



Long-Term Care Hospital Quality Reporting Program Provider Training



Focused Review of Sections B, C, H, J, and O (Influenza)

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Acronyms in This Presentation

- Confusion Assessment Method (CAM[©])
- Influenza Vaccination Season (IVS)
- Long-Term Care Hospital (LTCH)
- LTCH Continuity Assessment Record and Evaluation Data Set (LTCH CARE Data Set)

Overview

- Identify and explain the intent of each section:
 - Section B: Hearing, Speech, and Vision.
 - Section C: Cognitive Patterns.
 - Section H: Bladder and Bowel.
 - Section J: Health Conditions (Falls).
 - Section O: Special Treatments, Procedures and Programs (Influenza Vaccine).
- Discuss coding instructions and required information.
- Review practice coding scenarios.

Objectives

- Demonstrate a working knowledge of Sections B, C, H, J (Falls), and O (Influenza Vaccine).
- State the intent of Sections B, C, H, J (Falls), and O (Influenza Vaccine).
- Apply coding instructions to accurately code practice scenarios.

Section B: Hearing, Speech, and Vision

Section B: Objectives

- Describe the intent of Section B. Hearing, Speech, and Vision.
- Explain the revised definition of item BB0800.
- Apply coding instructions to accurately code practice scenarios.

Section B: Intent

- The intent of Section B items is to document the patient's ability to understand and communicate with others.
 - B0100. Comatose.
 - BB0700. Expression of Ideas and Wants.
 - BB0800. Understanding Verbal and Non-Verbal Content.
- Document the patient's ability to understand and communicate with others in his/her primary language, whether in speech, writing, sign language, gestures, or a combination.

Section B: Clarifications

- Between Long-Term Care Hospital (LTCH) Continuity Assessment Record and Evaluation (CARE) Data Set v3.00 and v4.00, no changes were made to items:
 - B0100. Comatose.
 - BB0700. Expression of Ideas and Wants.
- A clarification to item *BB0800. Understanding Verbal **and Non-Verbal** Content* reflects the intent to include the patient's understanding of verbal and non-verbal content.

B0100. Comatose

B0100. Comatose

Enter Code

Persistent vegetative state/no discernible consciousness

0. No → Continue to B0700, Expression of Ideas and Wants
1. Yes → Skip to GG0100, Prior Functioning: Everyday Activities

Applies to the Admission and Planned Discharge Assessments.

- Patients who are in a coma or persistent vegetative state are at risk for the complications of immobility.

B0100. Comatose Coding Tips

- **Only code 1, Yes**, if a diagnosis of coma or persistent vegetative state is documented in the patient's medical record.
- **Use code 0, No**, if a diagnosis of coma or persistent vegetative state **is not** present at the time of admission or discharge. This may include patients with progressive neurological disorders and/or are unresponsive, non-communicative, or often sleep during the daytime.

B0100 Coding Scenario

- Mrs. M was admitted to the LTCH and is non-communicative and often sleeps. Mrs. M's medical record includes the diagnosis of Alzheimer's disease.
- Mrs. M's medical record does not include a diagnosis of coma or persistent vegetative state.

BB0700. Expression of Ideas and Wants

- BB0700: Expression of Ideas and Wants

BB0700. Expression of Ideas and Wants (3-day assessment period)

Enter Code

Expression of ideas and wants (consider both verbal and non-verbal expression and excluding language barriers)

4. Expresses complex messages **without difficulty** and with speech that is clear and easy to understand
3. Exhibits some **difficulty** with expressing needs and ideas (e.g., some words or finishing thoughts) or speech is not clear
2. **Frequently** exhibits difficulty with expressing needs and ideas
1. **Rarely/Never** expresses self or speech is very difficult to understand

Applies to the Admission and Planned Discharge Assessment

BB0700 Coding Scenario

- Mr. B had a stroke several weeks ago and has a diagnosis of expressive aphasia. The certified nursing assistant asks Mr. B if he needs help with bathing. He looks at the certified nursing assistant and smiles, but does not respond verbally.
- The certified nursing assistant reports to the nurse that she has not been able to determine Mr. B's preferences and needs with any of his activities of daily living since he was admitted the day before. The nurse interacts with Mr. B and determines he rarely expresses himself.
- The nurse plans to collaborate with the speech language pathologist, other care team members, and Mr. B to increase Mr. B's ability to express himself.

