MDS Round-Up 2018!

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RELIAS

Presented by SIMPLELTC™

A BRIGGS HEALTHCARE COMPANY

Presenter

- **Ronald Orth, RN, CMAC, CHC** obtained a nursing degree from Milwaukee Area Technical College in 1985 and a B. A. in Health Care Administration from Concordia University in 1996. Mr. Orth possess over 30 years of nursing experience with over 20 of those in the Skilled Nursing industry. Mr. Orth has extensive experience in teaching Medicare regulations to healthcare providers both in the US and internationally. Mr. Orth is currently the Senior SNF Regulatory Analyst at Relias Learning and is certified in Healthcare Compliance through the Compliance Certification Board (CCB). Ron is also an approved ICD-10-CM trainer with AHIMA.

Interview Clarifications

Timing of Interviews

- Section C (BIMS) – Conducted during the 7 day lookback period, **preferably on the ARD or the day before.**
- Section D (PHQ-9) - **Conducted during the 7-day lookback period. Preferably on the ARD or the day before.**
- Section F (Activities/Preferences) – During the 7-day lookback period.
- Section J (Pain) – **Conducted anytime during the 5-day lookback period. It is PREFERRED to conduct on the ARD or the day before.**

Interview Clarifications

- Applies to all interview sections
  - Section C – BIMS
  - Section D – PHQ-9
  - Section F – Activities and Preferences
  - Section J – Pain
- **Staff interview** should **not be completed** in place of resident interview **if the resident interview should have been completed**.
  - Answer “Gateway” question as “yes”
  - Dash interview items
- B0700 should **NOT** be coded as “Rarely/Never Understood” if any of the **resident interviews were completed**.

Section I

New Item – I0020

- Resident's primary medical condition
- Provides check boxes for 14 different items

I0020. Indicate the resident's primary medical condition category

Enter Code ☐☐

Indicate the resident's primary medical condition category that best describes the primary reason for admission
Complete only if A0310B = 01

01. **Stroke**
02. **Non-Traumatic Brain Dysfunction**
03. **Traumatic Brain Dysfunction**
04. **Non-Traumatic Spinal Cord Dysfunction**
05. **Traumatic Spinal Cord Dysfunction**
06. **Progressive Neurological Conditions**
07. **Other Neurological Conditions**
08. **Amputation**
09. **Hip and Knee Replacement**
10. **Fractures and Other Multiple Trauma**
11. **Other Orthopedic Conditions**
12. **Debility, Cardiorespiratory Conditions**
13. **Medically Complex Conditions**
14. **Other Medical Condition** If "Other Medical Condition," enter the ICD code in the boxes

I0020A.

☐☐☐☐☐☐☐☐

RELIAS

Section I

- Select the condition that represents the primary condition that resulted in resident's admission to the nursing facility.
- If #14 selected, enter an appropriate ICD-10-CM code in I0020.
- If any condition 1 – 13 selected, then item I0020A is left blank.
- Include the primary medical condition in Section I, Active Diagnoses

Section I

- These items are used in the Risk Adjustment calculation for new QRP QMs:
  - Change in Self-Care Score for Medical Rehabilitation Residents
  - Change in Mobility Score for Medicare Rehabilitation Residents
  - Discharge Self-Care Score for Medical Rehabilitation Residents
  - Discharge Mobility Score for Medical Rehabilitation Residents

Section I

- **Code 01, Stroke,** *if the resident's primary medical condition category is due to stroke.* ***Examples include ischemic stroke, subarachnoid hemorrhage, cerebral vascular accident (CVA), and other cerebrovascular disease.***
- **Code 02, Non-Traumatic Brain Dysfunction,** *if the resident's primary medical condition category is non-traumatic brain dysfunction.* ***Examples include Alzheimer's disease, dementia with or without behavioral disturbance, malignant neoplasm of brain, and anoxic brain damage.***
- **Code 03, Traumatic Brain Dysfunction,** *if the resident's primary medical condition category is traumatic brain dysfunction.* ***Examples include traumatic brain injury, severe concussion, and cerebral laceration and contusion.***
- **Code 04, Non-Traumatic Spinal Cord Dysfunction,** *if the resident's primary medical condition category is non-traumatic spinal cord injury.* ***Examples include spondylosis with myelopathy, transverse myelitis, spinal cord lesion due to spinal stenosis, and spinal cord lesion due to dissection of aorta.***

Section I

- **Code 05, Traumatic Spinal Cord Dysfunction,** *if the resident's primary medical condition category is due to traumatic spinal cord dysfunction.* ***Examples include paraplegia and quadriplegia following trauma.***
- **Code 06, Progressive Neurological Conditions,** *if the resident's primary medical condition category is a progressive neurological condition.* ***Examples include multiple sclerosis and Parkinson's disease.***
- **Code 07, Other Neurological Conditions,** *if the resident's primary medical condition category is other neurological condition.* ***Examples include cerebral palsy, polyneuropathy, and myasthenia gravis.***
- **Code 08, Amputation,** *if the resident's primary medical condition category is an amputation. An example is acquired absence of limb.*

