



## LCDS Quarterly Q&As, September 2020

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*This document is intended to provide guidance on LCDS questions that were received by CMS help desks. Responses contained in this document may be superseded by guidance published by CMS at a later date.*

## Admission Items: General Questions

**Question 1: If a patient is admitted to a Long-Term Care Hospital (LTCH) on Monday but has to be transferred back to the acute care hospital the next day (Tuesday) and then returns to the LTCH on Thursday, we know that this is considered a program interruption. Can we use assessment information from Tuesday morning's functional assessments (the day the patient returned to the acute care hospital) to code the admission items?**

**Answer 1:** If the patient has a program interruption, the assessment data gathered on the discharge date (the day the patient is admitted to Acute Care from the LTCH) may be used to code the admission items.

*At times CMS provides new or refined instruction that supersedes previously published guidance. In such cases, use the most recent guidance.*

## GG0100, GG0110

**Question 2: We have questions regarding prior level of functioning and prior device use. A patient is admitted to our facility for rehab, has a medical issue, and is discharged to an acute care hospital for a week. When the patient returns to our facility, would the prior level of functioning reported in GG0100B – Prior Functioning: Indoor Mobility reflect the patient's ambulation status prior to the original admission (which is the reason we are still treating the patient) or is the prior level of functioning based on what the patient was doing during the hospital stay? Would this also apply to GG0110 – Prior Device Use?**

**Answer 2:** The intent of GG0100B – Prior Functioning: Indoor Mobility is to report the patient's need for assistance with walking from room to room, with or without a device such as a cane, crutch, or walker, prior to the current illness, exacerbation, or injury. The intent of GG0110 – Prior Device Use is to indicate which devices and aids were used by the patient prior to the current illness, exacerbation, or injury. The assessing clinician must consider each patient's unique circumstances and use clinical judgment to determine how prior functioning and prior device use apply for each individual patient.

In responding to GG0100 – Prior Functioning: Everyday Activities, the activities should be reported based on 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 judgment within these parameters in determining the time frame that is considered "prior to the current illness, exacerbation, or injury."

The same approach should be used in determining Prior Device Use for GG0110.

## GG0130, GG0170

### **Question 3: For section GG what is the definition of “therapeutic intervention”?**

**Answer 3:** At Admission, the self-care or mobility performance code is to reflect the patient’s baseline ability to complete the activity, prior to the benefit of services provided by your facility staff. “Prior to the benefit of services” means prior to provision of any care by your facility staff that would result in more independent coding.

Please note that the term “prior to the benefit of services” replaces the term “therapeutic intervention” for the GG activities.

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### **Question 4: Establishing a goal is required for at least one self-care or mobility activity in section GG. Can the GG goals be changed once established during the first 3 days if the patient’s status changes?**

**Answer 4:** The GG Self-care and Mobility Discharge Goals are used in the calculation of the Process Measure – Percentage of Patients with an Admission and Discharge Function Assessment and a Care Plan that Addresses Function. The measure reports, in part, that discharge goals were established, and does not take into consideration whether or not the goals were met. Once a goal is established, there is no need to update it if circumstances change or additional information becomes available either within or after the 3-day assessment time period.

### **Question 5: The LTCH CARE Data Set (LCDS) manual for section GG clarifies that a Code 03-Partial/moderate assistance indicates the helper is required to provide less than half the effort and a Code 02-Substantial/maximal assistance indicates the helper is required to provide more than half the effort. If a helper is required to provide exactly half the effort, how would the item be coded?**

**Answer 5:** In the situation described, the helper and patient each are providing exactly half of the effort to complete a GG activity. If the patient performs half of the effort, code the item 03-Partial/moderate assistance.

**Question 6: On day 2, during an evaluation, the physical therapist feels the patient is unable to complete an activity such as sit to stand without providing therapy services; for example: skilled instruction on safe body mechanics for transfers or proper technique to maintain weight bearing restrictions. Is it appropriate to code 88 as the admission assessment of baseline functional status prior to benefiting from therapy services? PT initiates treatment by providing a walker, instructing in its use, and offering cues for proper technique. The patient performed sit to stand transfers with moderate assistance the rest of the day 2 and day 3.**

**Answer 6:** At Admission, the self-care or mobility performance code is to reflect the patient's baseline ability to complete the activity, prior to the benefit of services provided by your facility staff.

