HOME HEALTH
QUALITY REPORTING PROGRAM
PROVIDER TRAINING

PARTICIPANT QUESTIONS FROM WEBINARS AND IN-PERSON TRAINING IN AUGUST, SEPTEMBER, AND NOVEMBER 2018

Current as of November 2018

Acronym List

Acronym	Definition
ACH	Acute Care Hospitalization
ADL	Activities of Daily Living
CASPER	Certification and Survey Provider Enhanced Reports
CMS	Centers for Medicare & Medicaid Services
COP	Condition of Participation
COTA	Certified Occupational Therapy Assistant
CY	Calendar Year
HH	Home Health
HHA	Home Health Agency
HHQI	Home Health Quality Initiative
HHRG	Home Health Resource Group
HHVBP	Home Health Value-Based Purchasing
IADL	Instrumental Activities of Daily Living
LPN	Licensed Practical Nurse
OAC	OASIS Automation Coordinator
OASIS	Outcome and Assessment Information Set
OT	Occupational Therapist
PAC	Post-Acute Care
PRA	Paperwork Reduction Act
PT	Physical Therapist
PTA	Physical Therapy Assistant
QAPI	Quality Assurance and Performance Improvement
QoPC	Quality of Patient Care
QRP	Quality Reporting Program
QTSO	QIES Technical Support Office
RN	Registered Nurse
ROC	Resumption of Care
SOC	Start of Care
TUG	Timed Up & Go

#	Question Category	Question	Answer
1	Changes in Skin Integrity	If a stage 3 pressure ulcer changes to a stage 4, would it not be a stage 4 at Start of Care (SOC)/Resumption of Care (ROC)?	If the first skin assessment completed on admission to home health (HH) services identifies a pressure ulcer, the stage of the pressure ulcer as identified on that initial skin assessment is what should be reported on the SOC Outcome and Assessment Information Set (OASIS). Any subsequent changes in numerical staging would be reported on subsequent OASIS assessments.
2	Changes in Skin Integrity	Would it be important to modify the OASIS once you can determine the unstageable ulcer current stage after the 5-day window?	You would not change the first skin assessment coding on the SOC/ROC.
3	Changes in Skin Integrity	I rarely see physician documentation on pressure ulcers. Can we obtain nursing notes or wound flowsheets from the referral source and use that information?	A pressure ulcer/injury may be reported on OASIS based on visualization of the wound, patient assessment and interview, review of relevant related historical documentation and clinical judgment re: etiology. Although the assessing clinician can report the observed ulcer/injury on the OASIS integumentary status items without physician confirmation, collaboration with the physician is required in order to add a diagnosis and ICD-10-CM code to the OASIS diagnosis items and the patient's plan of care and to receive related orders and/or provide physician ordered care related to the pressure ulcer/injury.
4	Changes in Skin Integrity	If the ulcer is related to a device (nasal cannula, endotracheal tube, etc.) on the skin from the pressure or friction of the tube, is that considered a pressure ulcer? Top of ear from nasal cannula is a common example.	An example of a pressure ulcer is a localized injury to skin/ or underlying tissue as a result of pressure. "Pressure ulcers/injuries are defined as localized injury to the skin and/or underlying tissue usually over a bony prominence, as a result of pressure, or pressure in combination with shear and/or friction. If pressure is not the primary cause of the lesion, do not report the wound as a pressure ulcer/injury." Mucosal injuries are not counted in pressure ulcer/injury coding.

#	Question Category	Question	Answer
5	Changes in Skin Integrity	Regarding Practice Coding Scenario 2 of the Changes in Skin Integrity Post-Acute Care: Pressure Ulcer/Injury (M1311) presentation from the November 6 and 7 Home Health QRP Provider Training in Baltimore, couldn't the pressure ulcer be coded as a stage 3 pressure ulcer even though the pressure ulcer was initially unstageable given the 5-day assessment window?	In this scenario, the initial skin assessment indicated the wound was covered with a nonremovable dressing, and then on day 4 an order to remove the dressing was received and the wound was assessed as a stage 3. The initial skin assessment is the one that should be coded on the OASIS. The general standard of practice for patients starting or resuming care is that patient assessments are completed as close to the actual time of the SOC/ROC as possible. For example, if a pressure ulcer/injury that is identified on the SOC date increases in numerical stage within the assessment time frame, the stage of the pressure ulcer/injury at the first skin assessment completed would be reported in M1311X1 at the SOC.
6	Changes in Skin Integrity	Do we need to document verification of the unstageable site that was then staged with a physician? If so, what information is needed in that documentation?	The assessing clinician can report the observed ulcer/injury on the OASIS integumentary status items without physician confirmation. Collaboration with the physician is required to add a diagnosis and ICD-10-CM code to the OASIS diagnosis items and the patient's plan of care and to receive related orders and/or provide physician-ordered care related to the pressure ulcer/injury.
7	Changes in Skin Integrity	If patient refuses to complete skin assessment since he or she is already up and sitting in chair, can another nurse return in the 5-day period and complete a skin assessment and collaborate versus the SOC nurse—including pressure ulcer info?	The assessing clinician may collaborate with a second clinician to gather information to code the pressure ulcer items, as long as the coding is based on the first skin assessment conducted at the SOC/ROC.
8	Changes in Skin Integrity	Can a SOC nurse elect to not do a skin assessment at SOC and allow second nurse to do it because a dressing can be changed within the 5-day period?	Assuming you are referring to a nonremovable dressing that the first nurse is visualizing, the pressure ulcer should be reported as unstageable due to a nonremovable dressing/device, as that was the status at the first skin assessment. This is true even if a second nurse observes the wound as a stageable pressure ulcer at a visit occurring within the 5-day assessment timeframe.
9	Drug Regimen Review	So if clinician sends a fax to the physician but only gets a confirmation that it was sent but no return of any changes or directions were given? So if the doctor gives no orders or changes then what would be chosen?	The communication must include both the clinician communicating with the physician and receiving a response from the physician or designee.