Section I

- **Code 09, Hip and Knee Replacement,** *if the resident's primary medical condition category is due to a hip or knee replacement. An example is total knee replacement.* ***If hip replacement is secondary to hip fracture, code as fracture.***
- **Code 10, Fractures and Other Multiple Trauma,** *if the resident's primary medical condition category is fractures and other multiple trauma.* ***Examples include hip fracture, pelvic fracture, and fracture of tibia and fibula.***
- **Code 11, Other Orthopedic Conditions,** *if the resident's primary medical condition category is other orthopedic condition. An example is unspecified disorders of joint.*
- **Code 12, Debility, Cardiorespiratory Conditions,** *if the resident's primary medical condition category is debility or a cardiorespiratory condition.* ***Examples include chronic obstructive pulmonary disease (COPD), asthma, and other malaise and fatigue.***

Section I

- **Code 13, Medically Complex Conditions,** *if the resident's primary medical condition category is a medically complex condition.* ***Examples include diabetes, pneumonia, chronic kidney disease, open wounds, pressure ulcer/injury, infection, and disorders of fluid, electrolyte, and acid-base balance.***
- **Code 14, Other Medical Condition,** *if the resident's primary medical condition category is not one of the listed categories.* ***Enter the International Classification of Diseases (ICD) code, including the decimal, in I0200A. If item I0020 is coded 1–13, do not complete I0020A.***

Example 1

Mrs. E is an 82-year-old female who was hospitalized for a hip fracture with subsequent total hip replacement and is admitted for rehabilitation. The admitting physician documents Mrs. E's primary medical condition as total hip replacement (THR) in her medical record. The hip fracture resulting in the total hip replacement is also documented in the medical record in the discharge summary from the acute care hospital.

Answer: I0020 = Code 10, Fractures and Other Multiple Trauma

Example 2

Mrs. H is a 93-year-old female with a history of hypertension and chronic kidney disease who is admitted to the facility, where she will complete her course of intravenous (IV) antibiotics after an acute episode of urosepsis. The discharge diagnoses of urosepsis, chronic kidney disease, and hypertension are documented in the physician's discharge summary from the acute care hospital and are incorporated into Mrs. H's medical record.

Answer: I0020 = Code 13, Complex Medical Condition

Section I

Quadriplegia Clarification

- Quadriplegia primarily refers to the paralysis of all four limbs, arms and legs, caused by spinal cord injury.
- Coding I5100 Quadriplegia is limited to spinal cord injuries and must be a primary diagnosis and not the result of another condition.
  - Functional Quadriplegia would NOT be coded
  - Spastic Quadriplegia due to Cerebral Palsy, would not be coded as quadriplegia.

Section J

New Item – J0200 Prior Surgery

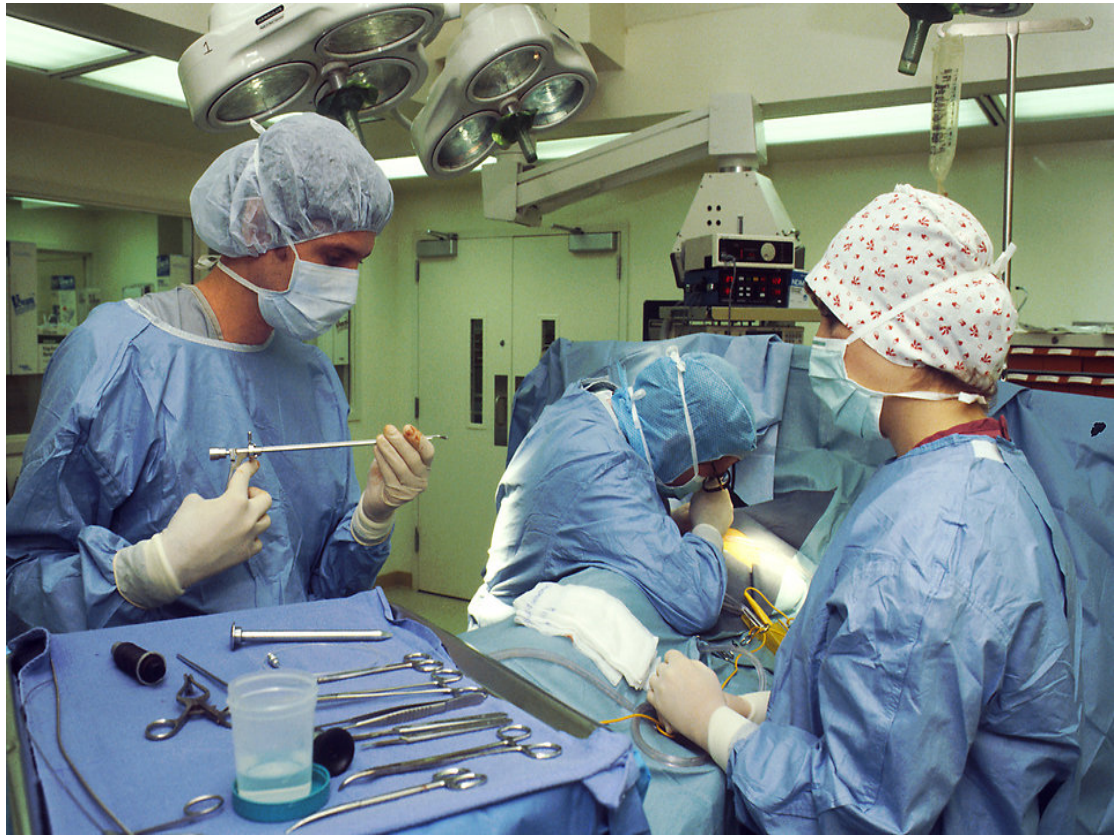
- Indicate if the resident has had a major surgery in the 100 days prior to admission.
- This item will be used to determine therapy category under the PDPM system.
  - Anticipate a subitem next year to identify the type of surgery.

