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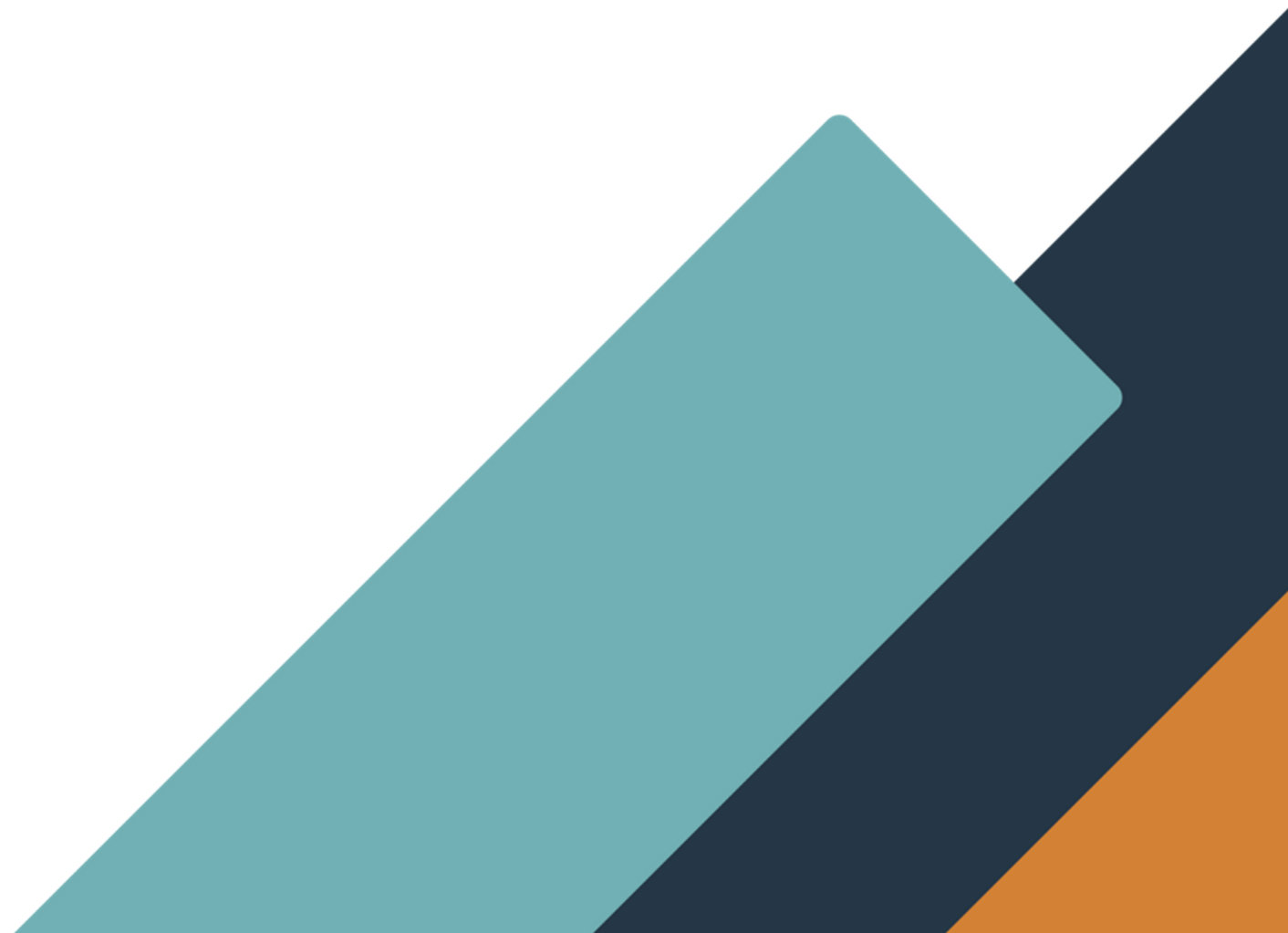
CMS OASIS Updates:

July 2020 - January 2021



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CMS OASIS Updates July 2020 – Jan 2021

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Locating Related CMS Documents

