SECTION J: HEALTH CONDITIONS

J1800: Any Falls Since SOC/ROC, whichever is more recent

J1800.	**Any Falls Since SOC/ROC,** whichever is more recent
Enter Code ☐	Has the patient **had any falls since SOC/ROC,** whichever is more recent**?** 0. **No** → Skip J1900 1. **Yes** → Continue to J1900, Number of Falls Since SOC/ROC, whichever is more recent

Item Intent

This item identifies if the patient had any witnessed or unwitnessed falls since the most recent SOC/ROC.

Time Points Item(s) Completed

Transfer to an inpatient facility

Death at home

Discharge from agency – not to an inpatient facility

Response-Specific Instructions

Review home health clinical record, incident reports and any other relevant clinical documentation (for example, fall logs)

Interview patient and/or caregiver about occurrence of falls

Coding Instructions

- **Code 0, No**, if the patient has not had any fall since the most recent SOC/ROC.
- **Code 1, Yes**, if the patient has fallen since the most recent SOC/ROC.
- **A dash** is a valid response for this item. CMS expects dash use to be a rare occurrence.

DEFINITION

FALL

- Unintentional change in position coming to rest on the ground, floor, or onto the next lower surface (such as a bed or chair). The fall may be witnessed or unwitnessed, 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 (such as, a person pushes a patient).
- 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—this is still considered a fall.
- CMS 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.

Examples

1. Unwitnessed Fall

The discharging RN reviews the clinical record and interviews the patient and caregiver, Mrs. K and her daughter Susan, determining that a single fall occurred since the most recent SOC/ROC. The fall is documented on a clinical note from an RN home visit in which Susan reported her mother slipped from her wheelchair to the floor the previous day.

Coding: J1800, Any Falls since SOC/ROC, would be coded 1, Yes.

Rationale: This item addresses unwitnessed as well as witnessed falls.

2. Intercepted Fall

An incident report describes an event in which Mr. S appeared to slip on a wet spot on the floor during a home health aide bath visit. He lost his balance and bumped into the wall, but was able to steady himself and remain standing.

Coding: J1800, Any Falls since SOC/ROC, would be coded 1, Yes.

Rationale: An intercepted fall is considered a fall.

3. Balance Training – Challenge Balance

A patient is participating in balance retraining activities during a therapy visit. The therapist is intentionally challenging 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 minimal assistance to allow the patient to maintain standing.

Coding: J1800, Any Falls since SOC/ROC, would be coded 0, No.

Rationale: The patient's balance was intentionally being challenged by the physical therapist, so a loss of balance is anticipated. When assistance is provided to a patient to allow him/her to maintain standing during an anticipated loss of balance during a supervised therapeutic intervention, this is not considered a fall or intercepted fall.

4. Unanticipated Fall During Therapy

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

Coding: J1800, Any Falls since SOC/ROC would be coded 1, Yes.

Rationale: The patient's stumble was not anticipated by the therapist. The therapist intervened to prevent a fall. An intercepted fall is considered a fall.

Data Sources/Resources

Patient report

Caregiver report

Patient record

Incident reports

Relevant clinical documentation, such as fall logs

J1900: Number of Falls Since SOC/ROC, whichever is more recent

J1900.	Number of Falls Since SOC/ROC, whichever is more recent	
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 Intent

This item identifies the number of falls a patient had since the most recent SOC/ROC, and fall-related injury.

Time Points Item(s) Completed

Transfer to an inpatient facility

Death at home

Discharge from agency – not to an inpatient facility

Response-Specific Instructions

Review the home health clinical record, incident reports and any other relevant clinical documentation, such as fall logs.

Interview the patient and/or caregiver about occurrence of falls.

Determine the number of falls that occurred since the most recent SOC/ROC, and, code the level of fall-related injury for each.

Code falls no matter where the fall occurred.

Code each fall only once.

If the patient has multiple injuries in a single fall, code the fall for the highest level of injury.

DEFINITIONS

INJURY RELATED TO A FALL
Any documented or reported 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.

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, subdural hematoma.

Coding Instructions for J1900A, No Injury

- **Code 0, None**, if the patient had no injurious falls since the most recent SOC/ROC.
- **Code 1, One**, if the patient had one non-injurious fall since the most recent SOC/ROC.
- **Code 2**, **Two or more**, if the patient had two or more non-injurious falls since the most recent SOC/ROC.
- **A dash** is a valid response for this item. CMS expects dash use to be a rare occurrence.

Coding Instructions for J1900B, Injury, Except Major

- **Code 0, None**, if the patient had no falls with injury, except major, since the most recent SOC/ROC.
- **Code 1, One**, if the patient had one fall with injury, except major, since the most recent SOC/ROC.
- **Code 2, Two or more**, if the patient had two or more falls with injury, except major, since the most recent SOC/ROC.
- **A dash** is a valid response for this item. CMS expects dash use to be a rare occurrence.

Coding Instructions for J1900C, Major Injury

- **Code 0, None**, if the patient had no falls with major injury since the most recent SOC/ROC.
- **Code 1, One**, if the patient had one fall with major injury since the most recent SOC/ROC.
- **Code 2, Two or more**, if the patient had two or more falls with major injury since the most recent SOC/ROC.
- **A dash** is a valid response for this item. CMS expects dash use to be a rare occurrence.