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10	Drug Regimen Review	Does there need to be a doctor order by midnight of the next day to answer yes? A lot of times we convey the information in time but do not hear back from the doctor until after the timeframe is over (e.g., 2 days later)?	The return communication does not necessarily need to be an order for an intervention, but there must be a response prior to midnight of the next day.
11	Drug Regimen Review	Does the SOC medication list have to match the hospital discharge med list or does it need to match what the patient is actually taking?	Medication reconciliation includes comparing available medications list(s) with medications the patient is currently taking to identify and resolve discrepancies.
12	Drug Regimen Review	If it is a known, repeat patient and the issue has been identified and resolved in prior episodes, does it need to be reported to the physician as a clinically significant issue if the physician has given prior instruction?	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)."
13	Drug Regimen Review	Does M2005 apply even if the issue is not identified or communicates what happened 3 years ago, before the M2001–M2005 series was in effect? Some of our patients are very long term...	M2005 says from the most recent SOC/ROC. If you have a very long-term patient who has not a single ROC after January 1, 2017, then yes, you would need to go back to the last SOC/ROC that defines the quality episode.
14	Drug Regimen Review	If no significant medication issues are documented throughout the stay, should I consider at discharge that no issues were identified mark N/A?	Yes, assuming the documentation accurately reflected the patient's status throughout the episode.
15	Drug Regimen Review	With a drug regimen review, what happens when SOC is Saturday and physician should reply by midnight Sunday an office is closed?	To report yes for M2003, the physician contact and completion of all prescribed/recommended actions must be completed by midnight of the next calendar day. This is true on weekends as well as weekdays.
16	Drug Regimen Review	A patient transfers from the hospital with the list of medication. Two days after admission, the pharmacy identifies an actual/potential medication issue, but not the agency's staff. The staff contacted the physician and implemented the order the same day. What would be responses to M2001 and M2003?	The agency/assessing clinician has collaborated with the pharmacy to identify the significant issue within the 5-day assessment timeframe, therefore the answer to M2001 would be yes. The physician was contacted the same day and responded the same day, and the action was implemented at that time. Therefore, the answer to M2003 would also be yes.

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17	Drug Regimen Review	Regarding Practice Coding Scenario 5 from the Drug Regimen Review with Follow-Up for Identified Issues presentation from the November 6 and 7 Home Health QRP Provider Training in Baltimore, the answer to M2005 on discharge was indicated as A. 0, No and the rationale was the response to M2003 at SOC being A. 0, No. Shouldn't the answer be C. 9, N/A with the rationale from bullet 4 on the question? No other medication issues arise during the episode.	M2005 would be 0. No. M2005 identifies if potential or actual clinically significant medication issues identified at the time of or at any time since the most recent SOC/ROC was communicated to the physician (or physician-designee) and to the extent possible, prescribed/recommended actions were completed by midnight of the next calendar day following their identification.
18	General	Are the OASIS-D datasets posted?	A draft version of the OASIS-D Guidance Manual containing the datasets is currently available for download from the Centers for Medicare & Medicaid Services (CMS) HH Quality Reporting Program (QRP) website. It can be accessed at the following URL: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HomeHealthQualityInits/HHQIOASISUserManual.html.
19	General	Explain when we should start using the OASIS-D? I know January 1, 2019, but does it go by the M0090 date? So if SOC date is December 31 and the OASIS is done the next day, January 1, then should we use the OASIS-C2?	Any OASIS assessment type (i.e., SOC, ROC, Follow-up, Discharge, Transfer, Death at home) with a M0090 "Date Assessment Completed" response of January 1, 2019, or later should utilize OASIS-D.