For the admission assessment, the patient may be assessed based on the first use of an assistive device or equipment that has not been previously used. The clinician would provide assistance, as needed, in order for the patient to complete the activity safely, and code based on the type and amount of assistance required, prior to the benefit of services provided by your facility/staff.

Introducing a new device should not automatically be considered as "providing a service." Whether a device used during the clinical assessment is new to the patient or not, use clinical judgment to code based on the type and amount of assistance that is required for the patient to complete the activity prior to the benefit of services provided by your facility/staff.

Communicating the activity request (e.g., "Can you stand up from the toilet?") would not be considered verbal cueing. If additional prompts are required in order for the patient to safely complete the activity ("Push down on the grab bar," etc.), the assessing clinician may need to use clinical judgment to determine the most appropriate code, utilizing the Coding Section GG Activities Decision Tree.

In your scenario, if even with assistance the patient was unable to perform the sit to stand activity prior to the benefit of services and the performance code cannot be determined based on patient/caregiver report, collaboration with other agency staff, or assessment of similar activities, use the appropriate "activity not attempted" code.

**Question 7: We understand that if a patient initially refuses to attempt an activity during the assessment period, but later agrees to perform the activity, the code that represents the patient's actual performance supersedes the refusal code (07). What if on day 1 or day 2 a safety or medical issue prevents the patient from attempting an activity, but on day 3, after benefiting from therapeutic intervention, the patient can now perform the activity? Which code should be reported on the LCDS: Code 88 – Not attempted due to medical conditions or safety concerns, or one of the performance codes, 01-06?**

**Answer 7:** At Admission, the self-care or mobility performance code is to reflect the patient's baseline ability to complete the activity, prior to the benefit of services provided by your facility

staff. “*Prior to the benefit of services*” means prior to provision of any care by your facility staff that would result in more independent coding.

Use of an “activity not attempted” code should occur only after determining that the activity is not completed prior to the benefit of services, and the performance code cannot be determined based on patient/caregiver report, collaboration with other facility staff, or assessment of similar activities.

If this is the case in your scenario code 88 even if the patient’s status changes and the patient is able to complete the activity on a later day during the assessment period.

## **GG0130B**

**Question 8: A helper gathers and sets out the patient’s oral hygiene items. The patient is able to brush their teeth with steady assist from a helper while standing at the sink. What is the code for oral hygiene?**

**Answer 8:** The intent of GG0130B – Oral hygiene is to determine the patient’s 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.

When coding activities in Section GG, clinicians should code based on the type and amount of assistance required to complete the activity, allowing the patient to perform the activity as independently as possible, as long as they are safe.

In your scenario, if the patient standing at the sink requiring steady assistance to brush their teeth represents the patient performing the activity as independently as possible, then code 04-Supervision or touching assistance for GG0130B – Oral hygiene.

## **GG0130C**

**Question 9: A patient used a bedpan for both bowel and bladder and was able to lift and lower her hospital gown (no brief or underwear were stated to be present), and the patient was not able to perform any of her own perineal hygiene for bowel or bladder. How is Toileting hygiene coded?**

**Answer 9:** The intent of GG0130C – Toileting hygiene is to assess the patient’s ability to maintain perineal hygiene and adjust clothes before and after voiding or having a bowel movement.

In your scenario, code GG0130C – Toileting hygiene based on the type and amount of assistance required to complete the ENTIRE activity, including toileting hygiene and adjusting any clothing relevant to the individual patient (in this case lifting and lowering the hospital gown). If, in the assessing clinician’s clinical judgment, the patient required a helper to provide less than half the effort, then code 03-Partial/moderate assistance; or if the patient required the helper to provide more than half the effort code 02-Substantial/maximal assistance.

## GG0170C

**Question 10: How do we code lying to sitting on side of bed for a bilateral amputee not wearing their prosthetics, since the definition states “with feet on floor”?**

**Answer 10:** If the patient with a unilateral (or bilateral) lower extremity amputation does not have or is not wearing a prosthesis (or prostheses), use clinical judgment to determine if the patient completes the activity (Lying to sitting on side of bed without back support). Code the activity based upon the type and amount of assistance the patient requires to safely complete the activity.