BB0800. Understanding Verbal and Non-Verbal Content

- BB0800. Understanding Verbal and **Non-Verbal Content**

BB0800. Understanding Verbal and **Non-Verbal Content** (3-day assessment period)

Enter Code

Understanding Verbal and **Non-Verbal Content** (with hearing aid or device, if used, and excluding language barriers)

4. **Understands:** Clear comprehension without cues or repetitions
3. **Usually Understands:** Understands most conversations, but misses some part/intent of message. Requires cues at times to understand
2. **Sometimes Understands:** Understands only basic conversations or simple, direct phrases. Frequently requires cues to understand
1. **Rarely/Never Understands**

Applies to the Admission and Planned Discharge Assessments.

BB0800. Understanding Verbal and Non-Verbal Content (cont.)

- Inability to understand direct person-to-person communication:
 - Can severely limit association with other people.
 - Can inhibit the individual's ability to follow instructions that can affect health and safety.

BB0800 Coding Scenario 1

- Mr. T sustained an acquired brain injury and is on an invasive mechanical ventilator. Mr. T uses a electronic communication device to respond to staff and family questions.
- Staff members report that he only understands basic conversations. The staff needs to simplify all communication for him to understand what is being asked.
- The family reports that simple and short messages are necessary during their conversation to elicit accurate responses.

BB0800 Coding Scenario 2

- Mrs. K is recovering from the surgical removal of a cancerous brain tumor and has severe hearing loss and some cognitive limitations. The staff, patient, and family use an electronic device to communicate with her.
- Staff members and family report Mrs. K has on a few occasions required visual cues to understand what is typed onto her electronic device in order for her to respond accurately to questions. Mrs. K can understand most conversations with the use of the electronic device.

Section B: Summary

- The intent of Section B has not changed.
- A clarification to item BB0800.
Understanding Verbal and Non-Verbal Content reflects the intent to include the patient's understanding of verbal and non-verbal content.

Section C: Cognitive Patterns

Section C: Objectives

- Define Section C: Cognitive Patterns.
- Explain the intent/rationale of Section C.
- Discuss coding instructions and required information for items.
- Apply coding instructions to accurately code practice scenarios.

Section C: Intent

The intent of the items in this section is to determine if the patient has **signs and symptoms of delirium** using the Confusion Assessment Method (CAM[©]).

Adapted with permission from: Inouye SK et al, Clarifying confusion: The Confusion Assessment Method. A new method for detection of delirium. Annals of Internal Medicine. 1990; 113: 941-948. Confusion Assessment Method: Training Manual and Coding Guide, Copyright 2003, Hospital Elder Life Program, LLC. Not to be reproduced without permission.

C1610. Signs and Symptoms of Delirium (From CAM[©])

C1610. Signs and Symptoms of Delirium (from CAM[©])

Confusion Assessment Method (CAM[©]) Shortened Version Worksheet (3-day assessment period)

CODING: 0. No 1. Yes	↓ Enter Code in Boxes	
	<input type="checkbox"/>	Acute Onset and Fluctuating Course A. Is there evidence of an acute change in mental status from the patient's baseline?
	<input type="checkbox"/>	B. Did the (abnormal) behavior fluctuate during the day, that is, tend to come and go or increase and decrease in severity?
	<input type="checkbox"/>	Inattention C. Did the patient have difficulty focusing attention, for example, being easily distractible or having difficulty keeping track of what was being said?
	<input type="checkbox"/>	Disorganized Thinking D. Was the patient's thinking disorganized or incoherent, such as rambling or irrelevant conversation, unclear or illogical flow of ideas, or unpredictable switching from subject to subject?
	<input type="checkbox"/>	Altered Level of Consciousness E. Overall, how would you rate the patient's level of consciousness? E1. Alert (Normal)
<input type="checkbox"/>	E2. Vigilant (hyperalert) or Lethargic (drowsy, easily aroused) or Stupor (difficult to arouse) or Coma (unarousable)	

Applies to Admission, Planned Discharge, and Unplanned Discharge Assessments.

