

Track Changes
from Chapter 3 Section J v1.17.1
to Chapter 3 Section J v1.18.11

Chapter	Section	Page(s) in version 1.18.11	Change
3	—	—	Updated language throughout to be gender neutral.
3	—	—	Updated screen captures of all items.
3	—	J-1	<p>Intent: The intent of the items in this section is to document a number of health conditions that impact the resident’s functional status and quality of life. The items include an assessment of pain which uses an interview with the resident or staff if the resident is unable to participate. The pain items assess the management of pain, the presence of pain, pain frequency, effect on function, intensity, management of pain on sleep, and control pain interference with therapy and day-to-day activities. Other items in the section assess dyspnea, tobacco use, prognosis, problem conditions, falls, prior surgery, and surgery requiring active SNF care.</p>
3	J0100	J-1	J0100: Pain Management (5-Day Look Back)
3	J0100	J-2	<p>Steps for Assessment</p> <ol style="list-style-type: none"> Review medical record to determine if a pain regimen exists. Review the medical record and interview staff and direct caregivers to determine what, if any, pain management interventions the resident received any time during the last 5- days look-back period. Include information from all disciplines.
3	J0100	J-2	<p>Coding Instructions for J0100A-C</p> <p><i>Determine all interventions for pain provided to the resident during any time in the last 5- days look-back period. Answer these items even if the resident currently denies pain.</i></p>
3	J0100	J-3	<p>Coding Tips</p> <ul style="list-style-type: none"> Code only pain medication regimens without PRN pain medications in J0100A. Code receipt of PRN pain medications in J0100B. For coding J0100B code only residents with PRN pain medication regimens here. If the resident has a scheduled pain medication J0100A should be coded.

Track Changes
from Chapter 3 Section J v1.17.1
to Chapter 3 Section J v1.18.11

Chapter	Section	Page(s) in version 1.18.11	Change
3	J0100	J-3	<p>Examples</p> <ol style="list-style-type: none"> The resident's medical record documents that shethey received the following pain management in the plast 5 days: <ul style="list-style-type: none"> Hydrocodone/acetaminophen 5/500 1 tab PO every 6 hours. Discontinued on day 1 of the look-back period. Acetaminophen 500mg PO every 4 hours. Started on day 2 of the look-back period. Cold pack to left shoulder applied by PT BID. PT notes that resident reports significant pain improvement after cold pack applied. <p>Coding: J0100A would be coded 1, yes. Rationale: Medical record indicated that resident received a scheduled pain medication duringin the last 5- days look-back period. Coding: J0100B would be coded 0, no. Rationale: No documentation was found in the medical record that resident received or was offered and declined any PRN medications duringin the last 5- days look-back period. Coding: J0100C would be coded 1, yes. Rationale: The medical record indicates that the resident received scheduled non-medication pain intervention (cold pack to the left shoulder) duringin the last 5- days look-back period.</p>

Track Changes
from Chapter 3 Section J v1.17.1
to Chapter 3 Section J v1.18.11

Chapter	Section	Page(s) in version 1.18.11	Change
3	J0100	J-3– J-4	<p>2. The resident’s medical record includes the following pain management documentation:</p> <ul style="list-style-type: none"> Morphine sulfate controlled-release 15 mg PO Q 12 hours: Resident refused every dose of medication duringin the last 5- days look-back period. No other pain management interventions were documented. <p>Coding: J0100A would be coded 0, no.</p> <p>Rationale: The medical record documented that the resident did not receive scheduled pain medication duringin the last 5- days look-back period. Residents may refuse scheduled medications; however, medications are not considered “received” if the resident refuses the dose.</p> <p>Coding: J0100B would be coded 0, no.</p> <p>Rationale: The medical record contained no documentation that the resident received or was offered and declined any PRN medications duringin the last 5- days look-back period.</p> <p>Coding: J0100C would be coded 0, no.</p> <p>Rationale: The medical record contains no documentation that the resident received non-medication pain intervention duringin the last 5- days look-back period.</p>
3	J0200	J-4	<p>Health-related Quality of Life</p> <ul style="list-style-type: none"> Most residents who are capable of communicating can answer questions about how they feel. Obtaining information about pain directly from the resident, sometimes called “hearing the resident’s voice,” is more reliable and accurate than observation alone for identifying pain. If a resident cannot communicate (e.g., verbal, gesture, written), then staff observations for pain behavior (J0800 and J0850) will be used.

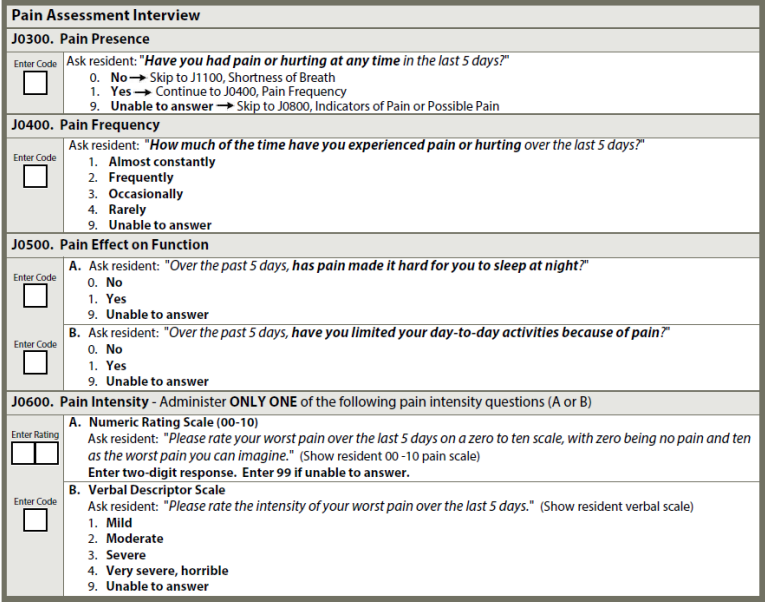
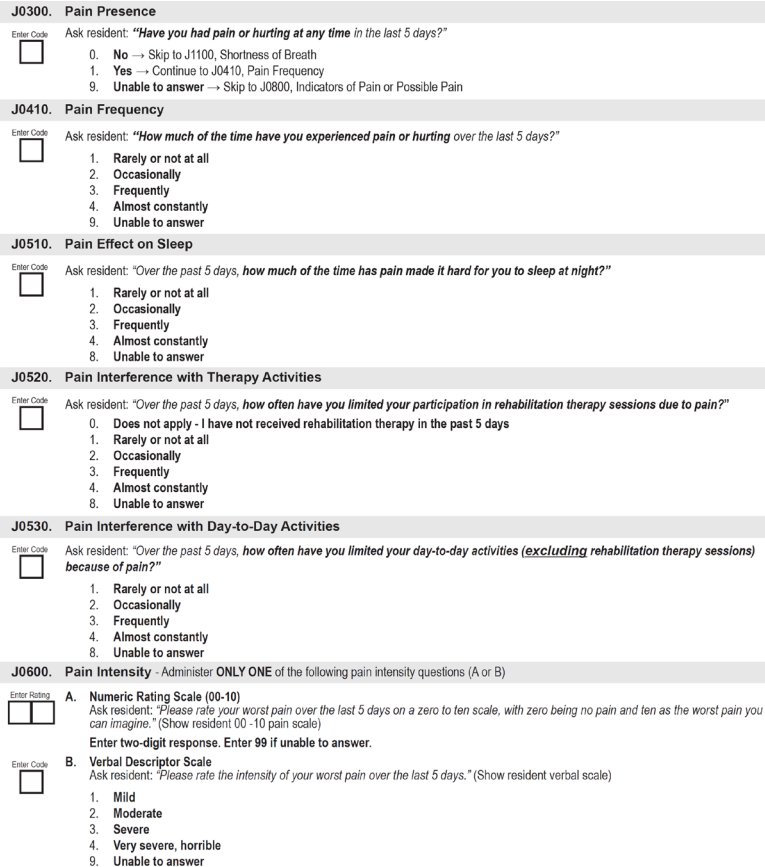
**Track Changes
from Chapter 3 Section J v1.17.1
to Chapter 3 Section J v1.18.11**