J2000. Prior Surgery - Complete only if A0310B = 01	
Enter Code ☐	Did the resident have major surgery during the **100 days prior to admission**? 0. **No** 1. **Yes** 8. **Unknown**

Section J

Definition of Major Surgery

- All 3 of the following must be met:
    1. Must have been an inpatient of a hospital
    2. Had general anesthesia
    3. Surgery carried some degree of risk to the resident's life or the potential for severe disability



Example(s)

- Bowel resection 5 months ago (admitted/general anesthesia)
  - **Answer = 0, No** (greater than 100 days ago).
- Admitted to SNF after 4 day stay following complicated cholecystectomy, under general anesthesia
  - **Answer – 1, Yes (meets criteria for ”Major Surgery”)**
- Skin lesion biopsy performed as outpatient 2 months ago.
  - **Answer = 0, No** (does not meet criteria for “Major Surgery”)
- Surgical debridement of a wound, outpatient under local anesthesia
  - **Answer = No** (does not meet criteria for “Major Surgery”)

Section K

Change in Coding Instructions related to K0510 and K0710

- CMS no longer requires completion of Column 1 for K0510C or K0510D
- Some states may still require. Need to check your State requirements

K0510. Nutritional Approaches

Check all of the following nutritional approaches that were performed during the last **7 days**

1. **While NOT a Resident**
   Performed ***while NOT a resident*** of this facility and within the ***last 7 days***. Only check column 1 if resident entered (admission or reentry) IN THE LAST 7 DAYS. If resident last entered 7 or more days ago, leave column 1 blank
2. **While a Resident**
   Performed ***while a resident*** of this facility and within the ***last 7 days***

	1. While NOT a Resident	2. While a Resident
	↓ Check all that apply ↓	
A. **Parenteral/IV feeding**	☐	☐
B. **Feeding tube** - nasogastric or abdominal (PEG)	☐	☐
C. **Mechanically altered diet** - require change in texture of food or liquids (e.g., pureed food, thickened liquids)	☒	☐
D. **Therapeutic diet** (e.g., low salt, diabetic, low cholesterol)	☒	☐
Z. **None of the above**	☐	☐

RELIAS

Section K

Change in coding instructions related to K0510 and K0710

- CMS no longer requires completion of Column 1 K0710A and B
- Some states may still require. Need to check your State requirements

K0710. Percent Intake by Artificial Route - Complete K0710 only if Column 1 and/or Column 2 are checked for K0510A and/or K0510B

	1. While NOT a Resident	2. While a Resident	3. During Entire 7 Days
1. While NOT a Resident Performed ***while NOT a resident*** of this facility and within the ***last 7 days***. Only enter a code in column 1 if resident entered (admission or reentry) IN THE LAST 7 DAYS. If resident last entered 7 or more days ago, leave column 1 blank **2. While a Resident** Performed ***while a resident*** of this facility and within the ***last 7 days*** **3. During Entire 7 Days** Performed during the entire ***last 7 days***	↓	Enter Codes	↓
A. Proportion of total calories the resident received through parenteral or tube feeding 1. **25% or less** 2. **26-50%** 3. **51% or more**	☐	☐	☐
B. Average fluid intake per day by IV or tube feeding 1. **500 cc/day or less** 2. **501 cc/day or more**	☐	☐	☐

Section M

Many wording revisions due to Ulcer vs. Injury

- Injury is used for closed wounds (Stage I, Deep Tissue Injury).
- Ulcer is used for open wounds (Stage 2 – 4, Unstageable D/T slough/eschar

Significant Change in Definition related to “Present on Admission”

- *If the pressure ulcer/injury was present on admission/entry or reentry and becomes unstageable due to slough or eschar, during the resident’s stay, the pressure ulcer/injury is coded at M0300F and* ***should not be coded as “present on admission.”***

Section M

Other Clarifications

- If two pressure ulcers/injuries occur on the same bony prominence and are separated, at least superficially, by skin, then count them as two separate pressure ulcers/injuries. Stage and measure each pressure ulcer/injury separately.
- *M1040D - Open lesions that develop as part of a disease or condition and are not coded elsewhere on the MDS, such as wounds, boils, cysts, and vesicles, should be coded in this item.*
- *M1040G-* Do not code cuts/lacerations or abrasions here. Although not recorded on the MDS, these skin conditions should be considered in the plan of care.
-

Section M

DELETED ITEMS!!!

- M0610 - Wound Measurements
- M0700 – Most Severe Tissue Type Present
- M0800 - New or Worsened Pressure Ulcer
- M0900 – Healed Pressure Ulcers

Section N

- 3 new items added
- To be used to fulfill **QRP QM** requirements
- QM- Drug Regimen Review
  - Medications reviewed upon admission
  - Significant clinical issues reported to physician or NPP and follow-up orders/recommendations implemented by midnight of the following day.
  - Upon discharge - any clinically significant clinical issues were reported and follow up orders/recommendations implemented by midnight of the following day.