## GG0170E

**Question 11: We understand that verbal cueing during a task should fall under the score of 04-Supervision or touching assistance. Our question is can a verbal cue provided prior to the task be considered set up as long as no further cues were provided during the actual task?**

**A specific example we just encountered was during the “chair/bed to chair transfer” activity. The therapist cued the patient prior to the activity where to place their hand for stability (in a novel environment), and then the patient completed all of the activity safely and without further cues or assistance. Is this Code 05-Setup or Code 04-Supervision?**

**Answer 11:** When assessing self-care and mobility activities, allow the patient to complete each activity as independently as possible, as long as he/she is safe. At admission, the self-care or mobility performance code is to reflect the patient’s baseline ability to complete the activity prior to benefit of services provided by your facility/staff. This may be achieved by having the patient attempt the activity prior to providing any instruction that could result in a more independent code, and coding based on the type and amount of assistance required.

Communicating the activity request (e.g., “Can you stand up from the toilet?”) would not be considered verbal cueing. If additional prompts are required in order for the patient to safely complete the activity (“Push down on the grab bar,” etc.), the assessing clinician may need to use clinical judgment to determine the most appropriate code, utilizing the Coding Section GG Activities Decision Tree.

In the scenarios described, assuming the verbal cues were only provided prior to the benefit of services and were required, and no other assistance was needed in order for the patient to complete the activity safely, then the verbal cues would be considered 05-Setup.

## GG0170F

**Question 12: If a patient gets up off the side of the bed, walks to the bathroom, and then sits down on the toilet, is the effort necessary to lift up off the bed considered for coding GG0170F – Toilet transfer?**

**Answer 12:** The intent of GG0170F – Toilet transfer is to assess the patient’s ability to get on and off a toilet (with or without a raised toilet seat) or commode once the patient is at the toilet or commode.

In the scenario described, the effort necessary to lift up off the bed does not count toward the toilet transfer in GG0170F – Toilet transfer.

## GG0170I

**Question 13: Can you give some clarification regarding scoring a performance with the help of a second person (if this second person is helping push an oxygen tank, IV pole, or wheelchair following the patient) because the first helper is physically assisting the patient during the walking activity? Both helpers are needed to complete the activity safely. The IRF-PAI manual says “if two or more helpers are required to assist the patient to complete the activity, code as 01, Dependent.”**

**Answer 13:** The intent of the GG0170 walking items is to assess the patient’s ability once standing to safely walk the stated distances and circumstances in each item.

You are correct that if a patient requires the assistance of two helpers to complete an activity (one to provide support to the patient and a second to manage the necessary equipment to allow the safe walk), Code 01 – Dependent is the appropriate code.

If a single helper only manages the oxygen tank or the IV pole and otherwise the patient needs no assistance to safely complete the walking activity, code the walking activity as 04 – Supervision or touching assistance. This is because the helper is required to be present during the activity for the patient to complete the activity safely.

**Question 14: How would you code a situation where the patient walks part of the distance, say 4 feet, and then the helper carries them the remaining distance to get to the 10 feet needed for GG0170I – Walk 10 feet? Would this be a Code 02-Substantial/maximal assistance because the helper is carrying the patient the majority of the distance? We understand that with the wheelchair activities a helper can complete the distance needed by pushing the patient in the wheelchair. Is this also true for the walking items?**

**Answer 14:** The intent of the walking item GG0170I – Walk 10 feet is to assess the type and amount of assistance a patient requires to ambulate 10 feet once in a standing position.

Since a helper cannot complete a walking activity for a patient, the walking activities cannot be considered completed without some level of patient participation that allows patient ambulation to occur for the entire stated distance.

In your scenario, where the patient participates in walking 4 feet and then requires the helper to carry them for further distances, the activity walking 10 feet (GG0170I) is not considered completed. If the stated distance of 10 feet was not walked by the patient, with or without some level of assistance, GG0170I would be coded with one of the “activity not attempted” codes, for example 88-Not attempted due to the medical condition or safety concerns.

Each LCDS item should be considered individually and coded based on the guidance provided for that item.

### **GG0170I, GG0170J, GG0170K**

**Question 15: Many of our patients with a stroke ambulate with PT along a railing mounted in the hall. We understand that walking/transferring in the parallel bars would not be used to code the GG activities. Could coding be based on the patient walking in the hallway if using a railing as a support?**

**Answer 15:** The intent of the walking items (GG0170I, GG0170J, GG0170K) is to assess the patient’s ability to ambulate once in a standing position.

As noted in your question, you would not code self-care and mobility activities with use of a device that is restricted to patient use during therapy sessions (e.g., parallel bars, exoskeleton, or overhead track and harness systems). Note that while a patient may use a hallway railing during therapy sessions, its use would not be restricted to therapy sessions only and therefore does not meet the definition described above.