Section C: Rationale

- **Delirium can be misdiagnosed as dementia.**
 - However, patients with dementia can experience delirium.
- A recent deterioration in cognitive function may indicate delirium, which may be reversible if detected and treated in a timely fashion.
- Delirium may be a symptom of an acute, treatable illness, such as infection or reaction to medications.
- Prompt detection of delirium is essential to identify and treat or eliminate the cause.

Section C: Definitions

- **Delirium:** A mental disturbance characterized by new or acutely worsening confusion, disordered expression of thoughts, change in level of consciousness, or hallucinations.
- **Fluctuation:** The behavior tends to come and go and/or increase or decrease in severity. The behavior may fluctuate over the course of an interview/discussion or the assessment period. Fluctuating behavior may be noted by staff or family or documented in the medical record.

Section C: Definitions (cont.)

- **Inattention:** Reduced ability to maintain attention to external stimuli and to appropriately shift attention to new external stimuli. Patient seems unaware or out of touch with the environment (e.g., dazed, fixated, or darting attention).
- **Disorganized Thinking:** Evidenced by rambling, irrelevant, and/or incoherent speech.

C1610A and C1610B. Acute Onset and Fluctuating Course Steps for Assessment

- Assess for acute change in mental status.
- Evidence of acute change:
 - Patient interactions.
 - Medical record.
 - Reports from family/significant other.
 - Staff reports.

C1610A Coding Instructions



Acute Onset and Fluctuating Course

A. Is there evidence of an acute change in mental status from the patient's baseline?

Applies to Admission, Planned Discharge, and Unplanned Discharge Assessments.

- **Code 0, No**, if there is no evidence of an acute change in mental status from the patient's baseline.
- **Code 1, Yes**, if there is evidence of an acute change in mental status from the patient's baseline.

C1610B Coding Instructions



Acute Onset and Fluctuating Course

B. Did the (abnormal) behavior fluctuate during the day, that is, tend to come and go or increase and decrease in severity?

Applies to Admission, Planned Discharge, and Unplanned Discharge Assessments.

- **Code 0, No**, if the (abnormal) behavior did not fluctuate during the day (i.e., did not tend to come or go or increase/decrease in severity).
- **Code 1, Yes**, if the (abnormal) behavior fluctuated during the day (i.e., tended to come and go and/or increase/decrease in severity).

C1610C. Inattention

Steps for Assessment

- Assess **attention** separately from **level of consciousness**.
- Evidence of inattention:
 - Patient/clinician interactions.
 - Medical record.
 - Reports from family/significant other.
 - Staff reports.
- An additional step to identify difficulty with attention is to ask the patient to count backward from 20.

C1610C. Inattention Coding Instructions



Inattention

C. Did the patient have difficulty focusing attention, for example, being easily distractible or having difficulty keeping track of what was being said?

Applies to Admission, Planned Discharge, and Unplanned Discharge Assessments.

- **Code 0, No**, if the patient remains focused, and was not easily distracted or having difficulty keeping track of what was said.
- **Code 1, Yes**, if the patient had difficulty focusing attention (e.g., being easily distractible or having difficulty keeping track of what was said).

C1610D. Disorganized Thinking

Steps for Assessment

- Assess for disorganized thinking.
- Evidence of disorganized thinking:
 - Patient interview.
 - Medical record.
 - Reports from family/significant other.
 - Staff reports.