N2001 and N2003

- **Coded only if assessment is coded as a 5-day (A0300B = 1)**
- 2 questions related to resident admission DRR

N2001. Drug Regimen Review - Complete only if A0310B = 01	
Enter Code ☐	**Did a complete drug regimen review identify potential clinically significant medication issues?** 0. **No** - No issues found during review → Skip to O0100, Special Treatments, Procedures, and Programs 1. **Yes** - Issues found during review → Continue to N2003, Medication Follow-up 9. **NA** - Resident is not taking any medications → Skip to O0100, Special Treatments, Procedures, and Programs
N2003. Medication Follow-up	
Enter Code ☐	**Did the facility contact a physician (or physician-designee) by midnight of the next calendar day and complete prescribed/ recommended actions in response to the identified potential clinically significant medication issues?** 0. **No** 1. **Yes**

Section N - N2001

N2001. Drug Regimen Review - Complete only if A0310B = 01	
Enter Code ☐	**Did a complete drug regimen review identify potential clinically significant medication issues?** 0. **No** - No issues found during review → Skip to O0100, Special Treatments, Procedures, and Programs 1. **Yes** - Issues found during review → Continue to N2003, Medication Follow-up 9. **NA** - Resident is not taking any medications → Skip to O0100, Special Treatments, Procedures, and Programs

Coding

0 – No, No issue found – DONE, go to Section 0.

1 – Yes, Issues found – Continue to N2003

9 – NA – Resident not taking medications – DONE, go to Section 0

Section N - N2003

N2003. Medication Follow-up	
Enter Code ☐	**Did the facility contact a physician (or physician-designee) by midnight of the next calendar day and complete prescribed/ recommended actions in response to the identified potential clinically significant medication issues?** 0. **No** 1. **Yes**

Only completed if answered ”YES” to N02001

Coding

0 – No

1 – Yes

Section N - N2005

N2005. Medication Intervention - Complete only if A0310H = 1	
Enter Code ☐	**Did the facility contact and complete physician (or physician-designee) prescribed/recommended actions by midnight of the next calendar day each time potential clinically significant medication issues were identified since the admission?** 0. **No** 1. **Yes** 9. **NA** - There were no potential clinically significant medication issues identified since admission or resident is not taking any medications

Covers entire stay, from Admission.

DRR is an ongoing process!

If N2003 is coded as “No”, then N2005 must also be coded as “No”

DRR

Examples of by ***midnight of the next calendar day****:*

- *A clinically significant medication issue is identified at 10:00 AM on 9/12/2017. The physician-prescribed/-recommended action is completed on or before 11:59 PM on 9/13/2017.*
- *A clinically significant medication issue is identified at 11:00 PM on 9/12/2017. The physician-prescribed/-recommended action is completed on or before 11:59 PM on 9/13/2017.*

DRR

If the physician prescribes an action that will take longer than midnight of the next calendar day to complete, then **code 1, Yes,** *should still be entered, if by midnight of the next calendar day, the clinician has taken the appropriate steps to comply with the recommended action.*

Example of a ***physician-recommended action that would take longer than midnight of the next calendar day to complete****:*

- *The physician writes an order instructing the clinician to monitor the medication issue over the next three days and call if the problem persists.*

DRR

The DRR includes **all medications:**

Prescribed and over-the-counter

- Including nutritional supplements, vitamins, and homeopathic and herbal products

Administered by any route

- Including oral, topical, inhalant, injection, sublingual, parenteral, and by infusion

Includes total parenteral nutrition (TPN) and oxygen

Clinically Significant Issues

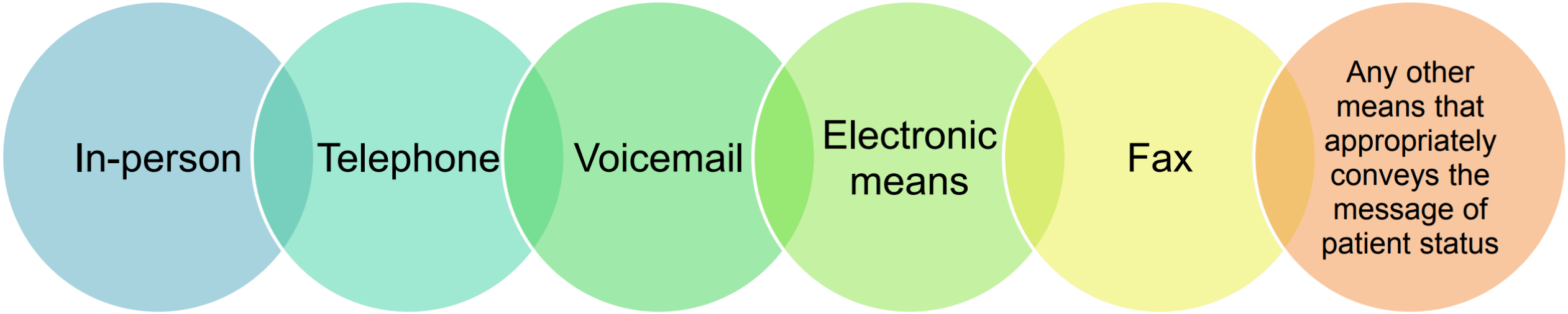
- A clinically significant medication issue is a potential or actual issue that, in the clinician's professional judgment, warrants:
  - Physician (or physician-designee) communication and
  - Completion of prescribed/recommended actions by **midnight of the next calendar day** (at the latest)