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20	General	Please specify the timeframe. The OASIS assessment needs to be completed within 5 days; however, how does day of assessment play into these GG items?	Assessment data can be collected entirely in the first visit or may be gathered during the assessment timeframe. The SOC/ROC function scores reflect the patient's baseline functional status from an assessment that occurs at or soon after the SOC/ROC. When collaboration is used, other agency staff may provide information to the assessing clinician on what he/she assessed during a visit conducted during the assessment timeframe. Each person who is collaborating may provide information that was collected utilizing the existing conventions, including the "day of assessment." For example, if desired, the physical therapist (PT) who visited on Wednesday may provide information that was relevant to the PT's "day of assessment" (the 24 hours that preceded the PT's visit and the time the PT was in the home) to the registered nurse (RN) for consideration when coding the SOC/ROC assessment items.
21	General	Any idea about when we will see Final Interpretive Guidelines for the Conditions of Participation (COPs)? Thank you.	"The final (Advanced Copy) of the Home Health Agency Interpretive Guidelines associated with the new Conditions of Participation (CoPs) have been completed and are now posted to the CMS website. They can be accessed at the following URL: https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Downloads/QSO18-25-HHA.pdf.
22	General	When would you utilize the dash?	A dash value indicates that no information is available. CMS expects use of the dash to be a rare occurrence. Please refer to the OASIS-D Guidance Manual for more information regarding dash use for specific OASIS items.
23	General	What if some of the removed elements were being used for agency Quality Assurance and Performance Improvement (QAPI) programs?	Data for the measures no longer included in the Home Health Quality Initiative (HHQI) or removed from the HH QRP may still appear on OASIS for previously established purposes that are not related to the HH QRP, and if still collected will be available to home health agencies, via the Certification and Survey Provider Enhanced Reports (CASPER) on-demand reports, for the purpose of monitoring and improving quality efforts.

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24	General	When can we download slides from the Introduction to OASIS-D webinar with the answers?	Training materials with answers to presentations are posted on the HH QRP Training web page at the following URL: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HomeHealthQualityInits/Home-Health-Quality-Reporting-Training.html.
25	General	Will software vendors be able to continue current format of the document, or will they be required to duplicate the actual format of OASIS-D?	There is no new or revised guidance on this issue for OASIS-D. Home health agencies (HHAs) are free to rearrange OASIS item sequence in a way that permits logical ordering within their own forms as long as the actual item content, skip patterns, and OASIS number remain the same. (See OASIS-D Guidance Manual, Appendix A).
26	General	Do you anticipate that the changes to OASIS will result in the completion of the OASIS taking less time? Has this been studied/quantified?	The HH Calendar Year (CY) 2018 Final Rule (CY2018 FR) page 51734, column 3, includes details of the calculations completed. CMS assumes that each data element requires 0.3 minutes of clinician time to complete. Considering the item removals, balanced with items added, this is determined to be a reduction in clinician burden per OASIS assessment of 11.4 minutes at SOC, 11.4 minutes at ROC, 0.6 minutes at Follow-Up, and 2.7 minutes at Discharge. There is an increase in clinician burden per assessment of 0.9 minutes at Death. In the Comment Responses 2018 (CMS 10545), CMS further clarified that the 0.3 minutes per item factor accounts for coding the items based on an assessment that takes place in the course of care. CMS's burden estimates are intended to reflect only the time needed to complete OASIS items and is independent of clinical time spent assessing the patient. CMS believes that burden estimates should not account for the time spent conducting a comprehensive assessment of the patient. Burden estimates are also not intended to reflect costs of training and operational processes; these are considered part of the operating costs for a HHA. CMS also points out that the Paperwork Reduction Act (PRA) guide states, "Generally, estimates should not include burden hours for customary and usual business practices."
27	General	Where can I get a copy of the OASIS-D guidance manual?	The draft version of the OASIS-D Guidance Manual can be found in the downloads section of the HH QRP User Manual web page at the following URL: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HomeHealthQualityInits/HHQIOASISUserManual.html.

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28	General	Can we use the patient scale for weights or does the agency need to provide the same for accuracy?	Weight should be measured in accordance with the agency's policies and procedures.
29	General	Which dataset (OASIS-C2 or OASIS-D) should be used for patients who began care prior to January 1, 2019?	The use of OASIS-D is based on M0090 date assessment completed. If the answer to M0090 will be January 1, 2019, or later, then you would use the OASIS-D data set. If the answer to M0090 will be December 31, 2018, or earlier, then you would use the OASIS-C2 dataset.
30	General	Will any of these measures be added to value-based purchasing States?	Our mission today is to focus on the HH quality reporting requirement. For value based purchasing questions, please ask HHVBPquestions@cms.hhs.gov.
31	General	Is the OASIS Item Set finalized now? Is the copy being used onsite in Baltimore, MD, now the final set?	CMS is still waiting final approval with the Office of Management and Budget. We assure you that we are aware of the need for this document. We will post it as soon as it is approved.
32	General	How will these changes impact value-based purchasing & Star quality measures?	The measures that have been removed or added to the HH QRP or HHQI and that are effective with OASIS-D implementation January 1, 2019, do not have an impact on the Quality of Patient Care (QoPC) Star Rating or on the Home Health Value-Based Purchasing (HHVBP) Model as these measures are not currently included in the QoPC Star Rating or HHVBP.
33	General	By licensed professionals, I assume you mean those identified by OASIS conventions as allowed to perform data collection even though licensed practical nurses (LPNs) and therapy assistants are licensed?	CMS has not made any revisions to who can complete the OASIS.
34	General	Please define episode.	A quality episode is the time period that is used to calculate quality measures. It begins with a SOC or ROC and ends with the next transfer, discharge, or death at home.
35	General	Was M2301 or M2310 revised?	The response options for item M2310 have changed. General guidance for item M2301 was updated in the OASIS Guidance Manual.