C1610D. Disorganized Thinking

Coding Instructions



Disorganized Thinking

D. Was the patient's thinking disorganized or incoherent, such as rambling or irrelevant conversation, unclear or illogical flow of ideas, or unpredictable switching from subject to subject?

Applies to Admission, Planned Discharge, and Unplanned Discharge Assessments.

- **Code 0, No**, if the patient's thinking was organized and coherent, even if the answers were inaccurate or wrong.
- **Code 1, Yes**, if the patient's thinking was disorganized or incoherent, such as rambling or irrelevant conversation, unclear or illogical flow of ideas, or unpredictable switching from subject to subject.

C1610E1 and C1610E2.

Altered Level of Consciousness

Steps for Assessment

- Assess for altered level of consciousness during the assessment period.
- Evidence of altered level of consciousness:
 - Patient/clinician interactions.
 - Medical record.
 - Reports from family/significant other.
 - Staff reports.

C1610E1 Coding Instructions

<input type="checkbox"/>	<p>Altered Level of Consciousness</p> <p>E. Overall, how would you rate the patient's level of consciousness?</p> <p>E1. Alert (Normal)</p>
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Applies to Admission, Planned Discharge, and Unplanned Discharge Assessments.

- **Code 0, No**, if the patient was not alert.
- **Code 1, Yes**, if the patient was alert.

C1610E2 Coding Instructions

<input type="checkbox"/>	Altered Level of Consciousness
	E. Overall, how would you rate the patient's level of consciousness? E2. Vigilant (hyperalert) or Lethargic (drowsy, easily aroused) or Stupor (difficult to arouse) or Coma (unarousable)

Applies to Admission, Planned Discharge, and Unplanned Discharge Assessments.

- **Code 0, No, if the patient did not exhibit any of the following:**
 - Vigilant (hyperalert): Patient startles easily to any sound or touch; his or her eyes are wide open.
 - Lethargy (drowsy, easily aroused): Patient repeatedly dozes off while you are asking questions, and it may be difficult to keep patient awake for interview, but he or she does respond to voice or touch.
 - Stupor (difficult to arouse): Patient is very difficult to arouse and keep aroused for the interview, requiring shaking and/or repeated shouting.
 - Coma (unarousable): Patient cannot be aroused despite shaking and shouting.
- **Code 1, Yes, if the patient exhibited any of the following:** vigilant (hyperalert), lethargy (drowsy, easily aroused), stupor (difficult to arouse), or coma (unarousable).

C1610D Coding Scenario

- Mrs. B was admitted to the LTCH with a tracheostomy in place and is receiving invasive mechanical ventilation. There are no plans for active weaning due to a current respiratory infection.
- Mrs. B is alert and oriented. Mrs. B's thinking is organized and coherent. She communicates effectively using a letter board and by writing notes.

Section C: Summary

- Section C has not changed.
- The purpose of Section C is to determine if the patient has signs and symptoms of delirium.
- Delirium is sometimes unrecognized and undocumented by clinicians. Early recognition and treatment can improve outcomes.

Section H: Bladder and Bowel

Section H : Objectives

- Define Section H: Bladder and Bowel.
- Explain the intent/rationale of Section H.
- Discuss coding instructions and required information for items.
- Apply coding instructions to accurately code a practice scenario.

Section H: Intent and Rationale

Intent: To gather information on bladder and bowel continence.

Rationale: Bladder and bowel incontinence can:

- Increase risk for longer lengths of stay.
- Lead to skin rashes, breakdown, and development and/or worsening of pressure ulcers/injuries.
- Increase risk for falls and injuries resulting from attempts to reach a toilet unassisted.
- Potentially be resolved or minimized by identifying and treating underlying potentially reversible conditions.
- Be socially embarrassing and lead to increased feelings of dependency and social isolation.

Section H: Definitions

- **Continence:** The ability to voluntarily release urine or stool in a commode, toilet, or bedpan.
- **Incontinence:** The involuntary passage of urine or stool.