Chapter	Section	Page(s) in version 1.18.11	Change
3	J0200	J-5	<p>Steps for Assessment</p> <ol style="list-style-type: none"> 1. Interact with the resident using his or hertheir preferred language. Be sure he or shethey can hear you and/or hashave access to his or hertheir preferred method for communication. If the resident appears unable to communicate, offer alternatives such as writing, pointing, sign language, or cue cards. 2. Determine whether or not the resident is rarely/never understood verbally, in writing, or using another method. If the resident is rarely/never understood, skip to item J0800, Indicators of Pain or Possible Pain. 3. Review Language item (A11010) to determine whether or not the resident needs or wants an interpreter.
3	J0200	J-5	<p>Coding Instructions</p> <p><i>Attempt to complete the interview if the resident is at least sometimes understoodwith all residents and an interpreter is present or not required.</i></p> <ul style="list-style-type: none"> • Code 0, no: if the resident is rarely/never understood or an interpreter is required but not available. Skip to Indicators of Pain or Possible Pain item (J0800). • Code 1, yes: if the resident is at least sometimes understood and an interpreter is present or not required. Continue to Pain Presence item (J0300).

**Track Changes
from Chapter 3 Section J v1.17.1
to Chapter 3 Section J v1.18.11**

Chapter	Section	Page(s) in version 1.18.11	Change
3	J0200	J-5	<p>Coding Tips and Special Populations</p> <ul style="list-style-type: none"> • Attempt to conduct the interview with ALL residents. This interview is conducted during the look-back period of the Assessment Reference Date (ARD) and is not contingent upon item B0700, Makes Self Understood. • If the resident interview should have been conducted, but was not done within the look-back period of the ARD (except when an interpreter is needed/requested and unavailable), item J0200 must be coded 1, Yes, and the standard “no information” code (a dash “—”) entered in the resident Pain Assessment Interview items (J0300–J0600). Item J0700, Should the Staff Assessment for Pain be Conducted?, is coded 0, No. • Do not complete the Staff Assessment for Pain items (J0800–J0850) if the resident Pain Assessment Interview should have been conducted, but was not done. • If it is not possible for an interpreter to be present during the look-back period, code J0200 = 0 to indicate the Pain Assessment Pain Assessment Interview was not attempted, skip the Pain Assessment Interview items (J0300–J0600), and complete the Staff Assessment of Pain item (J0800), instead of the Pain Interview items (J0300–J0600).

Track Changes
from Chapter 3 Section J v1.17.1
to Chapter 3 Section J v1.18.11

3	J0300– J0600	J-6	<p>Replaced screenshot.</p> <p>OLD</p>  <p>NEW</p> 
---	-----------------	-----	---


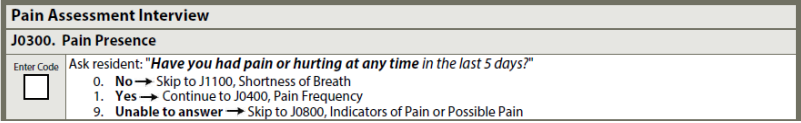
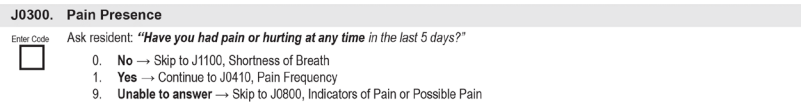
Track Changes
from Chapter 3 Section J v1.17.1
to Chapter 3 Section J v1.18.11

Chapter	Section	Page(s) in version 1.18.11	Change
3	J0300– J0600	J-7	<p>Planning for Care</p> <ul style="list-style-type: none"> • Directly asking the resident about pain rather than relying on the resident to volunteer the information or relying on clinical observation significantly improves the detection of pain. • Resident self-report is the most reliable means for assessing pain. • Pain assessment provides a basis for evaluation, treatment need, and response to treatment. • Assessing whether pain interferes with sleep or activities provides additional understanding of the functional impact of pain and potential care planning implications. • Assessment of pain provides insight into the need to adjust the timing of pain interventions to better cover sleep or preferred activities. • 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 nonpharmacologic and nonopioid approaches to pain management may be considered. There are a range of pain management strategies that can be used, including but not limited to non-opioid analgesic medications, transcutaneous electrical nerve stimulation (TENS) therapy, supportive devices, acupuncture, biofeedback, application of heat/cold, massage, physical therapy, nerve block, stretching and strengthening exercises, chiropractic, electrical stimulation, radiotherapy, and ultrasound.


Track Changes
from Chapter 3 Section J v1.17.1
to Chapter 3 Section J v1.18.11

Chapter	Section	Page(s) in version 1.18.11	Change
3	J0300–J0600	J-8	<p>Steps for Assessment: Basic Interview Instructions for Pain Assessment Interview (J0300-J0600)</p> <ol style="list-style-type: none"> 1. Interview any resident not screened out by the Should Pain Assessment Interview be Conducted? item (J0200). 2. The Pain Assessment Interview for residents consists of fourseven items: the primary question Pain Presence item (J0300); and threesix follow-up questions—Pain Frequency item (J0400); Pain Effect on Function item (J0500); and Pain Intensity item (J0600). If the resident is unable to answer the primary question on Pain Presence item J0300, skip to the Staff Assessment for Pain beginning with Indicators of Pain or Possible Pain item (J0800). 3. The look-back period on these items is 5 days. Because this item asks the resident to recall pain during the past 5 days, this assessment should be conducted close to the end of the 5-day look-back period; preferably on the day before, or the day of the ARD. This should more accurately capture pain episodes that occur during the 5-day look-back period.
3	J0300–J0600	J-8	<ol style="list-style-type: none"> 7. Directly ask the resident each item in J0300 through J0600the Pain Assessment Interview in the order provided. <ul style="list-style-type: none"> • Use other terms for pain or follow-up discussion if the resident seems unsure or hesitant. Some residents avoid use of the term “pain” but may report that they “hurt.” Residents may use other terms such as “aching” or “burning” to describe pain. 8. If the resident chooses not to answer a particular item, accept his/hertheir refusal, code 9, and move on to the next item. 9. If the resident is unsure about whether the pain or the effects or interference of pain occurred in the last 5- days time interval, prompt the resident to think about the most recent episode of pain and try to determine whether it occurred within the look-back periodlast 5 days.

