Codify
BY AAPC

MDS Alert

Coding Quizzer: Try Your Hand at Coding These MDS Falls Examples

Put your skills to the test with these RAI patient scenarios.

Steps for Assessment

The period of review is 180 days (6 months) prior to admission, looking back from the resident's entry date (A1600).

1. Ask the resident and family or significant other about a history of falls in the month prior to admission and in the 6 months prior to admission. This would include any fall, no matter where it occurred (see the Definitions box for the RAI definition of a fall).

2. Review inter-facility transfer information (if the resident is being admitted from another facility) for evidence of falls.

3. Review all relevant medical records received from facilities where the resident resided during the previous 6 months; also review any other medical records received for evidence of one or more falls.

RAI Coding Instructions for J1700A

Did the Resident Have a Fall Any Time in the Last Month Prior to Admission/Entry or Reentry?

- Code 0, no: if resident and family report no falls and transfer records and medical records do not document a fall in the month preceding the resident's entry date item (A1600).
- Code 1, yes: if resident or family report or transfer records or medical records document a fall in the month preceding the resident's entry date item (A1600).
- Code 9, unable to determine: if the resident is unable to provide the information or if the resident and family are not available or do not have the information and medical record information is inadequate to determine whether a fall occurred.

RAI Coding Instructions for J1700B

Did the Resident Have a Fall Any Time in the Last 2-6 Months Prior to Admission/Entry or Reentry?

- Code 0, no: if resident and family report no falls and transfer records and medical records do not document a fall in the 2-6 months prior to the resident's entry date item (A1600).
- Code 1, yes: if resident or family report or transfer records or medical records document a fall in the 2-6 months prior to the resident's entry date item (A1600).
- Code 9, unable to determine: if the resident is unable to provide the information, or if the resident and family are not available or do not have the information, and medical record information is inadequate to determine whether a fall occurred.

RAI Coding Instructions for J1700C

Did the Resident Have Any Fracture Related to a Fall in the 6 months prior to Admission/Entry or Rentry?

- Code 0, no: if resident and family report no fractures related to falls and transfer records and medical records do not document a fracture related to fall in the 6 months (0-180 days) preceding the resident's entry date item (A1600).
- Code 1, yes: if resident or family report or transfer records or medical records document a fracture related to fall in the 6 months (0-189 days) preceding the resident entry date item (A1600).

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- Code 9, unable to determine: if the resident is unable to provide the information, or if the resident and family are not available or do not have the information, and medical record information is inadequate to determine whether a fall occurred.

RAIS**cenario** N**o. 1:** On admission interview, Mrs. J. is asked about falls and says she has "not really fallen." However, she goes on to say that when she went shopping with her daughter about 2 weeks ago, her walker got tangled with the shopping cart and she slipped down to the floor.

RAIScenario No. 2: On admission interview a resident denies a history of falling. However, her daughter says that she found her mother on the floor near her toilet twice about 3-4 months ago.

RAIScenario No. 3: On admission interview, Mr. M. and his family deny any history of falling. However, nursing notes in the transferring hospital record document that Mr. M. repeatedly tried to get out of bed unassisted at night to go to the bathroom and was found on a mat placed at his bedside to prevent injury the week prior to nursing home transfer.››

RAIScenario No. 4: Medical records note that Miss K. had hip surgery 5 months prior to admission to the nursing home. Miss K.'s daughter says the surgery was needed to fix a broken hip due to a fall.

RAIScenario No. 5: Mr. O.'s hospital transfer record includes a history of osteoporosis and vertebral compression fractures. The record does not mention falls, and Mr. O. denies any history of falling.

RAIScenario No. 6: Ms. P. has a history of a "Colles' fracture" of her left writs about 3 weeks before nursing home admission. Her son recalls that the fracture occurred when Ms. P. tripped on a rug and fell forward on her outstretched hands.

- Code 0, no: if the resident has not had any fall since the last assessment. Skip to Swallowing Disorder item K0100.
- Code 1, yes: if the resident has fallen since the last assessment. Continue to item J1900.

RAIScenario No. 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.

1. If this is the first assessment (A0310E=1), review the medical record for the time period from the admission date to the ARD.

2. If this is not the first assessment (A0310E=0), the review period is from the day after the ARD of the last MDS assessment to the ARD of the current assessment.

3. Review all available sources for any fall since the last assessment, no matter whether it occurred while out in the community, in an acute hospital, or in the nursing home. Include medical records generated in any healthcare setting since last assessment. All relevant records received from acute and post-acute facilities where the resident was admitted during the look-back period should be reviewed for evidence of one or more falls.

4. Review nursing home incident reports and medical record (physician, nursing, therapy, and nursing assistant notes) for falls and level of injury.

5. Ask the resident, staff, and family about falls during the look-back period. Resident and family reports of falls should be captured here, whether or not these incidents are documented in the medical record.

Coding Instructions for J1900A, No Injury

- Code 0, none: if the resident had no injurious fall since the admission/entry or reentry or prior assessment (OBRA or Scheduled PPS).
- Code 1, one: if the resident had one non-injurious fall since admission/entry or reentry or prior assessment (OBRA or Scheduled PPS).

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- Code 2, two or more: if the resident had two or more non-injurious falls since admission/entry or reentry or prior assessment (OBRA or Scheduled PPS).

Coding Instructions for J1900B, Injury (Except Major)

- Code 0, none: if the resident had no injurious fall (except major) since admission/entry or reentry or prior assessment (OBRA or Scheduled PPS).
- Code 1, one: if the resident had one injurious fall (except major) since admission/entry or reentry or prior assessment (OBRA or Scheduled PPS).
- Code 2, two or more: if the resident had two or more injurious falls (except major) since admission/entry or reentry or prior assessment (OBRA or Scheduled PPS).

Coding Instructions for J1900C, Major Injury

- Code 0, none: if the resident had no major injurious fall since admission/entry or reentry or prior assessment (OBRA or Scheduled PPS).
- Code 1, one: if the resident had one major injurious fall since admission/entry or reentry or prior assessment (OBRA or Scheduled PPS).
- Code 2, two or more: if the resident had two or more major injurious falls since admission/entry or reentry or prior assessment (OBRA or Scheduled PPS).

RAIS**cenario** N**o. 1:** A nursing note states that Mrs. K. slipped out of her wheelchair onto the floor while at the dining room table. Before being assisted back into her chair, an assessment was completed that indicated no injury.

RAIScenario No. 2: Nurse's notes describe a situation in which Ms. Z. went out with her family for dinner. When they returned, her son stated that while at the restaurant, she fell in the bathroom. No injury was noted when she returned from dinner.

RAIScenario No. 3: A nurse's note describes a resident who, while being treated for pneumonia, climbed over his bedrails and fell to the floor. He had a cut over his left eye and some swelling on his arm. He was sent to the emergency room where X-rays revealed no injury and neurological checks revealed no changes in mental status.

RAIScenario No. 4: A resident fell, lacerated his head, and head CT scan indicated a subdural hematoma.

Source: The Long-Term Care Facility Resident Assessment Instruments User's Manual MDS 3.0, V1.08 (April 2012), pgs. J26-J33).

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