MDS Alert

Falls: Dig Deeper: Improve Your J1900 Coding To Avoid Quality Reporting Snafus

Beware that all resulting injuries may not occur within the look-back period.

Between the new quality measure involving falls with major injury and the apparent scrutiny of such incidences in the MDS-focused surveys, your coding of falls on the MDS has become more important than ever. Tighten up your falls coding now to prevent potential penalties in the future.

You code falls on the MDS 3.0 in Item J1900 – Number of Falls Since Admission/Entry or Reentry or Prior Assessment (OBRA or Scheduled PPS), whichever is more recent. And Item J1900 has three coding categories (0 – None; 1 – One; or 2 – Two or more) that apply to three sub-items:

- J1900A – 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 resident; no change in the resident's behavior is noted after the fall
- J1900B – Injury (except major) – skin tears, abrasions, lacerations, superficial bruises, hematomas and sprains; or any fall-related injury that causes the resident to complain of pain
- J1900C – Major injury – bone fractures, joint dislocations, closed head injuries with altered consciousness, subdural hematoma

Take 4 Steps to Accurately Code Falls

There's no question why falls are on surveyors' radar when it comes to quality of care issues – according to the RAI Manual, falls are a leading cause of morbidity and mortality among nursing home residents, and they can easily result in serious injury, particularly hip fractures. To keep your quality reporting as accurate as possible, you must follow these steps to properly code for falls:

1. Review the medical record for the time period from the admission date to the Assessment Reference Date (ARD), if this is the first assessment (A0310E = 1). 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.

2. 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. Look at medical records generated in any healthcare setting since the last assessment. Review all relevant records received from acute and post-acute facilities where the resident was admitted during the look-back period for evidence of one or more falls.

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

4. Ask the resident, staff and family about falls occurring during the look-back period. You should capture any resident- or family-reported falls in Item J1900, regardless of whether these incidents are documented in the medical record.

Follow These Coding Basics

Important: When coding Item J1900, make sure that you code each fall only once. Also, if the resident suffered multiple injuries from a single fall, you must code the fall for the highest level of injury.

For J1900A: code 0 if the resident had no injurious fall since the admission/entry or reentry or prior assessment (OBRA or Scheduled PPS); code 1 if the resident had one non-injurious fall; or code 2 if the resident had two or more non-injurious falls.

For J1900B: code 0 if the resident had no injurious fall (except major) since admission/entry or reentry or prior assessment (OBRA or Scheduled PPS); code 1 if the resident had one injurious fall (except major); or code 2 if the resident had two or more injurious falls (except major).

For 1900C: code 0 if the resident had no major injurious fall since admission/entry or reentry or prior assessment (OBRA or Scheduled PPS); code 1 if the resident had one major injurious fall; or code 2 if the resident had two or more major injurious falls.

Look Beyond the Look-Back Period

Watch out: The RAI Manual makes clear that the fall must happen in the look-back period, but the workup to determine the injury may occur after the look-back and outside the facility in the hospital, according to an Aug. 5 tutorial by Washington, D.C.-based **Leading Age**. Specifically, you can see this in coding example #3 on page J-33:

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.

For this scenario, the RAI Manual instructs you to code J1900B as 1, because lacerations and swelling without fracture are classified as injury (except major).