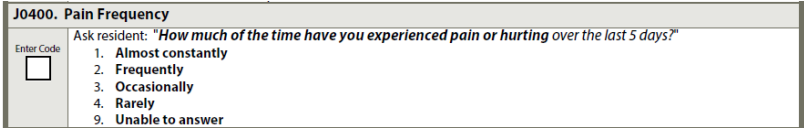
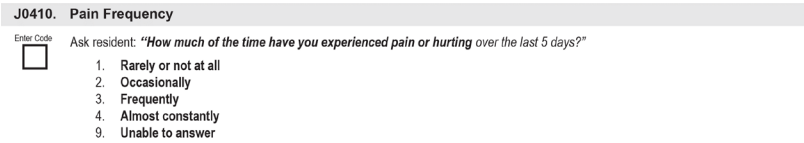
Track Changes
from Chapter 3 Section J v1.17.1
to Chapter 3 Section J v1.18.11

Chapter	Section	Page(s) in version 1.18.11	Change
3	J0300	J-9	<p>J0300: Pain Presence (5-Day Look Back)</p> 
3	J0300	J-9	<p>Replaced screenshot.</p> <p>OLD</p>  <p>NEW</p> 
3	J0300	J-9	<p>Coding Instructions for J0300, Pain Presence</p> <p><i>Code for the presence or absence of pain regardless of pain management efforts during in the last 5- days look-back period.</i></p> <ul style="list-style-type: none"> Code 0, no: if the resident responds “no” to having any pain or hurting in the last 5- days look-back period. Code 0, no: even if the reason for no pain is that the resident received pain management interventions. If coded 0, the pain interview is complete. Skip to Shortness of Breath item (J1100). Code 1, yes: if the resident responds “yes” to having any pain at any time during or hurting in the look-back period last 5 days. If coded 1, proceed to items J0400, J0500, J0600 AND J0700 the Pain Assessment Interview. Code 9, unable to answer: if the resident is unable to answer, does not respond, or gives a nonsensical response. If coded 9, skip to the Staff Assessment for Pain beginning with Indicators of Pain or Possible Pain item (J0800).

Track Changes
from Chapter 3 Section J v1.17.1
to Chapter 3 Section J v1.18.11

Chapter	Section	Page(s) in version 1.18.11	Change
3	J0300	J-9	<p>Examples</p> <p>1. When asked about pain, Mrs. Resident S- responds, “No. I have been taking the pain medication regularly, so fortunately I have had no pain.”</p> <p>Coding: J0300 would be coded 0, no. The assessor would skip to Shortness of Breath item (J1100).</p> <p>Rationale: Mrs. Resident S- reports having no pain during the look-back period. Even though she they received pain management interventions during the look-back period, the item is coded “No,” because there was no pain.</p>
3	J0300	J-9	<p>2. When asked about pain, Mr. Resident T- responds, “No pain, but I have had a terrible burning sensation all down my leg.”</p> <p>Coding: J0300 would be coded 1, yes. The assessor would proceed to Pain Frequency item (J0400).</p> <p>Rationale: Although Mr. Resident T-’s initial response is “no,” the comments indicate that he they has have experienced pain (burning sensation) during the look-back period.</p>
3	J0300	J-10	<p>3. When asked about pain, Ms. Resident G- responds, “I was on a train in 1905.”</p> <p>Coding: J0300 would be coded 9, unable to respond. The assessor would skip to Indicators of Pain item (J0800).</p> <p>Rationale: Ms. Resident G- has provided a nonsensical answer to the question. The assessor will complete the Staff Assessment for Pain beginning with Indicators of Pain item (J0800).</p>
3	J0410	J-10	<p>J04010: Pain Frequency (5-Day Look Back)</p> 


Track Changes
from Chapter 3 Section J v1.17.1
to Chapter 3 Section J v1.18.11

Chapter	Section	Page(s) in version 1.18.11	Change
3	J0410	J-10	<p>Replaced screenshot.</p> <p>OLD</p>  <p>NEW</p> 
3	J0410	J-10	<p>Coding Instructions</p> <p><i>Code for pain frequency during over the last 5- days look back period.</i></p> <ul style="list-style-type: none"> • Code 1, almost constantlyRarely or not at all: if the resident responds “almost constantlyrarely” to the question. • Code 2, frequentlyOccasionally: if the resident responds “frequentlyoccasionally” to the question. • Code 3, occasionallyFrequently: if the resident responds “occasionallyfrequently” to the question. • Code 4, rarelyAlmost constantly: if the resident responds “rarelyalmost constantly” to the question. • Code 9, uUnable to answer: if the resident is unable to respond, does not respond, or gives a nonsensical response. Proceed to items J0500, J0600 AND J0700.

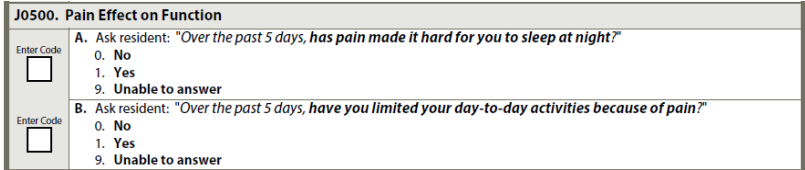
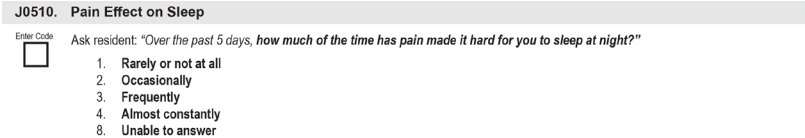
Track Changes
from Chapter 3 Section J v1.17.1
to Chapter 3 Section J v1.18.11

Chapter	Section	Page(s) in version 1.18.11	Change
3	J0410	J-11	<p>Examples</p> <p>1. When asked about pain, Mrs.Resident C- responds, “All the time. It has been a terrible week. I have not been able to get comfortable for more than 10 minutes at a time since I started physical therapy four days ago.”</p> <p>Coding: J04010 would be coded 14, aAlmost constantly.</p> <p>Rationale: Mrs.Resident C- describes pain that has occurred “all the time.”</p>
3	J0410	J-11	<p>2. When asked about pain, Mr.Resident J- responds, “I don’t know if it is frequent or occasional. My knee starts throbbing every time they move me from the bed or the wheelchair.”</p> <p>The interviewer says: “Your knee throbs every time they move you. If you had to choose an answer, would you say that you have pain frequently or occasionally?”</p> <p>Mr.Resident J- is still unable to choose between frequently and occasionally.</p> <p>Coding: J04010 would be coded 23, fFrequently.</p> <p>Rationale: The interviewer appropriately echoed Mr.Resident J-’s comment and provided related response options to help himthem clarify which response hethey preferred. Mr.Resident J- remained unable to decide between frequently and occasionally. The interviewer therefore coded for the higher frequency of pain.</p>

Track Changes
from Chapter 3 Section J v1.17.1
to Chapter 3 Section J v1.18.11

Chapter	Section	Page(s) in version 1.18.11	Change
3	J0410	J-11	<p>3. When asked about pain, Miss Resident K- responds: “I can’t remember. I think I had a headache a few times in the past couple of days, but they gave me acetaminophen and the headaches went away.”</p> <p>The interviewer clarifies by echoing what Miss Resident K- said: “You’ve had a headache a few times in the past couple of days and the headaches went away when you were given acetaminophen. If you had to choose from the answers, would you say you had pain occasionally or rarely?”</p> <p>Miss Resident K- replies “Occasionally.”</p> <p>Coding: J04010 would be coded 32, eOccasionally.</p> <p>Rationale: After the interviewer clarified the resident’s choice using echoing, the resident selected a response option.</p>
3	J0410	J-12	<p>4. When asked about pain, Ms. Resident M- responds, “I would say rarely. Since I started using the patch, I don’t have much pain at all, but four days ago the pain came back. I think they were a bit overdue in putting on the new patch, so I had some pain for a little while that day.”</p> <p>Coding: J04010 would be coded 41, fRarely or not at all.</p> <p>Rationale: Ms. Resident M- selected the “fRarely or not at all” response option.</p>
3	J0510	J-12	<p>J05010: Pain Effect on Function Sleep (5-Day Look Back)</p> 
3	J0510– J2300– J5000	J-12– J-49	Page length changed due to revised content.