H0350. Bladder Contenance

H0350. Bladder Contenance (3-day assessment period.)

Enter Code

Bladder continence - Select the one category that best describes the patient.

0. **Always continent** (no documented incontinence)
1. **Stress incontinence only**
2. **Incontinent less than daily** (e.g., once or twice during the 3-day assessment period)
3. **Incontinent daily** (at least once a day)
4. **Always incontinent**
5. **No urine output** (e.g., renal failure)
9. **Not applicable** (e.g., indwelling catheter)

Applies to Admission and Planned Discharge Assessments.

H0350. Bladder Continence Steps For Assessment

- Review the medical record:
 - Bladder incontinence records or flow sheets.
 - Nursing assessments and progress notes.
 - Physician history and physical examination.
- Interview the patient or family.
- Ask direct care staff.

H0350 Coding Instructions

Code according to the amount and number of episodes of incontinence that occur during the assessment period.

- **Code 0, Always continent**, if throughout the 3-day assessment period the patient was continent of urine, without any episodes of incontinence.
- **Code 1, Stress incontinence only**, if during the 3-day assessment period the patient had episodes of incontinence only associated with physical movement or activity such as coughing, sneezing, laughing, lifting heavy objects, or exercise.
- **Code 2, Incontinent less than daily**, if during the 3-day assessment period the patient was incontinent of urine once or twice.
- **Code 3, Incontinent daily**, if during the 3-day assessment period the patient was incontinent of urine at least once a day.

H0350 Coding Instructions (cont.)

Code according to the amount and number of episodes of incontinence that occur during the assessment period.

- **Code 4, Always incontinent**, if during the 3-day assessment period the patient had no continent voids.
- **Code 5, No urine output**, if during the 3-day assessment period the patient had no urine output (e.g., renal failure, on chronic dialysis with no urine output) for the entire 3 days.
- **Code 9, Not applicable**, if during the 3-day assessment period the patient had an indwelling bladder catheter, condom catheter, or ostomy for the entire 3 days.

H0350 Stress Incontinence

Stress incontinence has its own code (Code 1).

- Episodes of a small amount of urine leakage only associated with physical movement or activity such as:
 - Coughing.
 - Sneezing.
 - Laughing.
 - Lifting heavy objects.
 - Exercise.

H0350 Coding Tips

- Incontinence is the same as leakage.
- Review all documentation and discuss with staff to determine the frequency.
- If intermittent catheterization is used to drain the bladder, code the incontinence level based on continence between catheterizations.

H0400. Bowel Continence

H0400. Bowel Continence (3-day assessment period)

Enter Code

Bowel continence - Select the one category that best describes the patient.

0. **Always continent**
1. **Occasionally Incontinent** (one episode of bowel incontinence)
2. **Frequently Incontinent** (2 or more episodes of bowel incontinence, but at least one continent bowel movement)
3. **Always Incontinent** (no episodes of continent bowel movements)
9. **Not rated**, patient had an ostomy or did not have a bowel movement for the entire 3 days

Applies to Admission Assessment only.

H0400. Bowel Continence Steps for Assessment

- Review the medical record:
 - Bowel incontinence flow sheets.
 - Nursing assessments and progress notes.
 - Physician history and physical examination.
- Interview the patient or family.
- Ask direct care staff.

H0400 Coding Instructions

Code according to the number of episodes of bowel incontinence that occur during the assessment period.

- **Code 0, Always continent**, if during the 3-day assessment period the patient was continent for all bowel movements, without any episodes of incontinence.
- **Code 1, Occasionally incontinent**, if during the 3-day assessment period the patient was incontinent for bowel movement. This includes incontinence of any amount of stool at any time.
- **Code 2, Frequently incontinent**, if during the 3-day assessment period the patient was incontinent for bowel movements at least twice, but also had at least one continent bowel movement. This includes incontinence of any amount of stool at any time.

H0400 Coding Instructions (cont.)