#	Question Category	Question	Answer
36	Reports	How does an agency correct erroneous data on the HHA Review and Correct Report? The denominator on our new or worsened pressure ulcers is wrong for Q4 2017.	Assuming the report in question falls within the timeframe to be corrected, the provider should follow the manual instructions for submitting the corrections. These corrections must be submitted prior to the "freeze date" for the quarter in question. Questions related to how to correct OASIS data may be submitted to the agency's State OASIS Automation Coordinator (OAC). A list of OACs is available at (https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/OASIS/Downloads/OASISautomationcoordinators.pdf). Questions related to quality measure calculations or quality measure reports may be submitted to the HH Quality Help Desk at homehealthqualityquestions@cms.hhs.gov.
37	Reports	How are data corrected?	Each State has designated an OASIS Automation (Technical) Coordinator with the responsibility to ensure that all home care providers in the State have access to: Training on the electronic submission of OASIS data, Training on correction of errors to OASIS data, Support in answering questions on the technical aspects of OASIS. A list of OASIS Automation coordinators by state is available at https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/OASIS/Downloads/OASISautomationcoordinators.pdf.
38	Reports	What is the number of staff per agency that can access the CASPER report system?	Generally, there is a two-person limit to access. Agencies with requests for additional staff may contact the QIES Technical Support Office (QTSO) Help Desk at Help@qtso.com with their request and rationale for the request.
39	Reports	What do you mean by "OASIS- based"? How will the Acute Care Hospitalization (ACH) data track? Is this going to be on hold?	The term "OASIS-based" related to the quality measure of ACH indicates that this measure is calculated using OASIS data. The ACH measure will no longer be reported in the CASPER Reports in 2019 as an OASIS item used to calculate this measure is no longer included in OASIS-D, which is effective January 1, 2019.

#	Question Category	Question	Answer
40	Section GG	Is there a timeframe for determining "prior" functioning in GG0100. Prior Functioning: Everyday Activities?	In responding to GG0100. Prior Functioning: Everyday Activities, the activities should be reported based upon the patient's usual ability prior to the current illness, exacerbation, or injury. This is the patient's functional ability prior to the onset of the current illness, exacerbation of a chronic condition, or injury (whichever is most recent) that initiated this episode of care. Clinicians should use clinical judgement within these parameters in determining the timeframe that is considered "prior to the current illness, exacerbation, or injury."
41	Section GG	Does the "majority of tasks" convention apply to all Section GG items?	The "majority of tasks" convention that applies for the M1800 Activities of Daily Living (ADL)/Instrumental Activities of Daily Living (IADL) items does not apply to the GG Prior Functioning, Self-Care, and Mobility items. For GG0100. Prior Functioning, if a patient completed all of the activities by him/herself, with or without an assistive device, with no assistance from a helper, code as "3. Independent." If a patient needed partial assistance from another person to complete any of the activities, code as "2. Needed Some Help." If a helper completed all of the activities for the patient because the patient could not assist, code as "1. Dependent." For the GG0130/GG0170 activities that include multiple activities (e.g., Upper body dressing for a patient who wears an undershirt, blouse, and sweater), code GG0130F using the 6-point scale based on the patient's ability to complete all relevant upper body dressing tasks.
42	Section GG	When would a patient's prior level of function be coded "Not applicable" for GG0100?	For GG0100, code 09, N/A, when the patient's prior functional status was such that he/she could not complete an activity, and the activity could not be completed by a helper. For instance, for GG0100B. Ambulation, if prior to the current illness, exacerbation, or injury, the patient could not ambulate safely, even with assistance, code 09, N/A, since a helper could not complete the activity of walking for the patient.
43	Section GG	Is the intent behind the new GG questions to ask these questions based on how the patient can "safely" do these activities, similar to the M00 questions?	Safety is always a primary consideration. Patients should be allowed to perform these activities as independently as possible, as long as they can safely do so.