Track Changes
from Chapter 3 Section J v1.17.1
to Chapter 3 Section J v1.18.11

Chapter	Section	Page(s) in version 1.18.11	Change
3	J0510	J-12	<p>Replaced screenshot.</p> <p>OLD</p>  <p>NEW</p> 
3	J0510	J-12	<p>Steps for Assessment</p> <ol style="list-style-type: none"> 1. Ask the resident each of the two questions exactly as they are written. 2. If the resident's response does not lead to a clear "yes" or "no" answer, repeat the resident's response and then try to narrow the focus of the response. For example, if the resident responded to the question, "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?"
3	J0510	J-12	<p>Coding Instructions for J0500A, Over the Past 5 Days, Has Pain Made It Hard for You to Sleep at Night?</p> <ul style="list-style-type: none"> • Code 0, no: if the resident responds "no," indicating that pain did not interfere with sleep. • Code 1, yes: if the resident responds "yes," indicating that pain interfered with sleep. • Code 9, unable to answer: if the resident is unable to answer the question, does not respond or gives a nonsensical response. Proceed to items J0500B, J0600 AND J0700.

Track Changes
from Chapter 3 Section J v1.17.1
to Chapter 3 Section J v1.18.11

Chapter	Section	Page(s) in version 1.18.11	Change
3	J0510	J-12	<p>Coding Instructions for J0500B, Over the Past 5 Days, Have You Limited Your Day-to-day Activities because of Pain?</p> <ul style="list-style-type: none"> ▪ Code 0, no: if the resident indicates that pain did not interfere with daily activities. ▪ Code 1, yes: if the resident indicates that pain interfered with daily activities. ▪ Code 9, unable to answer: if the resident is unable to answer the question, does not respond or gives a nonsensical response. Proceed to items J0600 AND J0700.
3	J0510	J-12	<p>Examples for J0500A, Over the Past 5 Days, Has Pain Made It Hard for You to Sleep at Night?</p> <p>1. Mrs. D. responds, “I had a little back pain from being in the wheelchair all day, but it felt so much better when I went to bed. I slept like a baby.”</p> <p>Coding: J0500A would be coded 0, no.</p> <p>Rationale: Mrs. D. reports no sleep problems related to pain.</p>

Track Changes
from Chapter 3 Section J v1.17.1
to Chapter 3 Section J v1.18.11

Chapter	Section	Page(s) in version 1.18.11	Change
3	J0510	J-12	<p>2. Mr. E. responds, “I can’t sleep at all in this place.” The interviewer clarifies by saying, “You can’t sleep here. Would you say that was because pain made it hard for you to sleep at night?” Mr. E. responds, “No. It has nothing to do with me. I have no pain. It is because everyone is making so much noise.” Coding: J0500A would be coded 0, no. Rationale: Mr. E. reports that his sleep problems are not related to pain.</p> <p>3. Miss G. responds, “Yes, the back pain makes it hard to sleep. 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: J0500A would be coded 1, yes. Rationale: The resident reports pain-related sleep problems.</p>
3	J0510	J-12	<p>Examples for J0500B, Over the Past 5 Days, Have You Limited Your Day-to-day Activities because of Pain?</p> <p>1. Ms. L. responds, “No, I had some pain on Wednesday, but I didn’t want to miss the shopping trip, so I went.” Coding: J0500B would be coded 0, no. Rationale: Although Ms. L. reports pain, she did not limit her activity because of it.</p> <p>2. Mrs. N. responds, “Yes, I haven’t been able to play the piano, because my shoulder hurts.” Coding: J0500B would be coded 1, yes. Rationale: Mrs. N. reports limiting her activities because of pain.</p>


Track Changes
from Chapter 3 Section J v1.17.1
to Chapter 3 Section J v1.18.11

Chapter	Section	Page(s) in version 1.18.11	Change
3	J0510	J-12	<p>3. Mrs. S. responds, “I don’t know. I have not tried to knit since my finger swelled up yesterday, because I am afraid it might hurt even more than it does now.”</p> <p>Coding: J0500B would be coded 1, yes.</p> <p>Rationale: Resident avoided a usual activity because of fear that her pain would increase.</p> <p>4. Mr. Q. responds, “I don’t like painful activities.”</p> <p>Interviewer repeats question and Mr. Q. responds, “I designed a plane one time.”</p> <p>Coding: J0500B would be coded 9, unable to answer.</p> <p>Rationale: Resident has provided a nonsensical answer to the question. Proceed to items J0600 AND J0700.</p>
3	J0510	J-12	<p>Steps for Assessment</p> <ol style="list-style-type: none"> 1. Read the question and response choices exactly as they are written. 2. No predetermined definitions are offered to the resident. The resident’s response should be based on their interpretation of frequency response options. 3. If the resident’s response does not lead to a clear answer, repeat the resident’s response and then try to narrow the focus of the response. For example, if the resident 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.

Track Changes
from Chapter 3 Section J v1.17.1
to Chapter 3 Section J v1.18.11

Chapter	Section	Page(s) in version 1.18.11	Change
3	J0510	J-12	<p>Coding Instructions</p> <p><i>Code for pain effect on sleep over the last 5 days.</i></p> <ul style="list-style-type: none"> • Code 1, Rarely or not at all: if the resident responds that pain has rarely or not at all made it hard to sleep over the past 5 days. • Code 2, Occasionally: if the resident responds that pain has occasionally made it hard to sleep over the past 5 days. • Code 3, Frequently: if the resident responds that pain has frequently made it hard to sleep over the past 5 days. • Code 4, Almost constantly: if the resident responds that pain has almost constantly made it hard to sleep over the past 5 days. • Code 8, Unable to answer: if the resident is unable to answer the question, does not respond or gives a nonsensical response.
3	J0510	J-13	<p>Coding Tips</p> <ul style="list-style-type: none"> • This item should be coded based on the resident's interpretation of the provided response options for frequency. If the resident is unable to decide between two options, then the assessor should code for the option with the higher frequency. • If the resident reports they had pain over the past 5 days and the pain does not interfere with their sleep (e.g., because the resident is using pain management strategies successfully), code 1, Rarely or not at all.


Track Changes
from Chapter 3 Section J v1.17.1
to Chapter 3 Section J v1.18.11

Chapter	Section	Page(s) in version 1.18.11	Change
3	J0510	J-13	<p>Examples</p> <p>1. When asked, “Over the past 5 days, how much of the time has pain made it hard for you to sleep at night?” the resident replied, “I’ve had a little back pain from being in the wheelchair all day, but it felt so much better when I went to bed. The pain hasn’t kept me from sleeping at all.”</p> <p>Coding: J0510 would be coded 1, Rarely or not at all.</p> <p>Rationale: The resident reports pain has been present over the past 5 days but that they have had no sleep problems related to pain.</p>
3	J0510	J-13	<p>2. When asked, “Over the past 5 days, how much of the time has pain made it hard for you to sleep at night?” the resident responded, “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.”</p> <p>Coding: J0510 would be coded 4, Almost constantly.</p> <p>Rationale: The resident reports pain-related sleep problems “all the time” over the past 5 days, so the most applicable response is “Almost constantly.”</p>
3	J0520	J-14	<p>J0520: Pain Interference with Therapy Activities</p>  <div style="border: 1px solid black; padding: 5px; margin-top: 10px;"> <p>J0520. Pain Interference with Therapy Activities</p> <p>Enter Code <input type="checkbox"/> Ask resident: “Over the past 5 days, how often have you limited your participation in rehabilitation therapy sessions due to pain?”</p> <ul style="list-style-type: none"> 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 </div>
3	J0520	J-14	<p>Steps for Assessment</p> <p>1. Read the question and response choices as written.</p>

