

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 <input type="text"/>	<p>Ask patient: "Over the past 5 days, how much of the time has pain made it hard for you to sleep at night?"</p> <p>0. Does not apply - I have not had any pain or hurting in the past 5 days → Skip to J1750, History of Falls</p> <p>1. Rarely or not at all</p> <p>2. Occasionally</p> <p>3. Frequently</p> <p>4. Almost constantly</p> <p>8. Unable to answer</p>
J0520. Pain Interference with Therapy Activities	
Enter Code <input type="text"/>	<p>Ask patient: Over the past 5 days, how often have you limited your participation in rehabilitation therapy sessions due to pain?"</p> <p>0. Does not apply - I have not received rehabilitation therapy in the past 5 days</p> <p>1. Rarely or not at all</p> <p>2. Occasionally</p> <p>3. Frequently</p> <p>4. Almost constantly</p> <p>8. Unable to answer</p>
J0530. Pain Interference with Day-to-Day Activities	
Enter Code <input type="text"/>	<p>Ask patient: "Over the past 5 days, how often have you limited your day-to-day activities (excluding rehabilitation therapy sessions) because of pain?"</p> <p>1. Rarely or not at all</p> <p>2. Occasionally</p> <p>3. Frequently</p> <p>4. Almost constantly</p> <p>8. Unable to answer</p>

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.
- 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-

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.

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 <input type="text"/>	<p>Ask patient: "Over the past 5 days, how much of the time has pain made it hard for you to sleep at night?"</p> <p>0. Does not apply - I have not had any pain or hurting in the past 5 days → Skip to J1750, History of Falls</p> <p>1. Rarely or not at all</p> <p>2. Occasionally</p> <p>3. Frequently</p> <p>4. Almost constantly</p> <p>8. Unable to answer</p>

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 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?"
<input type="text"/>	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 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 (<u>excluding</u> rehabilitation therapy sessions) because of pain?"
<input type="text"/>	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 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.

J1750. History of Falls

Intent: These falls items (J1750, J1800, J1900) are intended to code a history of falls and any falls since admission, including any injury caused by 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?
<input type="text"/>	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 potential risk factors.

Steps for Assessment

- Indicate if the patient has had two or more falls in the past year or any fall with injury in the past year.
- Interview the patient and/or 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 is considered a fall. An intercepted fall occurs when the patient would have fallen if they had not caught themselves 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 a fall.

Example

1. The patient reports that they fell 3 months ago and then again 1 month ago while walking outside. The patient stated they only bruised their arm during the first fall and their knee during the second fall. The patient reported they did not seek medical advice and were able to recover without apparent injury.

Coding: J1750, History of Falls 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 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

- 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 falls 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 IRF during a program interruption.

Examples

- 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 themselves.

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 themselves or had not been intercepted by another person.

- 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 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.”

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
	<input type="text"/>	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
	<input type="text"/>	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
	<input type="text"/>	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

- 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.

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

- Include all falls that occurred since the time of admission. This would include any falls that occurred outside of the IRF during a program interruption.
- 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 IRF-PAI 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. Additional information can be found in Chapter 5 of 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 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, and subdural hematoma.

Examples

1. A nursing note states 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 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 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 IRF 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.

J2000. Prior Surgery

J2000. Prior Surgery	
Enter Code	Did the patient have major surgery during the 100 days prior to admission ?
<input type="text"/>	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 the IRF 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 to the IRF.

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

Coding Tips

- Generally, major surgery for item J2000, Prior Surgery refers to a procedure that meets the following criteria:
 - The patient was an inpatient in an acute care hospital for at least one day in the 100 days prior to admission to the IRF; AND
 - The surgery carried some degree of risk to the patient's life or the potential for severe disability.

Examples

- The patient reports that they required surgical removal of a skin tag from their neck a month and a half ago. They had the procedure as an outpatient. The patient reports no other surgeries in the last 100 days.

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

Rationale: The patient's skin tag removal surgery did not require an acute care inpatient stay; therefore, the skin tag removal does not meet the required criteria to be coded as major surgery and the patient did not have any other surgeries in the last 100 days.

2. The patient's significant other informs the patient's nurse that 6 months ago the patient was admitted to the hospital for 5 days following a bowel resection (partial colectomy) for diverticulitis. The patient's significant other reports the patient has had no other surgeries since the time of the bowel resection.

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

Rationale: Bowel resection is a major surgery that has some degree of risk for death or severe disability and the patient required a 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.