#	Question Category	Question	Answer
44	Section GG	How does patient safety factor into the coding of GG0100?	In responding to GG0100 Prior Functioning: Everyday Activities, the activities should be reported based upon the patient's usual ability prior to the current illness, exacerbation, or injury. This is the patient's functional ability prior to the onset of the current illness, exacerbation of a chronic condition, or injury (whichever is most recent) that initiated this episode of care. For a SOC, G0100 Prior Functioning most likely is gathered by patient/caregiver report. Clinicians should attempt to elicit from the patient/caregiver details that will allow determination of the patient's prior status, taking into consideration patient safety.
45	Section GG	For GG0100. Prior Functioning: Everyday Activities, what is the difference between a dash and Code 8, Unknown?	For GG0100, Code 8, Unknown, when no information about the patient's usual ability prior to the current illness, exacerbation, or injury is available after attempting to interview the patient or family and after reviewing the patient's clinical record. A dash indicates that no information is available and no attempt was made to gather the information.
46	Section GG	Cues and supervision are considered assistance, correct?	Yes. For coding GG0130 and GG0170, supervision and verbal cues would be considered Code 04, Supervision or touching assistance.
47	Section GG	Are verbal cues and set-up assist considered assistance for the GG0100 item?	Yes. For GG0100, verbal cues and set-up assistance would be considered as Code 2, Needed some help.
48	Section GG	Can you give examples of when to use the dash for item GG0100?	A dash would be an appropriate response if there is no information regarding the patient's prior ability with everyday activities because the agency did not attempt to collect this information. For example, at SOC, the patient was recently admitted to an assisted living facility after having a stroke with severe memory loss. The clinician did not attempt to communicate with the patient and did not attempt to access available medical records or caregivers to determine prior functioning. CMS expects the use of a dash to be a rare occurrence. GG0100. Prior Functioning would be coded with a "dash," as there was no information. If the agency attempted to gather the information by interviewing the patient and family and/or reviewing the patient's clinical record and no information was available, use Code 8, Unknown.
49	Section GG	Do we document the use of a cane or crutches for GG0110.Prior Device Use?	The use of a cane or crutches are not captured in GG0110. Prior Device Use. If the patient was only using a cane or crutch prior to the current illness, exacerbation, or injury, check Z. None of the above.

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50	Section GG	What is a mechanical lift for GG0110. Prior Device Use?	For GG0110C. Prior Device Use, a mechanical lift is defined as any device that a patient or caregiver requires for lifting or supporting the patient's bodyweight. Examples provided include a stair lift, Hoyer lift, and bathtub lift. Clinical judgment may be used to determine whether other devices, such as the electric lift chair described, meet the definition provided.
51	Section GG	Will CMS consider future inclusion of straight cane/quad cane or crutches for GG0110. Prior Device Use?	Thank you for your suggestion. CMS will take this under advisement for future versions of the instruments.
52	Section GG	Why do the OASIS M1800 ADL/IADL items collect different information than the Section GG items?	The data collected from each OASIS item have specific applications.
53	Section GG	Is the intent of GG0130. Self-Care and GG0170. Mobility to capture the patient's usual performance prior to the current illness, exacerbation, or injury?	The intent of items GG0130 and GG0170 is to assess the patient's status/abilities at the time of SOC/ROC, Follow-up, and Discharge.
54	Section GG	When you refer to "follow-up performance," does follow-up mean the next OASIS?	No, "Follow-up performance" refers to the coding of the Section GG items at a Recertification and/or Other Follow-up.

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55	Section GG	Can you clarify the comment made in the response-specific instructions that state the QRP only requires a minimum of one self-care or mobility discharge goal must be coded? Coding and focusing on just one task per GG0130 and GG0170 compared to all of them will make a huge difference in performance and efficiency. What are the best practices here? If an agency decides to just focus on 1 item, how would they code the other remaining items? How long can an agency focus on one goal?	Select activities from GG0130 and GG0170 are used to calculate the quality measure Application of % of Patients with an Admission and Discharge Functional Assessment and a Care Plan that addresses function (NQF #2631). The activities utilized in the measure are: • GG0130. Self-care items (GG0130A. Eating, GG0130B. Oral hygiene, GG0130C. Toileting hygiene). • GG0170. Mobility Items (GG0170B. Sit to lying, GG0170C. Lying to sitting on side of bed, GG0170D. Sit to stand, GG0170E. Chair/bed-to-chair transfer, GG0170F. Toilet Transfer, GG0170J. Walk 50 feet with two turns, GG0170K. Walk 150 feet, GG0170R. Wheel 50 feet with two turns, GG0170S. Wheel 150 feet). Per the measure specifications, the numerator is met when, for a home health quality episode, valid codes are reported for the SOC/ROC performance AND for the Discharge performance for all of the listed functional activities AND, at SOC/ROC, a valid numeric score is coded for a discharge goal for at least one of the listed self-care or mobility activities. As outlined in the Guidance Manual, agencies may choose to complete more than one self-care or mobility discharge goal, including reporting a discharge goal for all collected GG0130 and GG0170 items. A dash is a valid response for any activity where a discharge goal is not established."
56	Section GG	Is a "helper" considered a person or assistive device?	For the purposes of Section GG, a helper is defined as a person. The use of an assistive device should not affect coding of Section GG activity.
57	Section GG	If a patient refuses and all the other key coding items—09, 10, 88—did not apply, wouldn't the interviewer work to choose the appropriate 1–6 code? It's confusing to have the 07 option when we can interview.	When completing the GG items and a patient refuses to perform the activity, combine general observation, interview of patient/caregiver(s), collaboration with other agency staff, and other relevant strategies to complete any and all GG items, as needed. Code 07, Patient refused, when assessment/discussion of the activity is attempted, the patient refuses, and no other performance or Activity not attempted code is applicable.

