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 their head, and was sent to the emergency room, where a head computerized tomography (CT) scan revealed a subdural hematoma. The patient received treatment and returned to the LTCH after 2 days.

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

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

4. The therapist had a patient, who has Parkinson's disease, stand on one foot during their therapy session to intentionally challenge the patient's balance. Despite safety precautions, including contact guard assistance and safety mats, the patient fell while standing on one foot and landed on their left side. Due to pain and swelling in their left wrist, the physician ordered a left wrist x-ray for the patient. The x-ray confirmed a distal radius fracture (non-displaced) of the left wrist.

   Coding: J1800 would be **coded 1, Yes** and J1900C would be **coded 1, One**.

   Rationale: Despite safety precautions in place the patient sustained a radius fracture, a major injury, during a therapeutic intervention with physical therapy where their balance was being intentionally challenged. This is being considered a fall as there was a major injury even though the fall and major injury occurred when the patient's balance was being intentionally challenged.

Differentiating from Traumatic vs Pathological Fractures

5. A patient with osteoporosis falls, resulting in a right hip fracture. The physician confirms that the fracture is a result of the patient's bone disease and not a result of the fall.

   Coding: J1800 would be **coded 1, Yes** and J1900C would be **coded 0, None**.

   Rationale: The physician determined that the fracture was a pathological fracture and was a result of osteoporosis. Because it is not considered a traumatic fracture it would not be considered a major injury.

6. A patient with osteoporosis falls, resulting in a right hip fracture. The physician confirms that the fracture is a result of the patient's fall and not due to the patient's history of osteoporosis.

   Coding: J1800 would be **coded 1, Yes** and J1900C would be **coded 1, One**.

   Rationale: Because the physician determined that the fracture was a result of the fall it would be considered a traumatic fracture and therefore would be considered a major injury.