TIP SHEET
MDS CODING FOR PAIN

DEFINITION: According the RAI Manual, "pain refers to any type of physical pain or discomfort in any part of the body". "The pain experience is very subjective; pain is whatever the resident says it is". Pg 3-141

J2 INTENT: To record the **frequency and intensity** of signs and symptoms of pain. For care planning purposes this item can be used to identify indicators of pain as well as to monitor the resident's response to pain management interventions. **MDS 2.0 only captures pain symptoms, not treatment of pain.**

J2 PROCESS:
1. Speak to the resident
2. Observe the resident (guarding, protecting an area of the body, or particular behaviors noted)
3. Consult with direct care staff over all shifts
4. Review the resident's record

J2 CODING:
J2a: Code for the frequency of pain during the observation period.
J2b: Code the highest intensity of pain that occurred during the observation period.
Code for the presence or absence of pain, regardless of pain management efforts; i.e. breakthrough pain.

J2 DOCUMENTATION:
Facilities should have a consistent, uniform and standardized process to measure and assess pain. Use your best clinical judgment when coding. If you have difficulty determining the exact frequency or intensity of pain, code for the more severe level of pain.

J3 INTENT: To record the location of physical pain as described by the resident or discerned from objective physical and laboratory tests.

a. Back pain	f. Incisional pain
b. Bone pain	g. Joint pain (other than hip)
c. Chest pain while doing usual activities	h. Soft tissue pain
d. Headache	i. Stomach pain
e. Hip pain	j. Other

J3 PROCESS:
1. Speak to the resident
2. Observe the resident (guarding, protecting an area of the body, or particular behaviors noted)
3. Consult with direct care staff over all shifts
4. Review the resident's record
5. Use your best clinical judgment

J3 CODING: Check all that apply during the last 7 days. If the resident has mouth pain, check item K1c. Note that J3 is not included in the quarterly assessment forms.

EXAMPLES:
1. Mr. C. is cognitively intact. He has long-term DJD and his pain is well managed on Celebrex daily. He stated that on most days he feels little to no pain. However, Mr. C. was unable to ambulate for long distances on two days last week, as he was experiencing moderate pain in his knees. Mr. C stated that he needed additional assistance from the CNA to walk to the dining room on those days and required additional pain medication. He says that he no longer feels that intensity of pain. Code J2a (Frequency) as 1 (pain less than daily); J2b (Intensity) as 2 (moderate pain); and J3 (Site) should have g (joint pain) checked.

2. Mrs. S is cognitively intact. She has a Duragesic patch on due to persistent pain in most joints, especially her back and right hip, associated with DJD and Osteoporosis. During the last 7 days she has not required anything additional for pain (no breakthrough pain) and states that the patch is working well to relieve her pain. Code J2a as 0 (no pain). Nothing will be checked in either J2b or J3.

QIPMO: University of Missouri, Sinclair School of Nursing - October 2006