Track Changes
from Chapter 3 Section J v1.17.1
to Chapter 3 Section J v1.18.11

Chapter	Section	Page(s) in version 1.18.11	Change
3	J0520	J-14	<p>Coding Instructions</p> <p><i>Code for pain interference with therapy activities over the last 5 days.</i></p> <ul style="list-style-type: none"> • Code 0, Does not apply: if the resident responds that they did not participate in rehabilitation therapy for reasons unrelated to pain (e.g., therapy not needed, unable to schedule) over the past 5 days. • Code 1, Rarely or not at all: if the resident responds that pain has rarely or not at all limited their participation in rehabilitation therapy sessions over the past 5 days. • Code 2, Occasionally: if the resident responds that pain has occasionally limited their participation in rehabilitation therapy sessions over the past 5 days. • Code 3, Frequently: if the resident responds that pain has frequently limited their participation in rehabilitation therapy sessions over the past 5 days. • Code 4, Almost constantly: if the resident responds that pain has almost constantly limited their participation in rehabilitation therapy sessions over the past 5 days. • Code 8, Unable to answer: if the resident is unable to answer the question, does not respond, or gives a nonsensical response.
3	J0520	J-14	<p>DEFINITION</p> <p>REHABILITATION THERAPY</p> <p>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, physical therapy, occupational therapy, speech therapy, and cardiac and pulmonary therapies.</p>


Track Changes
from Chapter 3 Section J v1.17.1
to Chapter 3 Section J v1.18.11

Chapter	Section	Page(s) in version 1.18.11	Change
3	J0520	J-14– J-15	<p>Coding Tips</p> <ul style="list-style-type: none"> • This item should be coded based on the resident’s interpretation of the provided response options for frequency. If the resident 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 resident carrying out a prescribed therapy program without staff members present. • Rehabilitation therapies do not include restorative nursing programs.
3	J0520	J-15	<p>Example</p> <p>1. When asked, “Over the past 5 days, how often have you limited your participation in rehabilitation therapy sessions due to pain?” the resident responded, “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.”</p> <p>Coding: J0520 would be coded 3, Frequently. Rationale: The resident reports that pain frequently limited participation in therapies over the past 5 days.</p>
3	J0530	J-15	<p>J0530: Pain Interference with Day-to-Day Activities</p>  <div style="border: 1px solid black; padding: 5px; margin-top: 10px;"> <p>J0530. Pain Interference with Day-to-Day Activities</p> <p>Enter Code <input type="checkbox"/> Ask resident: “Over the past 5 days, how often have you limited your day-to-day activities (excluding rehabilitation therapy sessions) because of pain?”</p> <ol style="list-style-type: none"> 1. Rarely or not at all 2. Occasionally 3. Frequently 4. Almost constantly 8. Unable to answer </div>
3	J0530	J-15	<p>Steps for Assessment</p> <p>1. Read the question and response choices as written.</p>

Track Changes
from Chapter 3 Section J v1.17.1
to Chapter 3 Section J v1.18.11

Chapter	Section	Page(s) in version 1.18.11	Change
3	J0530	J-15– J-16	<p>Coding Instructions</p> <p><i>Code for pain interference with day-to-day activities over the last 5 days.</i></p> <ul style="list-style-type: none"> • Code 1, Rarely or not at all: if the resident responds that pain has rarely or not at all limited their day-to-day activities (excluding rehabilitation therapy sessions) over the past 5 days. • Code 2, Occasionally: if the resident responds that pain has occasionally limited their day-to-day activities (excluding rehabilitation therapy sessions) over the past 5 days. • Code 3, Frequently: if the resident responds that pain has frequently limited their day-to-day activities (excluding rehabilitation therapy sessions) over the past 5 days. • Code 4, Almost constantly: if the resident responds that pain has almost constantly limited their day-to-day activities (excluding rehabilitation therapy sessions) over the past 5 days. • Code 8, Unable to answer: if the resident is unable to answer the question, does not respond, or gives a nonsensical response.
3	J0530	J-16	<p>Coding Tips</p> <ul style="list-style-type: none"> • This item should be coded based on the resident's interpretation of the provided response options for frequency. If the resident is unable to decide between two options, then the assessor should code for the option with the higher frequency.

Track Changes
from Chapter 3 Section J v1.17.1
to Chapter 3 Section J v1.18.11

Chapter	Section	Page(s) in version 1.18.11	Change
3	J0530	J-16	<p>Examples</p> <p>1. When asked, “Over the past 5 days, how often have you limited your day-to-day activities (excluding rehabilitation therapy sessions) because of pain?” the resident responded, “Although I have some pain in my back, I’m still able to read, eat my meals, and take walks like I usually do.”</p> <p>Coding: J0530 would be coded 1, Rarely or not at all.</p> <p>Rationale: The resident reports that pain has not limited their participation in day-to-day activities over the past 5 days.</p>
3	J0530	J-16	<p>2. When asked, “Over the past 5 days, how often have you limited your day-to-day activities (excluding rehabilitation therapy sessions) because of pain?” the resident responded, “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.”</p> <p>Coding: J0530 would be coded 4, Almost constantly.</p> <p>Rationale: The resident reports that pain has constantly limited their participation in other activities over the past 5 days.</p>
3	J0600	J-17	<p>J0600: Pain Intensity (5-Day Look Back)</p> 

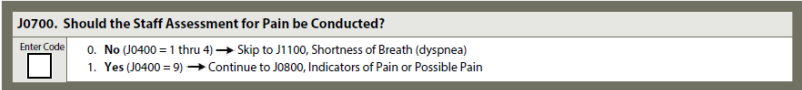
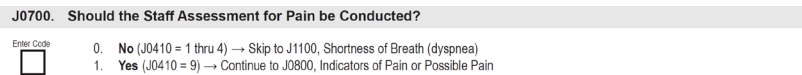
Track Changes
from Chapter 3 Section J v1.17.1
to Chapter 3 Section J v1.18.11

Chapter	Section	Page(s) in version 1.18.11	Change
3	J0600	J-17	<p>Steps for Assessment</p> <ol style="list-style-type: none"> 1. You may use either the Numeric Rating Scale item (J0600A) or the Verbal Descriptor Scale item (J0600B) to interview the resident about pain intensity. <ul style="list-style-type: none"> • For each resident, try to use the same scale used on prior assessments. 2. If the resident is unable to answer using one scale, the other scale should be attempted. 3. Record either the Numeric Rating Scale item (J0600A) or the Verbal Descriptor Scale item (J0600B). Leave the response for the unused scale blank.
3	J0600	J-17	<p>Coding Instructions for J0600A. Numeric Rating Scale (00-10)</p> <p><i>Enter the two digit number (00-10) indicated by the resident as corresponding to the intensity of his or her their worst pain during over the last 5- days look-back period, where zero is no pain, and 10 is the worst pain imaginable.</i></p>
3	J0600	J-18	<ul style="list-style-type: none"> • Code 9, unable to answer: if resident is unable to answer, chooses not to respond, does not respond or gives a nonsensical response. Proceed to item J0700. • If the Verbal Descriptor Scale is not used, leave the response box blank.