- Quarterly OASIS Q&A -
  - https://qtso.cms.gov/providers/home-health-agency-hha-providers/reference-manuals
- Medicare and Medicaid Programs; CY 2021 Home Health Prospective Payment System Rate Update, Home Health Quality Reporting Program Requirements, and Home Infusion Therapy Services and Supplier Enrollment Requirements; and Home Health Value-Based Purchasing Model Data Submission Requirements
  - https://www.federalregister.gov/documents/2020/11/04/2020-24146/medicare-and-medicaid-programs-cy-2021-home-health-prospective-payment-system-rate-update-home
- Home Health Agencies: CMS Flexibilities to Fight COVID-19
  - https://www.cms.gov/files/document/covid-home-health-agencies.pdf
- Draft OASIS-E Instrument -
  - https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HomeHealthQualityInits/OASIS-Data-Sets
- Risk Adjustment Updates Jan 2021
  - https://www.cms.gov/files/document/risk-adjustment-technicalspecifications508cfinal.pdf

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COVID 19- CMS UPDATES

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CMS COVID-19 Response - OASIS-E DELAYED

Published May 8,2020

- HHAs will be required to use OASIS-E to begin collecting data on the two Transfer of Health Information Measures beginning with discharges and transfers on January 1st of the year that is at least one full calendar year after the end of the COVID-19 public health emergency.
- We will also require HHAs to begin collecting data on the SPADEs (standardized patient assessment data elements) beginning with the start of care, resumption of care, and discharges (except for the hearing, vision, race, and ethnicity SPADEs, which would be collected at the start of care only) on January 1st of the year that is at least one full calendar year after the end of the COVID-19 public health emergency

For example, if the COVID-19 public health emergency ends on July 17, 2021, home health agencies will be required to begin collecting data on those measures beginning with patients discharged or transferred on January 1, 2023.

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CMS Public Health Emergency Waivers - COVID-19

The Take-Aways

- Home Health Agencies (HHAs) can provide more services to beneficiaries using telecommunications technology within the 30-day period of care, so long as it's part of the patient's plan of care and does not replace needed in-person visits as ordered on the plan of care.
- The initial assessment and determination of patients' homebound status can be completed remotely or by record review.
- The timeframe requirement for completion of the comprehensive assessment is extended from five to thirty days.
- The 30-day OASIS submission requirement is waived. The OASIS must be submitted prior to submitting the final claim.
- The October 2020 refresh of the Home Health Compare/Care Compare Sites is the last scheduled refresh of this data until the January 2022 refresh.
- Any rehabilitation professional (OT, PT, or SLP) may perform the initial and comprehensive assessment for all patients receiving therapy services as part of the plan of care, to the extent permitted under state law, regardless of whether or not the service establishes eligibility for the patient to be receiving home care.
- The existing regulations continue to apply that OTs and other therapists would not be permitted to perform assessments in nursing only cases. Therapists must act within their state scope of practice laws when performing initial and comprehensive assessments and access a registered nurse or other professional to complete sections of the assessment that are beyond their scope of practice.

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CMS OASIS Q&A

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Eligibility Certification - Who can order home care services?

October 2020 Q&A #4

The Take-Away

Nurse practitioners (NPs), physician assistants (PAs), and clinical nurse specialists (CNSs) can now certify eligibility for home health and establish a care plan permanently.

Q4. With the CARES Act, physician assistants, nurse practitioners, and other advanced practice nurses are now allowed to certify a patient's need and eligibility for home health services. Is this update permanent? Even after the PHE ends will these practitioners be allowed to order home care services?

A4. Yes, per the Coronavirus Aid, Relief, and Economic Security Act or the CARES Act (Public Law 116-136), this update is intended to be permanent. Even after the COVID-19 PHE ends, nurse practitioners, physician assistants and other advanced practice nurses that are identified in the CARES Act will continue to be allowed to certify their patient's need and eligibility and provide orders for home health services.

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CMS OASIS Q&A

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M0102/M0104: Physician ordered SOC / ROC dates and Referral Date

October 2020 Q&A #5

The Take-Away

The orders from non-physician practitioners are weighted equally and adequate for coding when a physician order is required.

Q5. For OASIS items where coding is affected by physician orders, would orders received from physician assistants, nurse practitioners or other advanced practice nurses have the same coding impact? For example, can new referrals/order information received from physician assistants, nurse practitioners, and other advanced practice nurses be used to code M0102 and M0104?

A5. Yes, when coding OASIS items where the presence of a physician's order affects the item coding, orders from a physician assistant, nurse practitioner, or other advanced practice nurse would satisfy the condition of having a physician's order.

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M1033: Risk for Hospitalization- Response 7

July 2020 Q&A #7

The Take-Away

All medications on the reconciled medication profile are counted when responding to M1033 Response 7- Gywirxp}$eomrk$9$ sv$q svi$q ihmgexmsrw, even if the patient is not compliant with the reconciled regimen

Q7. For M1033 - Risk for Hospitalization, Response 7 - Currently taking 5 or more medications, does this include medications that the patient is not taking due to non-compliance? For example, we have a patient that is prescribed 8 medications but is only actually taking 3 because of non-compliance with the other 5. Would we select Response 7 because the patient is prescribed more than 5 medications, even though the patient is not taking more than 5 medications?