CMS does not provide an exhaustive list of assistive devices that may be used when coding self-care and mobility performance. Other than the exceptions listed above, clinical assessments may include any device or equipment (including a hallway railing) that the patient can use to allow them to safely complete the activity as independently as possible.

### **GG0170Q**

**Question 16: We have a question regarding the appropriate scoring for an LTCH patient who does not use a wheelchair during the admission assessment, but then begins to use a wheelchair later during the LTCH stay. Our system software will not allow us to upload goals after the 3-day admission assessment has ended. When a patient does begin using a wheelchair later in the stay, would it be appropriate to go back to the initial wheelchair assessment on the LCDS and change GG0170Q to “YES” and add the corresponding goals even though they were established after the admission assessment has ended?**

**Answer 16:** The intent of GG0170Q – Does the patient use a wheelchair and/or scooter? is to document whether a patient uses a wheelchair or scooter at the time of the assessment. Only code

0-No if, at the time of the assessment, the patient does not use a wheelchair or scooter under any condition.

If, at the time of admission, GG0170Q is answered “No” correctly, and following the admission assessment period the patient begins to utilize a wheelchair, there is no need to update the admission performance and/or discharge goals for GG0170 activities on the admission LCDS. The gateway wheelchair item (GG0170Q1 and GG0170Q3) might not be coded the same on the admission and discharge assessments.

If, at the time of admission, GG0170Q was answered incorrectly then corrections to the admission LCDS should be made following Federal, State, and facility policy guidelines.

## GG0170S

**Question 17: A patient was able to propel his wheelchair for 100 feet with moderate assistance. He was unable to go farther and the therapist pushed the wheelchair the rest of the way to the gym, which was a total of 150 feet. What score would you give this patient for GG0170S – Wheel 150 feet?**

**Answer 17:** The intent of GG0170S – Wheel 150 feet is to assess the patient’s ability, once seated in a wheelchair/scooter, to wheel at least 150 feet. If the patient is unable to complete the entire distance required for this activity, the assessing clinician can assist the patient to complete the activity, and code this item based on the type and amount of assistance required to complete the entire activity.

In your example, the patient completed wheeling 100 feet of the 150 feet with moderate assistance and required the helper to complete the remaining distance. Use clinical judgment to determine if the patient required the helper to provide less than half the effort (then Code 03-Partial/moderate assistance) or if the patient required the helper to provide more than half the effort (then Code 02-Substantial/maximal assistance).

## H0400

**Question 18: If a patient only has one bowel movement during the admission assessment period, and that bowel movement is incontinent, how would H0400 be coded? With the current verbiage in the LCDS manual, it meets the definition of two scores; code 3 (because all bowel episodes were incontinent) and code 1 (because the patient only had one bowel movement).**

**Answer 18:** The intent of H0400 – Bowel Continence is to gather information on the frequency of bowel continence during the 3-day assessment period. Code 1-Occasionally incontinent should only be selected if during the 3-day assessment period the patient was incontinent for bowel movement once. This includes incontinence of any amount of stool at any time. Code 3-Always incontinent is selected if during the 3-day assessment period the patient was incontinent for all bowel movements (i.e., had no continent bowel movements).

If a patient has only one bowel movement that was incontinent during the 3-day assessment period, and there were no episodes of continent bowel movements, then Code 3-Always incontinent.

## **M0300**

**Question 19: I am seeking guidance on how to complete the LCDS accurately in this scenario. Patient is admitted with an Unstageable - Deep Tissue Injury on his right heel. On Discharge, the nurse's assessment of the patient right heel was that DTI had become Unstageable - due to the presence of eschar. How do we code M0300 at Discharge?**

**Answer 19:** For each pressure ulcer/injury observed at Discharge, consider current and historical levels of tissue involvement. Discharge coding for the scenario described is dependent upon the clinical progression of the wound during the LTCH stay.

If the DTI noted at admission does not evolve to be numerically stageable and becomes unstageable due to eschar or slough at the time of Discharge, code at Discharge as follows:

M0300F1. Unstageable - Slough and/or eschar = 1

M0300F2. Unstageable - Slough and/or eschar = 1

M0300G1. Unstageable - Deep tissue injury = 0

M0300G2. Unstageable - Deep tissue injury = skip

However, any pressure ulcer/injury that is observed to be unstageable due to slough and/or eschar at the time of Discharge, but was previously numerically stageable, is considered new, and not coded as present at admission on the Discharge assessment.