Clinically Significant Issues

- Medication prescribed despite medication allergy noted in the patient's medical record
- Adverse reactions to medications
- Ineffective drug therapy
- Drug interactions
  - Serious drug-drug, drug-food, and drug-disease interactions
- Duplicate therapy
  - For example, generic name and brand name-equivalent drugs are co-prescribed
- Wrong patient, drug, dose, route, and time errors
- Omissions (drugs missing from a prescribed regimen)
- Nonadherence (purposeful or accidental)

DRR

Examples of communication methods



DRR

Who can perform the DRR?

- The Centers for Medicare & Medicaid Services (CMS) does not provide guidance on who can or cannot code the DRR items
- Each facility determines their policies and procedures for completing the assessments
- Each facility provides patient care according to their unique characteristics and standards (for example, patient population)

- Not strictly a Pharmacy function!

DRR Overview

When should DRR be performed?

- Upon Admission, or as close to Admission as possible (Per CMS).
- Would try to get done within first 24 hours
- DRR is then ongoing throughout stay
  - Each new drug order
  - Each revision/change in drug order
  - Change in clinical status

DRR Overview

Medication Reconciliation

1. Compare admission orders with meds taken in hospital, prior to hospitalization?
2. Review diagnoses! Possible medications missing?
3. Labs (renal status, therapeutic levels)
4. Ongoing lab monitoring (digoxin, coumadin, etc.) – watch for increased frequency related to ATB usage, if applicable
5. Review allergies

DRR Overview

Admission Assessment

N2001

- Identifies if a drug regimen review was conducted upon admission, and if the clinician identified any potential or actual clinically significant medication issues

N2003

- Identifies if the facility contacted a physician (or physician-designee) and completed all physician- (or physician-designee)-prescribed/ recommended actions by midnight of the next calendar day in response to all potential or actual clinically significant medication issues identified upon admission

Discharge Assessment

N2005

- Identifies if the facility contacted a physician (or physician-designee) and completed all physician- (or physician-designee)-prescribed/ recommended actions by midnight of the next calendar day each time potential or actual clinically significant medication issues were identified throughout the stay

DRR Overview

Operational Changes

- Need to develop/review current process!
- Involve consulting pharmacist to assist in developing policy/procedure
- Need to educate nursing staff on what to look for upon admission and ongoing
- Educate physicians on new regulations and need for immediate response
- Documentation:
  - Statement by nurse that Admission DRR completed with no significant issues identified
  - Statement by nurse that Admission DRR completed with physician notified of significant clinical issues.
  - Statement by nurse that recommendations/new orders received and completed.

DRR

Example 1

- Mr. H was admitted to the SNF after undergoing cardiac surgery for a mitral valve replacement
- The acute care hospital discharge information indicated that Mr. H had a mechanical mitral heart valve and was to continue receiving anticoagulant medication
  - Are there anticoagulants ordered?
  - Do you have lab orders?
  - Do you have parameters for withholding the medication
  - When was the last lab checked?
  - Is the resident on any medications (i.e., antibiotics) that may impact the medication

DRR

Example 2

- Mr. P was admitted to the SNF with active diagnoses of pneumonia and atrial fibrillation
- The acute care facility medication record indicated that the resident was on a 7-day course of antibiotics and the resident had 3 remaining days of this treatment plan
- The nurse reviewing the discharge records from the acute care facility and the SNF admission medication orders noted that the resident had an order for an anticoagulation medication that required INR monitoring as well as the antibiotic

DRR

Example 2

- On the date of admission, the nurse contacted the physician caring for Mr. P and communicated a concern about a potential increase in Mr. P's INR with this combination of medications that could place the resident at greater risk for bleeding
- The physician provided orders for laboratory testing so that the resident's INR levels would be monitored over the next 3 days, starting that day
- However, the nurse did not request the first INR laboratory test until after midnight of the next calendar day

DRR

Example 3

- Ms. S was admitted to the SNF from an acute care hospital
- During the admitting nurse's review of the Ms. S's acute care hospital discharge records, it was noted that the resident had been prescribed metformin
- However, admission labs indicated that Ms. Shada serum creatinine of 2.4, consistent with renal insufficiency
- The admitting nurse contacted the physician to ask whether this drug would be contraindicated with Ms. S's current serum creatinine level.
- Three hours after the resident's admission to the facility, the physician provided orders to discontinue the metformin ordered a new medication.