Code according to the number of episodes of bowel incontinence that occur during the assessment period.

- **Code 3, Always incontinent**, if during the 3-day assessment period the patient was incontinent for all bowel movements (i.e., had no continent bowel movements).
- **Code 9, Not rated**, if during the 3-day assessment period the patient had an ostomy or other device, or the patient did not have a bowel movement during the entire 3 days. Note that patients who have not had a bowel movement for 3 days should be evaluated for constipation.

H0400 Coding Tips

- Being continent has to do with the ability to voluntarily release stool in a commode, toilet, or bedpan, or as a result of a planned bowel movement as part of a bowel program.
- If the patient *cannot* voluntarily control the passage of stool, which results in involuntary passage of stool, then he or she is considered incontinent.
- Patients who require assistance to maintain the passage of stool via artificial initiation (e.g., manual stimulation, rectal suppositories, enemas) would be considered *continent* of bowel as long as the result of releasing the stool was in a commode, toilet, or bedpan.
- Bowel incontinence precipitated by loose stools or diarrhea from any cause (including laxatives) would count as incontinence.

H0350 Coding Scenario

- Mrs. B has a history of stress incontinence. During the 3-day assessment period, she experienced a large amount of urine leakage daily.

Section H: Summary

- Section H has not changed.
- Section H gathers information on urinary and bowel incontinence.
- If intermittent catheterization is used, code the incontinence level based on continence between catheterizations.
- Interview the patient, family, or significant others regarding the patient's incontinence and ask direct care staff who routinely work with the patient.

Section J: Health Conditions (Falls)

Section J: Objectives

- Define Section J: Health Conditions (Falls).
- Explain the intent/rationale of Section J.
- Discuss coding instructions and required information for items.
- Apply coding instructions to accurately code a practice scenario.

Section J: Intent

- The intent of items J1800 and J1900 is to code falls since admission, including any injury caused by falls.
- Only falls with “major injury” (J1900C) are used in the calculation of the quality measure: Application of Percent of Residents Experiencing One of More Falls with Major Injury (Long Stay) (NQF #0674).

J1800 Item Rationale

- Falls are a leading cause of morbidity and mortality among LTCH patients.
- Fear of falling can limit an individual's activity and negatively impact quality of life.

Section J: Definitions

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.
- May be witnessed, reported by the patient or an observer, or identified when a patient is found on the floor or ground.
- Not a result of an overwhelming external force.
 - E.g., a patient pushes another patient.

Section J: Definitions (cont. 1)

- 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.
- **An intercepted fall is considered a fall.**

Section J: Definitions (cont. 2)

- The Centers for Medicare & Medicaid Services understands that challenging a patient's balance and training him/her to recover from a loss of balance is an intentional therapeutic intervention and does not consider anticipated losses of balance that occur during supervised therapeutic interventions as intercepted falls.

Section J: Definitions (cont. 3)

- **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.
- **Major injury :** Includes bone fractures, joint dislocations, closed head injuries with altered consciousness, and subdural hematoma.
- **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.

J1800 and J1900 Steps for Assessment

- Review the LTCH medical record:
 - Physician, nursing, therapy, and nursing assistant notes.
 - Incident reports.
 - Fall logs.

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 Ulcers/Injuries*
1. **Yes** → *Continue to J1900, Number of Falls Since Admission*

- *Applies to Planned Discharge Assessment, Unplanned Discharge Assessment and Expired Assessment.*

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="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
	<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
	<input type="checkbox"/> C. Major injury: Bone fractures, joint dislocations, closed head injuries with altered consciousness, subdural hematoma

Applies to Planned Discharge Assessment, Unplanned Discharge Assessment and Expired Assessment.

- Determine the number of falls that occurred since admission.
- 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.

J1900A Coding Instructions

J1900. Number of Falls Since Admission	
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

- **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.