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58	Section GG	Why is there no D in the GG answers?	GG0130 is a standardized cross-setting data item. Specific activities, such as GG0130D, may be omitted whenever they are not applied uniformly across post-acute care settings.
59	Section GG	When the discharging clinician is using collaboration to complete the discharge assessment, does it matter who made the visit in the last 5 days of care (RN vs. LPN, PT vs. Physical Therapy Assistant (PTA), Occupational Therapist (OT) vs. Certified Occupational Therapy Assistant (COTA))?	For GG0130 and GG0170, only a qualified clinician may complete the OASIS Discharge. However, he/she may collaborate to collect data for all OASIS items, if agency policy allows.
60	Section GG	If the patient sleeps in recliner, is “reclined” considered lying for lying to sitting question?	If the patient uses a recliner, sofa, or mattress on the floor as the patient’s “bed” (preferred or necessary sleeping surface), assess the patient’s need for assistance using that sleeping surface when determining ability in GG0170C. Lying to sitting on side of bed.
61	Section GG	Regarding bed to chair transfer, what if the patient is really dependent but only has one caregiver to transfer the patient? This is found more often in the home than in a facility.	Code 01, Dependent, should be used if one helper does ALL of the effort (patient does none of the effort) to complete the activity OR the assistance of two or more helpers is required for the patient to complete the activity.
62	Section GG	Is getting to the toilet considered part of the toilet transfer?	No. The toilet transfer activity involves a patient transfer on and off a toilet or commode,and does not include getting to the toilet or commode.
63	Section GG	All the mobility scenarios discussed during the Section GG: Functional Abilities and Goals Webinar on September 5 involve the therapist. Are agencies going to be having therapy see all patients to do this functional assessment? What is the expectation to have nursing do this?	Patient need, physician order, and agency policy will determine who visits the patient and conducts or contributes to patient assessment and OASIS data.
64	Section GG	Regarding GG0170J. Walk 50 feet with 2 turns, do the turns need to be consecutive?	For the activity of ambulating 50 feet with two turns, the turns can occur at any time during the 50-foot walk. The turns are 90-degree turns and may be in the same direction (two 90-degree turns to the right or two 90-degree turns to the left) or may be in different directions (one 90-degree turn to the right and one 90-degree turn to the left).

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65	Section GG	Would it be okay to take information from another facility to complete an initial assessment?	The response-specific instructions state that coding should be based on a functional assessment that occurs at or soon after the patient's SOC/ROC. Scores are to be reflective of the patient's baseline and should be based on observation of activities to the extent possible. Direct observation is preferred, but performance may be based on reports from the patient, clinicians, care staff, and/or family. While documentation from a prior care setting may be helpful in the assessment process, it is not expected that functional status scores from a prior care setting would automatically be utilized as the functional status code for today's assessment.
66	Section GG	How do the GG questions impact the Home Health Resource Group (HHRG)?	The OASIS Section GG items do not impact the HHRG.
67	Section GG	GG0170K does not indicate turns, but your "tip" discussed during the Section GG: Functional Abilities and Goals Webinar on September 5 did. Which is correct?	The coding tip shared was based on a scenario where the patient's environment does not accommodate a linear walk of 150 feet. Given that circumstance, if the patient demonstrates the ability to walk and turn to continue to walk for a total distance of 150 feet, the 6-point coding scale can be used to code GG0170K.
68	Section GG	Do the Section GG items need to be answered by a therapist? What if a therapist's SOC OASIS assessment is completed after the 5-day assessment timeframe? What if a therapist's and nurse's functional assessments of the same patient differ?	Although CMS invites a multidisciplinary approach to patient assessment, coding the GG Functional Ability items does not require a therapy assessment. The assessing clinician may elicit input from the patient, caregivers, and other agency staff who have had direct contact with the patient to assist in completing any or all OASIS items integrated within the comprehensive assessment document. When collaboration is utilized, the assessing clinician is responsible for considering available input from these other sources and selecting the appropriate OASIS item response(s), within the appropriate timeframe and consistent with data collection guidance.
69	Section GG	Regarding toilet transfer (GG0170F). The ability to safely get on and off a toilet or commode, how would you code this item if the patient is only using a bedpan or adult diaper?	A patient who is not able to get on and off a toilet or commode, with or without assistive devices, and with or without some level of assistance would be coded with the appropriate "activity was not attempted" code.