A7: For M1033 – Risk for Hospitalization, medications include prescribed and over the counter (OTC) medications, nutritional supplements, vitamins, and homeopathic and herbal products administered by any route and as noted on the reconciled medication profile. Medications may also include total parenteral nutrition (TPN) and oxygen (as defined in M2001 Drug Regimen Review). In your scenario, if your patient has 8 medications on their reconciled medication profile, M1033 – Risk for Hospitalization coding would include "Response 7 - Currently taking 5 or more medications," even if the patient is not consistently taking the medication as prescribed.

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M1311: Current Number of Unhealed Pressure Ulcers/ Injuries at each Stage

January 2021 Q&A #1

The Take-Away

A pressure ulcer that is present at the SOC/ ROC that heals during the quality episode but re-opens at the same stage would be reported as "present at SOC/ROC". A previously closed Stage 3 ulcer that is open again should be reported as a Stage 3. A previously closed Stage 4 ulcer that is open again should be reported as a Stage 4. An ulcer that is present at DC at a worse stage than at SOC/ROC would not be reported as "present at SOC/ROC" at the higher stage. (Ch. 3 Section F guidance)

Q1: Is a pressure ulcer that was present when the first skin assessment was completed, then healed during the quality episode and reopened at the same stage during the same episode, considered "present at the most recent Start of Care/ Resumption of Care (SOC/ROC)" when completing the discharge OASIS?

A1: For M1311 -Current Number of Unhealed Pressure Ulcers/Injuries at Each Stage, if the patient has a pressure ulcer that was documented at SOC/ROC and at discharge is documented at the same stage, it would be considered as "present at the most recent SOC/ROC." This guidance is true even if during the episode the original pressure ulcer healed and reopened. In addition to coding the pressure ulcer as "present at the most recent SOC/ROC," a previously closed pressure ulcer that opens again should be reported at its worst stage.

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M1810/1820: Upper/ Lower Body Dressing
January 2021 Q&A #2

The Take-Away

In order to select Response "3" dependent, a patient should rely ENTIRELY on another person for the MAJORITY of dressing tasks related to each item. Entirely means Entirely dependent for the task- the patient is unable to assist in ANY MEANINGFUL WAY.

Q2. Is it safe to say that if a patient requires minimal assist or higher for M1810 -Ability to Dress Upper Body and M1820 -Ability to Dress Lower Body, response "3" can be chosen? The guidance states that a patient requiring standby assist (a "spotter") would be coded "2," and a patient requiring minimal assist is more dependent than a patient requiring standby assist.

A2. For M1810 and M1820, response 3 -Patient depends entirely upon another person to dress the upper body/lower body is selected only when the patient is dependent, relying entirely on another person to complete the majority of dressing tasks.

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M1870: Feeding or Eating
July 2020 Q&A #8

The Take-Away

If a patient is not taking nutrients by NG tube or gastrostomy and is taking nutrients orally, responses 3-5 do not apply regardless of the reason (non-adherence to medical advice). Due to safety concerns with the swallowing aspect of M1870 intent, constant supervision would be required during the task to decrease aspiration risk through instruction or respond to emergent needs during the task of eating. Response 2 is indicated.

Q8.We have a patient who has been medically advised to obtain a feeding tube due to the patient's inability to safely take in oral nutrition due to risk (and recent history) of aspiration. The patient continues to eat against medical advice and refused alternate nutrition, such as tube feeding or TPN. In this situation, would M1870 be answered as a 2 or a 5? The patient has the motor skills to bring the food to his mouth; however, is unsafe in swallowing.

A8. M1870 - Feeding or Eating identifies the patient's ability to feed him/herself, including the process of eating, chewing, and swallowing food. The intent of the item is to identify the patient's ABILITY, not necessarily actual performance. "Willingness" and "adherence" are not the focus of these items. These items address the patient's ability to safely self-feed, given the current physical and mental/emotional/cognitive status, activities permitted, and environment. Responses 3, 4 and 5 include non-oral intake. In your scenario, the patient is feeding himself orally and is at risk for aspiration due to unsafe swallowing. If a patient requires constant supervision throughout the meal in order to complete this activity safely, the appropriate M1870 response is a "2-Unable to feed self and must be assisted or supervised throughout the meal/snack". Response 5 - Unable to take in nutrients orally or by tube feeding, is the best response for patients who are not able to take in nutrients orally or by tube feeding. This may be the case for patients who receive all nutrition intravenously (such as TPN) or for patients who are receiving only intravenous hydration.