Track Changes
from Chapter 3 Section J v1.17.1
to Chapter 3 Section J v1.18.11

Chapter	Section	Page(s) in version 1.18.11	Change
3	J0600	J-18	<p>Examples for J0600A. Numeric Rating Scale (00-10)</p> <p>1. The nurse asks Ms. Resident T- to rate herhertheir pain on a scale of 0 to 10. Ms. Resident T- states that sheshethey isisare not sure, because sheshethey hashashave shoulder pain and knee pain, and sometimes it is really bad, and sometimes it is OK. The nurse reminds Ms. Resident T- to think about all the pain sheshethey had duringduringover the last 5 days and select the number that describes herhertheir worst pain. SheSheThey reports that herhertheir pain is a “6.”</p> <p>Coding: J0600A would be coded 06.</p> <p>Rationale: The resident said herhertheir pain was 6 on the 0 to 10 scale. Because a 2-digit number is required, it is entered as 06.</p>
3	J0600	J-18	<p>2. The nurse asks Ms. Resident U- to rate herhertheir pain, reviews use of the verbal descriptor scale, and provides a cue card as a visual aid. Ms. Resident U- says, “I’m not sure whether it’s mild or moderate.” The nurse reminds Ms. Resident U- to think about herhertheir worst pain duringduringover the last 5 days. Ms. Resident U- says, “At its worst, it was moderate.”</p> <p>Coding: Item J0600B would be coded 2, moderate.</p> <p>Rationale: The resident indicated that herhertheir worst pain was “Moderate.”</p>
3	J0700	J-19	<p>J0700: Should the Staff Assessment for Pain be Conducted? (5-Day Look Back)</p>

Track Changes
from Chapter 3 Section J v1.17.1
to Chapter 3 Section J v1.18.11

Chapter	Section	Page(s) in version 1.18.11	Change
3	J0700	J-19	<p>Replaced screenshot.</p> <p>OLD</p>  <p>NEW</p> 
3	J0700	J-19	<p>Item Rationale</p> <p>Item J0700 closes the pain interview and determines if the resident interview was complete or incomplete and based on this determination, whether a staff assessment needs to should be completed.</p>
3	J0700	J-19	<p>DEFINITION</p> <p>COMPLETED PAIN ASSESSMENT INTERVIEW</p> <p>The pPain Assessment Interview is successfully completed if the resident reported no pain (answered No to J0300 = 0, No), or if the resident reported pain (J0300 = 1, Yes) and the follow-up question J04010 is answered.</p>
3	J0700	J-19	<p>Steps for Assessment</p> <ol style="list-style-type: none"> 1. Review the resident's responses to items J0200-J0400. The Staff Assessment for Pain should only be completed if the Pain Assessment Interview (J02300-J0600) was not completed. <p>Note: Steps renumbered</p>

Track Changes
from Chapter 3 Section J v1.17.1
to Chapter 3 Section J v1.18.11

Chapter	Section	Page(s) in version 1.18.11	Change
3	J0700	J-19	<p>Coding Instructions for J0700. Should the Staff Assessment for Pain be Conducted? This item is to be coded at the completion of items J0400-J0600.</p> <ul style="list-style-type: none"> • Code 0, no: if the resident completed the Pain Assessment Interview item (J04010 = 1, 2, 3, or 4). Skip to Shortness of Breath (dyspnea) item (J1100). • Code 1, yes: if the resident was unable to complete the Pain Assessment Interview (J04010 = 9). Continue to Indicators of Pain or Possible Pain item (J0800).
3	J0800	J-20	<p>J0800: Indicators of Pain (5-Day Look Back)</p> <p><i>Complete this item only if the Pain Assessment Interview (J0200-J0600) was not completed.</i></p>
3	J0800	J-21	<p>Steps for Assessment</p> <ol style="list-style-type: none"> 1. Review the medical record for documentation of each indicator of pain listed in J0800 that occurred during in the last 5- days look-back period. If the record documents the presence of any of the signs and symptoms listed, confirm your record review with the direct care staff on all shifts who work most closely with the resident during activities of daily living (ADL). 2. Interview staff because the medical record may fail to note all observable pain behaviors. For any indicators that were not noted as present in medical record review, interview direct care staff on all shifts who work with the resident during ADL. Ask directly about the presence of each indicator that was not noted as being present in the record. 3. Observe resident during care activities. If you observe additional indicators of pain during in the last 5- days look-back period, code the corresponding items.

Track Changes
from Chapter 3 Section J v1.17.1
to Chapter 3 Section J v1.18.11

Chapter	Section	Page(s) in version 1.18.11	Change
3	J0800	J-21– J-22	<p>Coding Instructions</p> <p><i>Check all that apply in the plast 5 days based on staff observation of pain indicators.</i></p> <ul style="list-style-type: none"> • If the medical record review and the interview with direct care providers and observation on all shifts provide no evidence of pain indicators, Check J0800Z, None of these signs observed or documented, and proceed to the Shortness of Breath item (J1100). • Check J0800A, nonverbal sounds: included but not limited to if crying, whining, gasping, moaning, or groaning were observed or reported duringin the look-back periodlast 5 days. • Check J0800B, vocal complaints of pain: included but not limited to if the resident was observed to or reported to have make vocal complaints of pain (e.g. “that hurts,” “ouch,” or “stop”) in the last 5 days. • Check J0800C, facial expressions: included but not limited to if grimaces, winces, wrinkled forehead, furrowed brow, clenched teeth or jaw were observed or reported duringin the look-back periodlast 5 days. • Check J0800D, protective body movements or postures: included but not limited to if bracing, guarding, rubbing or massaging a body part/area, or clutching or holding a body part during movement were observed or reported duringin the look-back periodlast 5 days. • Check J0800Z, none of these signs observed or documented: if none of these signs were observed or reported duringin the look-back periodlast 5 days.

Track Changes
from Chapter 3 Section J v1.17.1
to Chapter 3 Section J v1.18.11

Chapter	Section	Page(s) in version 1.18.11	Change
3	J0800	J-22	<p>2. Mrs. Resident M- has end-stage Parkinson's disease and is unable to verbally communicate. There is no documentation of pain in her their medical record during in the last 5- days look-back period. The CNAs caring for her them report that on some mornings she they moans and winces when her their arms and legs are moved during morning care. During direct observation, you note that Mrs. Resident M- cries and attempts to pull her their hand away when the CNA tries to open the contracted hand to wash it.</p> <p>Coding: Nonverbal Sounds items (J0800A); Facial Expressions item (J0800C); and Protective Body Movements or Postures item (J0800D), would be checked. Rationale: Mrs. Resident M- has demonstrated nonverbal sounds (crying, moaning); facial expression of pain (wince), and protective body movements (attempt to withdraw).</p>
3	J0800	J-23	<p>4. Mr. Resident S- is in a persistent vegetative state following a traumatic brain injury. He They is are unable to verbally communicate. There is no documentation of pain in his their medical record during in the last 5- days look-back period. The CNA reports that he they appears comfortable whenever she the CNA cares for him them. You observe the CNA providing morning care and transferring him them from bed to chair. No pain indicators are observed at any time.</p> <p>Coding: None of These Signs Observed or Documented item (J0800Z), would be checked. Rationale: All steps for the assessment have been followed and no pain indicators have been documented, reported or directly observed.</p>
3	J0850	J-23	<p>J0850: Frequency of Indicator of Pain or Possible Pain (5-Day Look Back)</p>

Track Changes
from Chapter 3 Section J v1.17.1
to Chapter 3 Section J v1.18.11

Chapter	Section	Page(s) in version 1.18.11	Change
3	J0850	J-23	<p>Steps for Assessment</p> <p>1. Review medical record and interview staff and direct caregivers to determine the number of days the resident either complained of pain or showed evidence of pain as described in J0800 overin the pllast 5 days.</p>
3	J0850	J-24	<p>Coding Instructions</p> <p><i>Code for pain frequency overin the last 5 days.</i></p> <ul style="list-style-type: none"> • Code 1: if based on staff observation, the resident complained or showed evidence of pain 1 to 2 days. • Code 2: if based on staff observation, the resident complained or showed evidence of pain on3 to 4 of the last 5 days. • Code 3: if based on staff observation, the resident complained or showed evidence of pain on a daily basis.
3	J0850	J-24	<p>Examples</p> <p>1. Mr.Resident M- is an 80-year-old maleindividual with advanced dementia. During the last 5- days look-backperiod, Mr.Resident M- was noted to be grimacing and verbalizing “ouch” over the past 2 days when histheir right shoulder was moved.</p> <p>Coding: Item J0850 would be coded 1, indicators of pain observed 1 to 2 days.</p> <p>Rationale: HeThey hashave demonstrated vocal complaints of pain (“ouch”), facial expression of pain (grimacing) on 2 of the last 5 days.</p>