Examples

1. One Fall Since Most Recent SOC/ROC, with No Injury

The discharging RN reviews the clinical record and interviews Mrs. K and her daughter Susan, the patient and caregiver, determining that a single fall occurred since the most recent SOC/ROC. The fall is documented on a clinical note from an RN home visit in which Susan reported that her mother slipped from her wheelchair to the floor the previous day. Susan contacted the EMTs for help returning Mrs. K to her wheelchair; the EMT assessment at that time identified no injury. Documentation of the RN assessment during the home visit details no injury identified related to the fall.

Coding:

J1900A, No injury would be coded 1, one non-injurious fall since the most recent SOC/ROC.

J1900B, Injury (except major), would be coded 0, no falls with injury, except major, since the most recent SOC/ROC.

J1900C, Major injury would be coded 0, no falls with major injury since the most recent SOC/ROC.

Rationale: Only one fall is identified since the most recent SOC/ROC, and the patient sustained no injury in the fall.

2. One Fall Since Most Recent SOC/ROC with Injury (not major)

Review of the clinical record and incident reports, and, patient and caregiver report, identify that a single fall occurred since the most recent SOC/ROC. The fall is documented on a clinical note from an RN home visit that describes the patient Mr. R's report of a fall that occurred between visits, in which he tripped on the dog, fell against the wall and banged his elbow, sustaining a skin tear that he treated himself. Documentation of the RN assessment during the home visit details the healing skin tear, and no other injury or symptom identified related to the fall.

Coding:

J1900A. No injury, would be coded 0, no non-injurious falls since the most recent SOC/ROC.

J1900B. Injury (except major), would be coded 1, one injurious (except major) fall since the most recent SOC/ROC.

J1900C. Major injury, would be coded 0, no falls with major injury since the most recent SOC/ROC.

Rationale: Documentation of only one fall since the most recent SOC/ROC is identified. A laceration is considered an injury (except major).

3. One Fall Since the Most Recent SOC/ROC, with Major Injury

Review of the patient record and incident reports, and, patient and caregiver report identify that a single fall occurred since the most recent SOC/ROC. The fall is documented on an incident report that describes a telephone call received from the patient, Mrs. B's, daughter Mary, in which Mary reported Mrs. B fell at home and hit her head, and was transported via ambulance to the emergency room. Examination and testing revealed a subdural hematoma. Mrs. B was held in observation stay and received treatment, returning home in stable condition after 48 hours.

Coding:

J1900A, No injury, would be coded 0, no non-injurious falls since the most recent SOC/ROC.

J1900B, Injury (except major), would be coded 0, no falls with injury (except major) since the most recent SOC/ROC.

J1900C, Major injury, would be coded 1, one fall with major injury since the most recent SOC/ROC.

Rationale: Documentation of only one fall since the most recent SOC/ROC is identified. Subdural hematoma is considered a major injury.

4. Two Falls Since the Most Recent SOC/ROC, One with Injury (except major), One with No Injury

Review of the patient record, incident reports and patient and caregiver report identify that two falls occurred since the most recent SOC/ROC. The falls are documented on clinical notes. The first describes an event during which Mr. G tripped on the bathroom rug and almost fell, but caught himself against the sink. The RN assessment identified no injury. The second describes an event during which Mr. G, while coming up the basement stairs with the laundry, fell against the stair and sustained a bruise and laceration on his left knee.

Coding:

J1900A, No injury, would be coded 1, one non-injurious fall since the most recent SOC/ROC.

J1900B, Injury (except major), would be coded 1, one injurious (except major) fall since the most recent SOC/ROC.

J1900C, Major injury, would be coded 0, no falls with major injury since the most recent SOC/ROC.

Rationale: The first fall is an intercepted fall, which is considered a fall. The patient sustained no injury as a result of this fall. The second fall resulted in a laceration and bruising, considered injury, but not major injury.

5. One Fall Since the Most Recent SOC/ROC, with Multiple Injuries

Review of the patient record, incident reports and patient and caregiver report identify that a single fall occurred since the most recent SOC/ROC. The fall is documented on an incident report, which describes an event during which Mrs. J fell while walking from her bedroom to the bathroom and was transported to the emergency room via ambulance. Examination and testing revealed a skin tear on Mrs. J's left hand, bruising on both knees, and a fractured left hip.

Coding:

J1900A, No injury, would be coded 0, no non-injurious falls since the most recent SOC/ROC.

J1900B, Injury (except major), would be coded 0, no injurious (except major) falls since the most recent SOC/ROC.

J1900C, Major injury, would be coded 1, one fall with major injury since the most recent SOC/ROC.

Rationale: Documentation of only one fall since the most recent SOC/ROC was identified. The patient sustained multiple injuries in the fall. When multiple injuries are sustained in a single fall, code the injury of highest severity.

Data Sources/Resources

Patient report

Caregiver report

Patient record

Incident reports

Relevant clinical documentation, such as fall logs