J1900B Coding Instructions

J1900. Number of Falls Since Admission	
CODING: 0. None 1. One 2. Two or more	↓ Enter Codes in Boxes
	<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
	<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
	<input type="checkbox"/> C. Major injury: Bone fractures, joint dislocations, closed head injuries with altered consciousness, subdural hematoma

- **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.

J1900C Coding Instructions

J1900. Number of Falls Since Admission	
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

- **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.

J1800 Coding Scenario

- Ms. K is transferred from the LTCH to the acute care hospital for a radiology exam.
- During the course of the exam, Ms. K sustains a fall and fractures her right arm. She is treated at the acute care hospital, requiring an overnight stay, and returns to the LTCH the following day.

J1800 and J1900 Coding Scenario

- A patient reports to his nurse that while transferring to the bathroom, he fell backward and hit his back on the toilet.
- An x-ray reveals a spinal fracture.

Section J: Summary

- Section J has not changed.
- Section J captures any falls and injuries from falls since admission.
- Applies to the following assessments:
 - Planned Discharge.
 - Unplanned Discharge.
 - Expired.

Section O: Special Treatments, Procedures, and Programs (Influenza Vaccination)

Section O: Objectives

- Identify the time period (beginning and end) of the influenza season and the influenza vaccination season (IVS).
- Distinguish the relationship between influenza season/IVS and the LTCH CARE Data Set.
- Apply coding instructions to accurately code the influenza vaccine data elements.

00250 Item Rationale

- When infected with influenza, older adults and persons with underlying health problems are at increased risk for complications and are more likely than the general population to require hospitalization.
- An institutional Influenza A outbreak can result in up to 60 percent of the population becoming ill, with 25 percent of those affected developing complications severe enough to result in hospitalization or death.
- Influenza-associated mortality results not only from pneumonia, but also from subsequent events arising from cardiovascular, cerebrovascular, and other chronic or immunocompromising diseases that can be exacerbated by influenza.

Influenza Vaccination Season

- Influenza season:
 - Begins July 1 of the current year and ends June 30 of the following year.
 - E.g., 2017-2018 Influenza season begins July 1, 2017 and ends June 30, 2018.
- Influenza vaccination season (IVS):
 - Begins October 1 of the current year, or when the influenza vaccine becomes available (whichever comes first), and ends March 31 of the following year.
 - E.g., 2017-2018 IVS begins October 1, 2017 and ends March 31, 2018.

Influenza Vaccination Season (cont.)

- LTCHs should document year-round, including when a patient has been vaccinated outside the IVS.
- If the influenza vaccination was administered to a patient for the current influenza season at the time of or prior to admission, then that information should be reflected on the patient's discharge assessment.
- For the quality measure, only the records of patients in the LTCH 1 or more days during the IVS (at least 1 day between October 1 and March 31) are included in the calculation.

O0250. Influenza Vaccine

O0250. Influenza Vaccine - Refer to current version of LTCH Quality Reporting Program Manual for current influenza season and reporting period.

Enter Code

A. Did the patient receive the influenza vaccine in this facility for this year's influenza vaccination season?

0. No → Skip to O0250C, If influenza vaccine not received, state reason

1. Yes → Continue to O0250B, Date influenza vaccine received

B. Date influenza vaccine received → Complete date and skip to Z0400, Signature of Persons Completing the Assessment

 - -

Month

Day

Year

Enter Code

C. If influenza vaccine not received, state reason:

1. Patient not in this facility during this year's influenza vaccination season
2. Received outside of this facility
3. Not eligible - medical contraindication
4. Offered and declined
5. Not offered
6. Inability to obtain influenza vaccine due to a declared shortage
9. None of the above

Applies to the Admission, Planned Discharge, Unplanned Discharge, and Expired Assessments.

00250. Influenza Vaccine (cont.)

Documents three aspects of the administration of the vaccine:

- **00250A:** Whether a vaccine for the current influenza season was administered in the facility.
- **00250B:** Date the patient received the vaccine if administered in the facility.
- **00250C:** Reason the patient did not receive the vaccine.