#	Question Category	Question	Answer
70	Section GG	GG0170R and GG0170S: How are these supposed to be accomplished in a patient's home? There is not enough room. Are staff required to complete this task outside of the home (such as a driveway or sidewalk)? This will create liability issues, will it not?	If the patient's environment does not accommodate wheelchair/scooter use of 150 feet without turns but the patient demonstrates the ability to mobilize the wheelchair/scooter with or without assistance for 150 feet with turns without jeopardizing the patient's safety, code using the 6-point scale.
71	Section GG	Are some of the mobility questions designed to be clues to homebound status?	The OASIS-D Guidance Manual does not refer to homebound status.
72	Section GG	How would you code GG0170Q. Using wheelchair, if the patient is unsafe walking and should have a wheelchair, but does not have one yet?	If self-mobilizing in a wheelchair is intended to be part of the patient's plan of care, GG0170Q would be 1 - Yes. If the use of a wheelchair for self-mobilization is not planned to be part of the plan of care, GG0170Q would be 0 - No.
73	Section GG	Would you confirm that verbal cueing is supervision needed?	Yes. For coding GG0130 and GG0170, supervision and verbal cues would be considered Code 04, Supervision or touching assistance.
74	Section GG	What if the patient falls on the floor and injures him/herself during a therapy intervention?	It is possible for a patient to have an unanticipated fall/injury during a therapy intervention. In this example, the fall and the injury would be captured in J1800 and J1900.
75	Section GG	How will we address the GG items at discharge/follow-up if and OASIS-C2 was done for SOC/ROC not an OASIS-D assessment?	OASIS-D will be used for all assessments with a M0090 Date Assessment completed of January 1, 2019, or later. GG0130 and GG0170 report the patient's status at the time of assessment, so they should report the patient's follow-up or discharge status. This is true whether the SOC was completed in 2018 with OASIS-C2, or in 2019 with OASIS-D.
76	Section GG	What counts as "before the current illness..."? One week? One month? Usual status on the day before the determination of the orders for home health?	In responding to GG0100. Prior Functioning: Everyday Activities, the activities should be reported based upon the patient's usual ability prior to the current illness, exacerbation, or injury. This is the patient's functional ability prior to the onset of the current illness, exacerbation of a chronic condition, or injury (whichever is most recent) that initiated this episode of care. Clinicians should use clinical judgement within these parameters in determining the timeframe that is considered "prior to the current illness, exacerbation, or injury."
77	Section GG	When completing GG0100 Prior ability will the clinician need to document the patient's safe prior ability?	Safety is always a primary consideration. Patients should be allowed to perform these activities as independently as possible, as long as they can safely do so.

#	Question Category	Question	Answer
78	Section GG	Is a lift chair (recliner) considered a mechanical lift?	For GG0110C. Prior Device Use, a mechanical lift is defined as any device that a patient or caregiver requires for lifting or supporting the patient's bodyweight. Examples provided include a stair lift, Hoyer lift, and bathtub lift. Clinical judgment may be used to determine whether other devices, such as the electric lift chair described, meet the definition provided.
79	Section GG	If you cannot assess a patient for one of the GG performance questions is it better to take the word of the patient/family (esp. if does not appear to be accurate) or use one of the not able to assess codes.	When completing the GG items, combine general observation, interview of patient/caregiver(s), collaboration with other agency staff, and other relevant strategies to complete any and all OASIS items, as needed.
80	Section GG	If a self-care or mobility goal is set for expected decline in patient status, will that count against the agency for publicly reported data?	For the process measure, the requirement is to establish and code a self-care or mobility goal. The process measure does not consider whether the coded goal was achieved.
81	Section GG	What if the patient lives by themselves but needs a caregiver to assist? How would you code them in GG0130 and GG0170? If you see them complete the activity but it is not safe, would you code them 06 independent?	Safety is always a primary consideration. Patients should be allowed to perform these activities as independently as possible, as long as they can safely do so. Code based on the type and amount of assistance required.
82	Section GG	Is the Section GG coding decision tree available somewhere?	Yes, it is available in the slide deck.
83	Section GG	In regards to GG0130/GG0170, can code 10, Not attempted due to environment, be used for in-home environment issues such as clutter or hoarding, or would it be preferred to use code 88, Not attempted due to safety concerns.	Use clinical judgement to determine which code best applies to your patient.
84	Section GG	Does the eating also consider the meal set up as it did previously? Example: Mashing potato, pouring milk, etc.	Yes, opening containers and cutting up meat, pouring liquids would be considered setup assistance. Setup only occurs prior to the patient beginning the eating activity, not during.

#	Question Category	Question	Answer
85	Section GG	For eating question GG0130, how do we address a modified diet if the patient can only eat safely if he or she has thickened liquids or chopped food/mechanical soft that he or she was not able to prepare him or herself? Should this be considered in the eating question or is that considered meal prep?	The assessment starts once the meal is placed before the patient, regardless of the type of diet.
86	Section GG	Is it true that only one self-care or mobility goal is required for GG0130 and GG0170?	Yes, for the function process measure, at least 1 of the 12 self-care or mobility goals that is included in the measure should be coded.
87	Section GG	GG0130B: the patient cannot get to bathroom, so a helper must bring supplies to the patient; the patient is then able to brush teeth. Is this only setup?	If the patient can complete oral hygiene activity only after a helper retrieves or sets up supplies necessary to perform included tasks, code 05 – Setup or clean-up assistance.
88	Section GG	Code 07: Patient refused. Why would one use this option when the clinician has the option to ask family and or caregivers for this answer.?	When completing the GG items and a patient refuses to perform the activity, combine general observation, interview of patient/caregiver(s), collaboration with other agency staff, and other relevant strategies to complete any and all OASIS items, as needed. Code 07, Patient refused, when assessment/discussion of the activity is attempted, the patient refuses, and no other performance or Activity not attempted code is applicable.
89	Section GG	OASIS conventions require assessing what the patient “usually” wears. Does GG dressing items only include what the patient is wearing at the moment of assessment?	Assess the patient based on the clothing the patients routinely wears.
90	Section GG	Is the intention for HHAs to be moving from same day SOC ‘s M090 date’s to using more of the 5-day window so collaboration can take place to answer the GG questions?	No.
91	Section GG	For GG0130G, is donning/doffing an orthotic still considered a “device” or is it considered “footwear” in this circumstance?	If donning and doffing an elastic bandage, elastic stockings, or an orthosis or prosthesis occurs while the patient is putting on and taking off socks and shoes or other footwear, then consider it when determining the amount of assistance the patient needs when coding the dressing item.