Track Changes
from Chapter 3 Section J v1.17.1
to Chapter 3 Section J v1.18.11

Chapter	Section	Page(s) in version 1.18.11	Change																				
3	J0850	J-24	<p>2. Mrs. Resident C is a 78-year-old female individual with a history of CVA with expressive aphasia and dementia. DuringIn the last 5- days look-back period, the resident was noted on a daily basis to be rubbing hertheir right knee and grimacing.</p> <p>Coding: Item J0850 would be coded 3, indicators of pain observed daily.</p> <p>Rationale: The resident was observed with a facial expression of pain (grimacing) and protective body movements (rubbing hertheir knee) every day duringin the look-back periodlast 5 days.</p>																				
3	J1900	J-36	<p>Replaced screenshot.</p> <p>OLD</p> <table><tr><td colspan="2">J1900. Number of Falls Since Admission/Entry or Reentry or Prior Assessment (OBRA or Scheduled PPS), whichever is more recent</td></tr><tr><td></td><td>Enter Codes in Boxes</td></tr><tr><td rowspan="3">Coding: 0. None 1. One 2. Two or more</td><td><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 resident; no change in the resident's behavior is noted after the fall</td></tr><tr><td><input type="checkbox"/> B. 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</td></tr><tr><td><input type="checkbox"/> C. Major injury - bone fractures, joint dislocations, closed head injuries with altered consciousness, subdural hematoma</td></tr></table> <p>NEW</p> <table><tr><td colspan="2">J1900. Number of Falls Since Admission/Entry or Reentry or Prior Assessment (OBRA or Scheduled PPS), whichever is more recent</td></tr><tr><td colspan="2">Coding: 0. None 1. One 2. Two or more</td></tr><tr><td colspan="2">Enter Codes in Boxes</td></tr><tr><td><input type="checkbox"/></td><td>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 resident; no change in the resident's behavior is noted after the fall</td></tr><tr><td><input type="checkbox"/></td><td>B. 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</td></tr><tr><td><input type="checkbox"/></td><td>C. Major injury - bone fractures, joint dislocations, closed head injuries with altered consciousness, subdural hematoma</td></tr></table>	J1900. Number of Falls Since Admission/Entry or Reentry or Prior Assessment (OBRA or Scheduled PPS), whichever is more recent			Enter Codes in Boxes	Coding: 0. None 1. One 2. Two or more	<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 resident; no change in the resident'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 resident to complain of pain	<input type="checkbox"/> C. Major injury - bone fractures, joint dislocations, closed head injuries with altered consciousness, subdural hematoma	J1900. Number of Falls Since Admission/Entry or Reentry or Prior Assessment (OBRA or Scheduled PPS), whichever is more recent		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 resident; no change in the resident'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 resident to complain of pain	<input type="checkbox"/>	C. Major injury - bone fractures, joint dislocations, closed head injuries with altered consciousness, subdural hematoma
J1900. Number of Falls Since Admission/Entry or Reentry or Prior Assessment (OBRA or Scheduled PPS), whichever is more recent																							
	Enter Codes in Boxes																						
Coding: 0. None 1. One 2. Two or more	<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 resident; no change in the resident'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 resident to complain of pain																						
	<input type="checkbox"/> C. Major injury - bone fractures, joint dislocations, closed head injuries with altered consciousness, subdural hematoma																						
J1900. Number of Falls Since Admission/Entry or Reentry or Prior Assessment (OBRA or Scheduled PPS), whichever is more recent																							
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 resident; no change in the resident'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 resident to complain of pain																						
<input type="checkbox"/>	C. Major injury - bone fractures, joint dislocations, closed head injuries with altered consciousness, subdural hematoma																						
3	J1900	J-38	<p>Coding Tip</p> <ul style="list-style-type: none">If the level of injury directly related to a fall that occurred during the look-back period is identified after the ARD and is at a different injury level than what was originally coded on an assessment that was submitted to the Internet Quality Improvement and Evaluation System (iQIES) Assessment Submission and Processing (ASAP) system, the assessment must be modified to update the level of injury that occurred with that fall.																				

Track Changes
from Chapter 3 Section J v1.17.1
to Chapter 3 Section J v1.18.11

Chapter	Section	Page(s) in version 1.18.11	Change
3	J1900	J-39	<p>5. Mr. Resident R- fell on histheir right hip in the facility on the ARD of histheir Quarterly MDS and complained of mild right hip pain. The initial x-ray of the hip did not show any injury. The nurse completed Mr. Resident R's Quarterly assessment and coded the assessment to reflect this information. The assessment was submitted to iQIES-ASAP. Three days later, Mr. Resident R- complained of increasing pain and had difficulty ambulating, so a follow-up x-ray was done. The follow-up x-ray showed a hairline fracture of the right hip. This injury is noted by the physician to be attributed to the recent fall that occurred during the look-back period of the Quarterly assessment.</p> <p>Original Coding: J1900B, Injury (except major) is coded 1, one and J1900C, Major Injury is coded 0, none.</p> <p>Rationale: Mr. Resident R. had a fall-related injury that caused himthem to complain of pain.</p> <p>Modification of Quarterly assessment: J1900B, Injury (except major) is coded 0, none and J1900C, Major Injury, is coded 1, one.</p> <p>Rationale: The extent of the injury did not present itself right after the fall; however, it was directly related to the fall that occurred during the look-back period of the Quarterly assessment. Since the assessment had been submitted to iQIES-ASAP and the level of injury documented on the submitted Quarterly was now found to be different based on a repeat x-ray of the resident's hip, the Quarterly assessment needed to be modified to accurately reflect the injury sustained during that fall.</p>

Track Changes
from Chapter 3 Section J v1.17.1
to Chapter 3 Section J v1.18.11

Chapter	Section	Page(s) in version 1.18.11	Change
3	J2000	J-40	
			DEFINITION MAJOR SURGERY Refers to a procedure that meets the following criteria: 1. The resident was an inpatient in an acute care hospital for at least 1 day in the 100 days prior to admission to the skilled nursing facility (SNF), and 2. The surgery carried some degree of risk to the resident's life or the potential for severe disability.
3	J2000	J-40	Coding Tips <ul style="list-style-type: none"> • Generally, major surgery for item J2000 refers to a procedure that meets the following criteria: <ol style="list-style-type: none"> the resident was an inpatient in an acute care hospital for at least one day in the 100 days prior to admission to the skilled nursing facility (SNF), and the surgery carried some degree of risk to the resident's life or the potential for severe disability.