O0250A Coding Instructions

- **Code 0, No**, if the patient did not receive the influenza vaccine in this facility (LTCH) during this year's IVS.
 - Proceed to O0250C. If influenza vaccine was not received, state reason.
- **Code 1, Yes**, if the patient received the influenza vaccine in this facility (LTCH) during this year's IVS.
 - Continue to O0250B. Date Vaccine Received.

00250B Coding Instructions

- Enter the date that the vaccine was received by the patient in your LTCH. Do not leave any boxes blank.
- If the month contains only a single digit, fill in the first box of the month with a “0.” If the day contains only a single digit, then fill the first box of the day with the “0.”
 - For example, October 6, 2017, should be entered as 10-06-2017. January 7, 2018, should be entered as 01-07-2018.
- A full eight-character date is required. If the date is unknown or the information is not available, a single dash (-) needs to be entered in the first box.

00250C Coding Instructions

- **Code 1, Patient not in facility during this year's influenza vaccination season**, if the patient was not in the facility during this year's IVS.
- **Code 2, Received outside of this facility**, if the patient received an influenza vaccination in another setting (e.g., physician office, health fair, grocery store/pharmacy, hospital, fire station) during this year's IVS.
- **Code 3, Not eligible – medical contraindication**, if the influenza vaccination was not received because of medical contraindications or precautions, including, but not limited to, severe allergic reaction to eggs or other vaccine component(s), previous adverse reaction to influenza vaccine, a physician order not to immunize, moderate to severe illness with or without fever, and/or history of Guillain-Barré Syndrome within 6 weeks of previous influenza vaccination. However, the patient should be vaccinated if contraindications or precautions end.

00250C Coding Instructions (cont.)

- **Code 4, Offered and declined**, if the patient or responsible party or legal guardian has been informed of what is being offered and chooses not to accept the influenza vaccine.
- **Code 5, Not offered**, if the patient or responsible party or legal guardian was not offered the influenza vaccine.
- **Code 6, Inability to obtain vaccine due to a declared shortage**, if the influenza vaccine was unavailable at the facility due to a declared vaccine shortage. However, the patient should be vaccinated once the facility receives the vaccine. The annual supply of inactivated influenza vaccine and the timing of its distribution cannot be guaranteed in any year.
- **Code 9, None of the above**, if none of the listed reasons describe why the influenza vaccine was not administered. This code is also used if the answer is unknown.

O0250 Coding Scenario 1

- Mrs. J received the influenza vaccine in the LTCH during this year's influenza vaccination season, on October 2, 2017.
- **How would you code O0250?**
- **What is your rationale?**

O0250 Coding Scenario 2

- Mrs. T received the influenza vaccine at her doctor's office during this year's IVS.
- Her doctor provided documentation of Mrs. T's receipt of the vaccine to the LTCH to place in Mrs. T's medical record. He also provided documentation that Mrs. T was explained the benefits and risks for the vaccine prior to administration.
- **How would you code O0250?**
- **What is your rationale?**

O0250 Coding Scenario 3

- Mr. N was offered the influenza vaccine during his LTCH hospitalization beginning in February 2017. Mr. N refused the influenza vaccine, asserting it always gave him the flu when he received it in the past.
- **How would you code O0250?**
- **What is your rationale?**

Section O: Summary

- When infected with influenza, older adults and persons with underlying health problems are at increased risk for complications and are more likely than the general population to require hospitalization.
 - The Centers for Disease Control and Prevention recommends annual influenza vaccinations.

Summary of Focused Review Sections

- Sections C, H, J (Falls), and O (Influenza Vaccine) have not changed.
- Clarification was added to Section B to include non-verbal communication.

Focused Review Sections: Action Plan

- Review the intent, rationale, and steps for assessment for all sections.
- Review the language clarification made in Section B and its implication.
- Review key dates related to IVS.
- Practice coding a variety of scenarios with staff.