Section O

Section O100

- Split Ventilator/Respirator into 2 different items

F. Invasive Mechanical Ventilator (ventilator or respirator)	☐	☐
G. Non-Invasive Mechanical Ventilator (BiPAP/CPAP)	☐	☐

Section O

Chemotherapy Clarification

- *Hormonal and other agents administered to prevent the recurrence or slow the growth of cancer should **NOT** be coded in this item, as they are not considered chemotherapy for the purpose of coding the MDS.*

- Has been CMS longstanding policy
- Now manualized

Section O

Selective Estrogen Receptor Modulator*

Block effects of estrogen

- Tamoxifen
- Evista
- Fareston

Aromatase Inhibitor*

Lower amount of estrogen

- Arimidex
- Aromasin
- Femara

Gonadotropin-releasing hormone*

Overstimulates production of certain hormones

Used to treat prostate cancer and endometriosis

- Lupron
- Eligard
- Lupron Depot
- Viadur

* May not be an all inclusive list

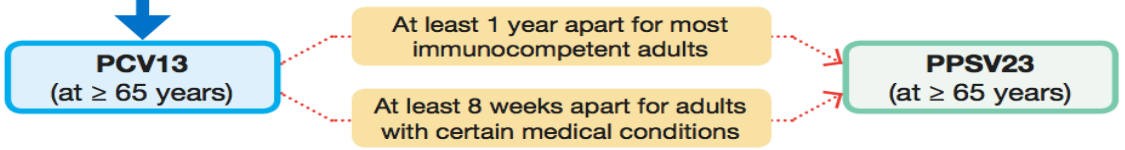
Section O

Pneumococcal

- *Removed old CDC diagram – was inconsistent with current guidance.*
- *Follow guidance at:*
  - ***https://www.cdc.gov/vaccines/vpd/pneumo/downloads/pneumo-vaccine- timing.pdf.***

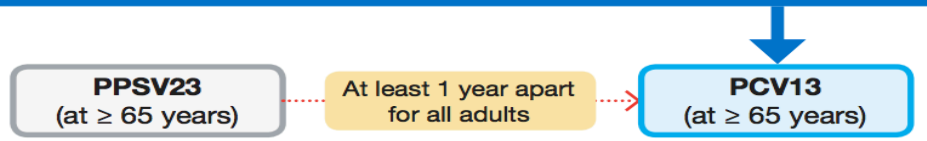
Pneumococcal vaccine timing for adults 65 years or older

For those who have not received any pneumococcal vaccines, or those with unknown vaccination history



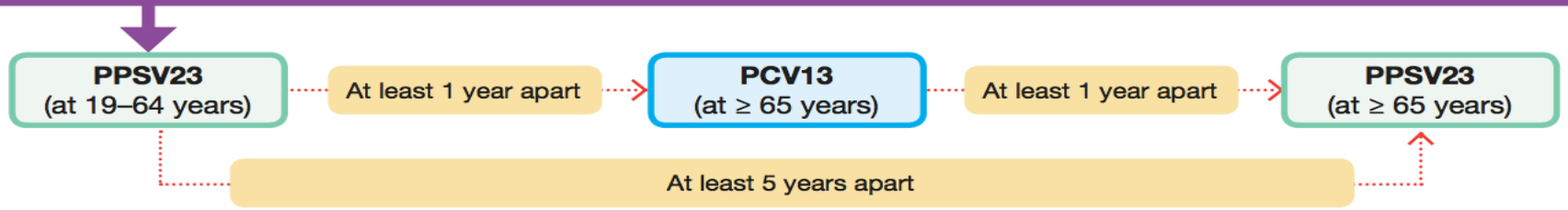
- Administer 1 dose of PCV13.
- Administer 1 dose of PPSV23 **at least 1 year** later for most immuno*competent* adults or **at least 8 weeks** later for adults with immuno*compromising* conditions, cerebrospinal fluid leaks, or cochlear implants. *See Table 1 for specific guidance.*

For those who have previously received 1 dose of PPSV23 at ≥ 65 years and no doses of PCV13



- Administer 1 dose of PCV13 **at least 1 year** after the dose of PPSV23 for all adults, regardless of medical conditions.

Indicated to receive 1 dose of PPSV23 at 19 through 64 years



Includes adults with:

- chronic heart or lung disease
- diabetes mellitus
- alcoholism
- chronic liver disease

Also includes adults who smoke cigarettes

For those who have **not** received any pneumococcal vaccines, or those with unknown vaccination history:

- Administer 1 dose of PPSV23 at 19 through 64 years.
- Administer 1 dose of PCV13 at 65 years or older. This dose should be given **at least 1 year** after PPSV23.
- Administer 1 final dose of PPSV23 at 65 years or older. This dose should be given **at least 1 year** after PCV13 and at least 5 years after the most recent dose of PPSV23.

Section GG

New Items Added

GG0100 Prior Functioning: Everyday Activities

Intent: To identify resident's functional status prior to current illness

GG0100. Prior Functioning: Everyday Activities. Indicate the resident's usual ability with everyday activities prior to the current illness, exacerbation, or injury

Coding:

3. **Independent** - Resident completed the activities by him/herself, with or without an assistive device, with no assistance from a helper.
2. **Needed Some Help** - Resident needed partial assistance from another person to complete activities.
1. **Dependent** - A helper completed the activities for the resident.
8. **Unknown.**
9. **Not Applicable.**

↓ Enter Codes In Boxes	
☐	**A. Self-Care:** Code the resident's need for assistance with bathing, dressing, using the toilet, or eating prior to the current illness, exacerbation, or injury.
☐	**B. Indoor Mobility (Ambulation):** Code the resident's need for assistance with walking from room to room (with or without a device such as cane, crutch, or walker) prior to the current illness, exacerbation, or injury.
☐	**C. Stairs:** Code the resident's need for assistance with internal or external stairs (with or without a device such as cane, crutch, or walker) prior to the current illness, exacerbation, or injury.
☐	**D. Functional Cognition:** Code the resident's need for assistance with planning regular tasks, such as shopping or remembering to take medication prior to the current illness, exacerbation, or injury.

