J0100: Pain Management

J0100. Pain Management - Complete for all residents, regardless of current pain level

At any time in the last **5** days, has the resident:

Enter Code ☐ **A. Received scheduled pain medication regimen?**
0. **No**
1. **Yes**

Enter Code ☐ **B. Received PRN pain medications OR was offered and declined?**
0. **No**
1. **Yes**

Enter Code ☐ **C. Received non-medication intervention for pain?**
0. **No**
1. **Yes**

Item Rationale

Health-related Quality of Life

- Pain can cause suffering and is associated with inactivity, social withdrawal, depression, and functional decline.
- Pain can interfere with participation in rehabilitation.
- Effective pain management interventions can help to avoid these adverse outcomes.

Planning for Care

- Goals for pain management for most residents should be to achieve a consistent level of comfort while maintaining as much function as possible.
- Identification of pain management interventions facilitates review of the effectiveness of pain management and revision of the plan if goals are not met.
- Residents may have more than one source of pain and will need a comprehensive, individualized management regimen.
- Most residents with moderate to severe pain will require regularly dosed pain medication, and some will require additional PRN (as-needed) pain medications for breakthrough pain.
- Some residents with intermittent or mild pain may have orders for PRN dosing only.

DEFINITION

PAIN MEDICATION REGIMEN

Pharmacological agent(s) prescribed to relieve or prevent the recurrence of pain. Include all medications used for pain management by any route and any frequency during the look-back period. Include oral, transcutaneous, subcutaneous, intramuscular, rectal, intravenous injections or intraspinal delivery. This item does not include medications that primarily target treatment of the underlying condition, such as chemotherapy or steroids, although such treatments may lead to pain reduction.

J0100: Pain Management (cont.)

- Non-medication pain (non-pharmacologic) interventions for pain can be important adjuncts to pain treatment regimens.
- Interventions must be included as part of a care plan that aims to prevent or relieve pain and includes monitoring for effectiveness and revision of care plan if stated goals are not met. There must be documentation that the intervention was received and its effectiveness was assessed. It does not have to have been successful to be counted.

Steps for Assessment

1. Review medical record to determine if a pain regimen exists.
2. 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 day*s*. Include information from all disciplines.

Coding Instructions for J0100A-C

Determine all interventions for pain provided to the resident any time in the last 5 days. Answer these items even if the resident currently denies pain.

Coding Instructions for J0100A, Been on a Scheduled Pain Medication Regimen

- **Code 0, no:** if the medical record does not contain documentation that a scheduled pain medication was received.
- **Code 1, yes:** if the medical record contains documentation that a scheduled pain medication was received.

Coding Instructions for J0100B, Received PRN Pain Medication

- **Code 0, no:** if the medical record does not contain documentation that a PRN medication was received or offered.
- **Code 1, yes:** if the medical record contains documentation that a PRN medication was either received OR was offered but declined.

DEFINITIONS

SCHEDULED PAIN MEDICATION REGIMEN
Pain medication order that defines dose and specific time interval for pain medication administration. For example, "once a day," "every 12 hours."

PRN PAIN MEDICATIONS
Pain medication order that specifies dose and indicates that pain medication may be given on an as needed basis, including a time interval, such as "every 4 hours as needed for pain" or "every 6 hours as needed for pain."

NON-MEDICATION PAIN INTERVENTION
Scheduled and implemented nonpharmacological interventions include, but are not limited to, biofeedback, application of heat/cold, massage, physical therapy, nerve block, stretching and strengthening exercises, chiropractic, electrical stimulation, radiotherapy, ultrasound and acupuncture. Herbal or alternative medicine products are not included in this category.

J0100: Pain Management (cont.)

Coding Instructions for J0100C, Received Non-medication Intervention for Pain

- **Code 0, no:** if the medical record does not contain documentation that a non-medication pain intervention was received.
- **Code 1, yes:** if the medical record contains documentation that a non-medication pain intervention was scheduled as part of the care plan and it is documented that the intervention was actually received and assessed for efficacy.

Coding Tips

- Code only pain medication regimens without PRN pain medications in J0100A. Code receipt of PRN pain medications in J0100B.
- For J0100B code only residents with PRN pain medication regimens here. If the resident has a scheduled pain medication J0100A should be coded.

Examples

1. The resident's medical record documents that *they* received the following pain management in the *l*ast 5 days:
   - 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.

     Coding: J0100A would be **coded 1, yes**.

     Rationale: Medical record indicated that resident received a scheduled pain medication *in* the *last* 5 day*s*.

     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 *in* the *last* 5 day*s*.

     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) *in* the *last* 5 day*s*.
2. The resident's medical record includes the following pain management documentation:
   - Morphine sulfate controlled-release 15 mg PO Q 12 hours: Resident refused every dose of medication *in* the *last* 5 day*s*. No other pain management interventions were documented.

J0100: Pain Management (cont.)

Coding: J0100A would be **coded 0, no.**

Rationale: The medical record documented that the resident did not receive scheduled pain medication *in* the *last* 5 day*s*. Residents may refuse scheduled medications; however, medications are not considered "received" if the resident refuses the dose.

Coding: J0100B would be **coded 0, no**.

Rationale: The medical record contained no documentation that the resident received or was offered and declined any PRN medications *in* the *last* 5 day*s*.

Coding: J0100C would be **coded 0, no**.

Rationale: The medical record contains no documentation that the resident received non-medication pain intervention *in* the *last* 5 day*s*.