Track Changes
from Chapter 3 Section J v1.17.1
to Chapter 3 Section J v1.18.11

3	J2300– J5000	J-43	<p>Replaced screenshot.</p> <p>OLD</p> <div> <p>Surgical Procedures - Complete only if J2100 = 1</p> <p>↓ Check all that apply</p> <p>Major Joint Replacement</p> <p><input type="checkbox"/> J2300. Knee Replacement - partial or total</p> <p><input type="checkbox"/> J2310. Hip Replacement - partial or total</p> <p><input type="checkbox"/> J2320. Ankle Replacement - partial or total</p> <p><input type="checkbox"/> J2330. Shoulder Replacement - partial or total</p> <p>Spinal Surgery</p> <p><input type="checkbox"/> J2400. Involving the spinal cord or major spinal nerves</p> <p><input type="checkbox"/> J2410. Involving fusion of spinal bones</p> <p><input type="checkbox"/> J2420. Involving lamina, discs, or facets</p> <p><input type="checkbox"/> J2499. Other major spinal surgery</p> <p>Other Orthopedic Surgery</p> <p><input type="checkbox"/> J2500. Repair fractures of the shoulder (including clavicle and scapula) or arm (but not hand)</p> <p><input type="checkbox"/> J2510. Repair fractures of the pelvis, hip, leg, knee, or ankle (not foot)</p> <p><input type="checkbox"/> J2520. Repair but not replace joints</p> <p><input type="checkbox"/> J2530. Repair other bones (such as hand, foot, jaw)</p> <p><input type="checkbox"/> J2599. Other major orthopedic surgery</p> <p>Neurological Surgery</p> <p><input type="checkbox"/> J2600. Involving the brain, surrounding tissue or blood vessels (excludes skull and skin but includes cranial nerves)</p> <p><input type="checkbox"/> J2610. Involving the peripheral or autonomic nervous system - open or percutaneous</p> <p><input type="checkbox"/> J2620. Insertion or removal of spinal or brain neurostimulators, electrodes, catheters, or CSF drainage devices</p> <p><input type="checkbox"/> J2699. Other major neurological surgery</p> <p>Cardiopulmonary Surgery</p> <p><input type="checkbox"/> J2700. Involving the heart or major blood vessels - open or percutaneous procedures</p> <p><input type="checkbox"/> J2710. Involving the respiratory system, including lungs, bronchi, trachea, larynx, or vocal cords - open or endoscopic</p> <p><input type="checkbox"/> J2799. Other major cardiopulmonary surgery</p> <p>Genitourinary Surgery</p> <p><input type="checkbox"/> J2800. Involving male or female organs (such as prostate, testes, ovaries, uterus, vagina, external genitalia)</p> <p><input type="checkbox"/> J2810. Involving the kidneys, ureters, adrenal glands, or bladder - open or laparoscopic (includes creation or removal of nephrostomies or urostomies)</p> <p><input type="checkbox"/> J2899. Other major genitourinary surgery</p> <p>Other Major Surgery</p> <p><input type="checkbox"/> J2900. Involving tendons, ligaments, or muscles</p> <p><input type="checkbox"/> J2910. Involving the gastrointestinal tract or abdominal contents from the esophagus to the anus, the biliary tree, gall bladder, liver, pancreas, or spleen - open or laparoscopic (including creation or removal of ostomies or percutaneous feeding tubes, or hernia repair)</p> <p><input type="checkbox"/> J2920. Involving the endocrine organs (such as thyroid, parathyroid, neck, lymph nodes, or thymus) - open</p> <p><input type="checkbox"/> J2930. Involving the breast</p> <p><input type="checkbox"/> J2940. Repair of deep ulcers, internal brachytherapy, bone marrow or stem cell harvest or transplant</p> <p><input type="checkbox"/> J5000. Other major surgery not listed above</p> </div> <p>NEW</p> <div> <p>Surgical Procedures - Complete only if J2100 = 1</p> <p>↓ Check all that apply</p> <p>Major Joint Replacement</p> <p><input type="checkbox"/> J2300. Knee Replacement - partial or total</p> <p><input type="checkbox"/> J2310. Hip Replacement - partial or total</p> <p><input type="checkbox"/> J2320. Ankle Replacement - partial or total</p> <p><input type="checkbox"/> J2330. Shoulder Replacement - partial or total</p> <p>Spinal Surgery</p> <p><input type="checkbox"/> J2400. Involving the spinal cord or major spinal nerves</p> <p><input type="checkbox"/> J2410. Involving fusion of spinal bones</p> <p><input type="checkbox"/> J2420. Involving lamina, discs, or facets</p> <p><input type="checkbox"/> J2499. Other major spinal surgery</p> <p>Other Orthopedic Surgery</p> <p><input type="checkbox"/> J2500. Repair fractures of the shoulder (including clavicle and scapula) or arm (but not hand)</p> <p><input type="checkbox"/> J2510. Repair fractures of the pelvis, hip, leg, knee, or ankle (not foot)</p> <p><input type="checkbox"/> J2520. Repair but not replace joints</p> <p><input type="checkbox"/> J2530. Repair other bones (such as hand, foot, jaw)</p> <p><input type="checkbox"/> J2599. Other major orthopedic surgery</p> <p>Neurological Surgery</p> <p><input type="checkbox"/> J2600. Involving the brain, surrounding tissue or blood vessels (excludes skull and skin but includes cranial nerves)</p> <p><input type="checkbox"/> J2610. Involving the peripheral or autonomic nervous system - open or percutaneous</p> <p><input type="checkbox"/> J2620. Insertion or removal of spinal or brain neurostimulators, electrodes, catheters, or CSF drainage devices</p> <p><input type="checkbox"/> J2699. Other major neurological surgery</p> <p>Cardiopulmonary Surgery</p> <p><input type="checkbox"/> J2700. Involving the heart or major blood vessels - open or percutaneous procedures</p> <p><input type="checkbox"/> J2710. Involving the respiratory system, including lungs, bronchi, trachea, larynx, or vocal cords - open or endoscopic</p> <p><input type="checkbox"/> J2799. Other major cardiopulmonary surgery</p> <p>Genitourinary Surgery</p> <p><input type="checkbox"/> J2800. Involving genital systems (such as prostate, testes, ovaries, uterus, vagina, external genitalia)</p> <p><input type="checkbox"/> J2810. Involving the kidneys, ureters, adrenal glands, or bladder - open or laparoscopic (includes creation or removal of nephrostomies or urostomies)</p> <p><input type="checkbox"/> J2899. Other major genitourinary surgery</p> <p>Other Major Surgery</p> <p><input type="checkbox"/> J2900. Involving tendons, ligaments, or muscles</p> <p><input type="checkbox"/> J2910. Involving the gastrointestinal tract or abdominal contents from the esophagus to the anus, the biliary tree, gall bladder, liver, pancreas, or spleen - open or laparoscopic (including creation or removal of ostomies or percutaneous feeding tubes, or hernia repair)</p> <p><input type="checkbox"/> J2920. Involving the endocrine organs (such as thyroid, parathyroid, neck, lymph nodes, or thymus) - open</p> <p><input type="checkbox"/> J2930. Involving the breast</p> <p><input type="checkbox"/> J2940. Repair of deep ulcers, internal brachytherapy, bone marrow or stem cell harvest or transplant</p> <p><input type="checkbox"/> J5000. Other major surgery not listed above</p> </div>
---	-----------------	------	---

Track Changes
from Chapter 3 Section J v1.17.1
to Chapter 3 Section J v1.18.11

Chapter	Section	Page(s) in version 1.18.11	Change
3	J2300– J5000	J-44	<p>2. Determine whether the surgeries require active care during the SNF stay: Once a recent surgery is identified, <u>it must be determined if the surgery requires active care during the SNF stay.</u> Surgeries requiring active care during the SNF stay are surgeries that have a direct relationship to the resident’s primary SNF diagnosis, as coded in I0020B.</p> <ul style="list-style-type: none"> Do not include conditions that have been resolved, do not affect the resident’s current status, or do not drive the resident’s plan of care during the 7-day look-back period-period, as these would be considered surgeries that do not require active care during the SNF stay.