Section GG

Coding Instructions:

Code 3, Independent – no assistance, with/without assistive devices

Code 2, Needed Some Help – needed partial assistance

Code 1, Dependent – helper completed activity; includes needing 2 person assist

Code 8, Unknown

Code 9, Not Applicable – were not applicable to the resident prior to current illness

Section GG

Example:

Mr. K has mild dementia and recently sustained a fall resulting in complex multiple fractures requiring multiple surgeries. Mr. K has been admitted to the SNF for rehabilitation. Mr. K's caregiver reports that when living at home, Mr. K needed reminders to take his medications on time, manage his money, and plan tasks, especially when he was fatigued.

GG0100D would be coded 2, Needed Some Help.

Section GG

New Item Added

G0110 – Prior Device Used

Check all that apply

GG0110. Prior Device Use. Indicate devices and aids used by the resident prior to the current illness, exacerbation, or injury	
↓ **Check all that apply**	
☐	**A. Manual wheelchair**
☐	**B. Motorized wheelchair and/or scooter**
☐	**C. Mechanical lift**
☐	**D. Walker**
☐	**E. Orthotics/Prosthetics**
☐	**Z. None of the above**

Section GG

Clarifications

Walker – any type of walker (pickup walker, hem-walker, rolling walkers, platform walkers.

Mechanical Lift = sit-to-stand, stand assist, full body lifts (e.g., Hoyer)

Section GG

New Items

GG0130 Self Care - 4 New Items

1. Admission Performance	2. Discharge Goal	
↓ Enter Codes In Boxes ↓		
☐☐	☐☐	**A. Eating:** The ability to use suitable utensils to bring food and/or liquid to the mouth and swallow food and/or liquid once the meal is placed before the resident.
☐☐	☐☐	**B. Oral hygiene:** The ability to use suitable items to clean teeth. Dentures (if applicable): The ability to insert and remove dentures into and from the mouth, and manage denture soaking and rinsing with use of equipment.
☐☐	☐☐	**C. Toileting hygiene:** The ability to maintain perineal hygiene, adjust clothes before and after voiding or having a bowel movement. If managing an ostomy, include wiping the opening but not managing equipment.
☐☐	☐☐	**E. Shower/bathe self:** The ability to bathe self, including washing, rinsing, and drying self (excludes washing of back and hair). Does not include transferring in/out of tub/shower.
☐☐	☐☐	**F. Upper body dressing:** The ability to dress and undress above the waist; including fasteners, if applicable.
☐☐	☐☐	**G. Lower body dressing:** The ability to dress and undress below the waist, including fasteners; does not include footwear.
☐☐	☐☐	**H. Putting on/taking off footwear:** The ability to put on and take off socks and shoes or other footwear that is appropriate for safe mobility; including fasteners, if applicable.

Section GG

New Items

GG0170 Mobility - 7 New Items

1. Admission Performance	2. Discharge Goal	
↓ Enter Codes in Boxes ↓		
☐☐	☐☐	**A. Roll left and right:** The ability to roll from lying on back to left and right side, and return to lying on back on the bed.
☐☐	☐☐	**B. Sit to lying:** The ability to move from sitting on side of bed to lying flat on the bed.
☐☐	☐☐	**C. Lying to sitting on side of bed:** The ability to move from lying on the back to sitting on the side of the bed with feet flat on the floor, and with no back support.
☐☐	☐☐	**D. Sit to stand:** The ability to come to a standing position from sitting in a chair, wheelchair, or on the side of the bed.
☐☐	☐☐	**E. Chair/bed-to-chair transfer:** The ability to transfer to and from a bed to a chair (or wheelchair).
☐☐	☐☐	**F. Toilet transfer:** The ability to get on and off a toilet or commode.
☐☐	☐☐	**G. Car transfer:** The ability to transfer in and out of a car or van on the passenger side. Does not include the ability to open/close door or fasten seat belt.
☐☐	☐☐	**I. Walk 10 feet:** Once standing, the ability to walk at least 10 feet in a room, corridor, or similar space. If admission performance is coded 07, 09, 10, or 88 → Skip to GG0170M, 1 step (curb)
☐☐	☐☐	**J. Walk 50 feet with two turns:** Once standing, the ability to walk at least 50 feet and make two turns.
☐☐	☐☐	**K. Walk 150 feet:** Once standing, the ability to walk at least 150 feet in a corridor or similar space.