#	Question Category	Question	Answer
92	Section J	It seems like slipping on a wet floor is an external force causing the fall, similar to being pushed, yet it is counted as a fall?	It sounds like you are referring to J1800 Practice Coding Scenario 2 from the Section J: Health Conditions presentation given at the November 6 and 7 Home Health QRP Provider Training in Baltimore, in which the patient, Mr. S, appeared to slip on a wet spot on the floor during a home health aide bath visit. In this example, slipping is caused by an environmental condition (water on the floor), not by an external force (a person pushing the patient).
93	Section J	To clarify: A fall can occur outside the home? Away from the home?	For the purposes of OASIS items J1800 and J1900, a fall may be witnessed or unwitnessed, reported by a patient or observer, or identified when a patient is found on the floor or ground.
94	Section J	Why are intercepted falls being considered a fall? This is opposite of what our agency considers a fall. It seems as though this is going to penalize agencies for falls that did not occur.	An intercepted fall is considered a fall because the patient would have fallen if he or she had not caught him/herself or had not been intercepted by another person. The cross-setting quality measure adopted for the CY 2020, “Application of Percent of Residents Experiencing One or More Falls with Major Injury,” reports only falls that resulted in major injury during the episode of care (J1900 = Coding 1, 2).
95	Section J	When we ask about falls and determine that a patient was found on the floor, why would we assume they had a fall and not a syncopal episode. Again, this seems to harshly penalize agencies.	The reason for the fall is not considered when coding J1800. Any Falls Since SOC/ROC. For the purpose of the OASIS assessment, a fall is defined as an unintentional change in position, coming to rest on the ground, floor, or onto the next lower surface.
96	Section J	“Supervised therapeutic interventions”: Does this also count during a Timed Up & Go (TUG) or other part of nursing assessment?	J1800 should report any witnessed or unwitnessed fall or intercepted fall except those resulting from an overwhelming external force or those resulting from intentional therapeutic intervention intended to challenge the patient’s balance for balance recovery/training.
97	Section J	What if patient fell on purpose?	J1800 should report any witnessed or unwitnessed fall or intercepted fall except those resulting from an overwhelming external force or those resulting from intentional therapeutic intervention intended to challenge the patient’s balance for balance recovery/training.
98	Section J	Are all three boxes expected to be completed when answering J1900?	Yes. When coding J1900, a response must be provided for each level of injury: J1900A. No Injury; J1900B. Injury except Major; and J1900C. Major injury.

#	Question Category	Question	Answer
99	Section J	What happens if Mr. W sustains a fracture due to a fall? If hospitalized, would anything be coded on ROC?	No, J1800 and J1900 are not completed at SOC or ROC. In the example provided, Mr. W's fall would be captured on J1800 and J1900 at transfer to an inpatient facility, death at home, or discharge from agency, not to an inpatient facility.
100	Section J	So, a fall with therapy is not a fall because it is a risk of the therapy. Clarify therapist. Is this a physical therapist or an occupational therapist or both?	CMS understands that challenging a patient's balance and training him/her to recover from a loss of balance is an intentional therapeutic intervention and does not consider anticipated losses of balance that occur during supervised therapeutic interventions as intercepted falls. This would be true regardless of which of the agency's licensed staff are providing the intervention of intentionally challenging the patient's balance. Falls that occur during balance retraining are not reported when (1) there was intentional challenge and (2) the loss of balance was anticipated.
101	Section J	As a physical therapist, you are training a caregiver/family member or even a patient to catch themselves or stabilize the patient to intercept a fall. So why should that be counted as a fall?	The intercepted fall demonstrates risk. This is consistent with how a fall is defined across Post-Acute Care (PAC) settings.
102	Section J	What would be an acceptable use of the dash for J1900?	Clinicians are expected to review the medical record and interview the patient and caregiver to obtain the information needed for accurate coding. Use of the dash does have an impact on your reporting outcomes. A dash should only be used when no information is available.
103	Section J	Does stitches include major injury?	The categorization of the level of injury for J1900 is based on the injury sustained by the patient, not necessarily the treatment for that injury. Major injuries include bone fractures, joint dislocations, closed head injuries with altered consciousness, and subdural hematoma.
104	Section J	Since J1800 and J1900 go into our quality report and into the PRA report, does CMS think agencies will report intercepted falls?	CMS expects that all OASIS assessment items will be answered accurately, based upon the direction provided in the OASIS Guidance Manual.
105	SOC	What if the patient is bedbound or other reasons making it unable to weight the patient?	If a patient cannot be weighed, for example, because of extreme pain, immobility, or risk of pathological fractures, the use of a dash (–) is appropriate. Document the rationale on the patient's medical record.