Section GG

New Items

GG0170 Mobility - 7 New Items

1. Admission Performance	2. Discharge Goal	
↓ Enter Codes in Boxes ↓		
☐☐	☐☐	**L. Walking 10 feet on uneven surfaces:** The ability to walk 10 feet on uneven or sloping surfaces (indoor or outdoor), such as turf or gravel.
☐☐	☐☐	**M. 1 step (curb):** The ability to go up and down a curb and/or up and down one step. If admission performance is coded 07, 09, 10, or 88 → Skip to GG0170P, Picking up object
☐☐	☐☐	**N. 4 steps:** The ability to go up and down four steps with or without a rail. If admission performance is coded 07, 09, 10, or 88 → Skip to GG0170P, Picking up object
☐☐	☐☐	**O. 12 steps:** The ability to go up and down 12 steps with or without a rail.
☐☐	☐☐	**P. Picking up object:** The ability to bend/stoop from a standing position to pick up a small object, such as a spoon, from the floor.
	☐	**Q1. Does the resident use a wheelchair and/or scooter?** 0. **No** → Skip to GG0130, Self Care (Discharge) 1. **Yes** → Continue to GG0170R, Wheel 50 feet with two turns
☐☐	☐☐	**R. Wheel 50 feet with two turns:** Once seated in wheelchair/scooter, the ability to wheel at least 50 feet and make two turns.
	☐	**RR1. Indicate the type of wheelchair or scooter used.** 1. **Manual** 2. **Motorized**
☐☐	☐☐	**S. Wheel 150 feet:** Once seated in wheelchair/scooter, the ability to wheel at least 150 feet in a corridor or similar space.
	☐	**SS1. Indicate the type of wheelchair or scooter used.** 1. **Manual** 2. **Motorized**

Section GG

Coding of GG0130 and GG0170 – No Change in 01 – 06 Scoring

Code the resident's usual performance at the start of the SNF PPS stay (admission) for each activity using the 6-point scale. If activity was not attempted at the start of the SNF PPS stay (admission), code the reason. Code the resident's end of SNF PPS stay (discharge) goal(s) using the 6-point scale. Use of codes 07, 09, 10, or 88 is permissible to code end of SNF PPS stay (discharge) goal(s).

Coding:

Safety and **Quality of Performance** - If helper assistance is required because resident's performance is unsafe or of poor quality, score according to amount of assistance provided.

Activities may be completed with or without assistive devices.

06. **Independent** - Resident completes the activity by him/herself with no assistance from a helper.
05. **Setup or clean-up assistance** - Helper sets up or cleans up; resident completes activity. Helper assists only prior to or following the activity.
04. **Supervision or touching assistance** - Helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity. Assistance may be provided throughout the activity or intermittently.
03. **Partial/moderate assistance** - Helper does LESS THAN HALF the effort. Helper lifts, holds, or supports trunk or limbs, but provides less than half the effort.
02. **Substantial/maximal assistance** - Helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs and provides more than half the effort.
01. **Dependent** - Helper does ALL of the effort. Resident does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the resident to complete the activity.

Section GG

Coding of GG0130 and GG0170

4 “Not Attempted” Codes items

10 – Not attempted due to environmental limitations (NEW)

If activity was not attempted, code reason:

07. **Resident refused**
09. **Not applicable** - Not attempted and the resident did not perform this activity prior to the current illness, exacerbation, or injury.
10. **Not attempted due to environmental limitations** (e.g., lack of equipment, weather constraints)
88. **Not attempted due to medical condition or safety concerns**

Section GG

Overview of Coding Instructions

- **Admission Performance** – code based on first 3 days of Medicare Part A stay (based on A2400B)
- **Discharge Performance** – code based on last 3 days of Medicare Part A stay (based on A2400C).
- Coding is based on "**Usual Performance**" – will require **clinical judgement**
- If activity occurs multiple times (e.g., eating, toileting, dressing, bed mobility activities, bed/chair transfers , do not code most dependent, do not code most independent.
- Some items may only be assessed once, code that status. (e.g., car transfers, curbs, stairs)

Section GG

5-Day Assessment (Column 1)

- **ALL** items in Column 1 must be completed
- Base coding on first 3 days of Medicare Part A stay.
- **No DASHES!**
- Choose any number from the 1-6 scale; OR
- 1 of the 4 “not attempted” codes

5-day Assessment (Column 2)

- Must have **AT LEAST ONE** Discharge goal completed (may be in GG0130 or GG0170).
- **May use 1 of the 4 “Not Attempted” as goals.**
- May have more than 1 goal.
- Dash goals not completed.
- Goals may indicate an improvement, maintain, or possible decline.

Section GG

SNF PPS Discharge Assessment (Column 3)

- **ALL** items in Column 3 must be completed
- Base coding on last 3 days of Medicare Part A stay (A2400C)
- **No DASHES!**
- Choose any number from the 1-6 scale; OR
- 1 of the 4 “Not Attempted” codes

Use of Dashes

- Section GG # 1 reason for 2% penalty.
- Confusion on coding rules
- Use of dashes
- Not completed for Medicare Advantage, but assessment submitted.
- **Not all dashes are created equal**
- ONLY items used for QRP QM calculation are subject to the 2% penalty if dashed.

Section GG

PDPM Therapy Function Score

- Self Care: Eating
- Self Care Oral hygiene
- Self Care: Toileting hygiene
- Mobility: Sit to lying
- Mobility: Lying to sitting on side of bed
- Mobility: Sit to stand
- Mobility: Chair/bed transfer
- Mobility: Toilet Transfer
- Mobility: Walk 50 feet w/ 2 turns
- Mobility: Walk 150 feet

Nursing Function Score

- Self Care: Eating
- Self Care: Toileting hygiene
- Mobility: Sit to lying
- Mobility: Lying to sitting on side of bed
- Mobility: Sit to stand
- Mobility: Chair/bed transfer
- Mobility: Toilet Transfer

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