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M2001: Drug Regimen Review
January 2021 Q&A #3

The Take-Away

A dash must be available for clinician use where the dash is a valid response option for the OASIS item. It is not acceptable to adjust the OASIS data set to meet agency mandated requirements.

Q3. We have educated clinicians that it is a requirement that medication reconciliation be done. With this in mind, is it acceptable to electronically restrict clinicians from using a dash (–) as a response to M2001 by eliminating it as a response option in the Electronic Medical Record (EMR), understanding that there still may be scenarios where the dash is the only correct response to this item?

A3: A dash (–) is a valid response for M2001 - Drug Regimen Review. CMS expects dash use to be a rare occurrence. If elements of the drug regimen review were skipped, (for example drug-to-drug interactions were not completed), a dash should be reported, indicating the drug regimen review was not completed. A dash is also a valid response for this item and indicates no information is available. To be compliant, a dash must be available for clinician use where the dash is a valid response option for the OASIS item.

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GG0110- Prior Device Use
January 2021 Q&A #4

The Take-Away

CMS does not provide an exhaustive list of assistive devices, use clinical judgement to determine the best response based on the patient's unique circumstances related to prior assistive device use.

Q4. Should a transport chair be considered a "wheelchair" for GG0110 - Prior Device Use?

A4. 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 device use applies for each individual patient. CMS does not provide an exhaustive list of assistive devices that may be used when coding prior device use.

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GG0130,GG0170- General Guidance
October 2020 Q&A #7

The Take-Away

GG items should be scored PRIOR to the benefit of therapeutic intervention. The clinical judgement of the assessing clinician may be required to differentiate between therapeutic interventions provided which benefit and improve the patient's ability to complete an activity and provision of routine assistance required to complete the activity safely. (from July 2019 Q&A #18)

Q7. We understand that if a patient initially refuses to attempt a GG activity during the assessment period, and later agrees to perform the activity, the code which represents the patient's actual performance will supersede the refusal code (07). If the clinical staff determine on day 1 or day 2 that the patient has a safety or medical issue which prevents them from attempting an activity, but on day 3 has progressed to the point where he/she can now perform the activity, would that code supersede the earlier code (88)? A patient may not be safe to attempt the activity on day 1 (their baseline prior to the benefit of therapeutic interventions), but after two days of therapy, may then be safe to perform the activity. Which code would be reported on the OASIS: code 88 or a Performance Code 06-01?

A7. At Start of Care (SOC)/Resumption of Care (ROC), 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 agency staff. 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 agency staff, or assessment of similar activities. "Prior to the benefit of services" means prior to provision of any care by your agency staff that would result in more independent coding. In your scenario, if the patient's baseline status prior to the benefit of services was that the activity could not be completed due to a medical or safety concern and the performance code could not be determined based on patient/caregiver report, collaboration with other agency staff, or assessment of a similar activity, code 88 – Not attempted due to medical conditions or safety concerns, even if the patient's status changes and he is able to complete the activity on a later day during the assessment period.

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GG0130,GG0170- General Guidance
January 2021 Q&A #7

The Take-Away

The definition of assistance includes cues/ supervision and therefore the requirement of a second helper for safety would be taken into consideration when responding to GG items, by definition if help of 2 or more helpers is required the patient is considered 01- dependent. This is true even in ambulation question assessments. (January 2020 Q&A #15)

Q7. How would you code the following scenario for the GG activities: Two people are present when a patient is performing an activity; one person is assisting a patient and the second person is standing by for safety/assist as needed but when the activity is completed the 2nd person is not needed. Would you code the activity as Code 01 -Dependent due to having the second person present just in case or a code based on the type and amount of assistance provided by the one person only?

A7. For the GG self-care and mobility activities, Code 01 -Dependent is when a helper is required to do all the effort and the 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. If the role of the second helper is to provide standby assistance, then the presence of two helpers meets the definition of Code 01 -Dependent. This would be true even if the 2nd helper was there for supervision/stand by assist and did not end up needing to provide hands on assistance.

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GG0130A- Eating
January 2021 Q&A #5

The Take-Away

Score based on the baseline ability noted at the assessment.

Q5. How would the following scenario for GG0130A - Eating be coded? A patient was admitted and at Start of Care (SOC) required only set up assistance for eating. The following day, the patient went to the Emergency Department and returned within 24 hours with an overall decline in status and an order for no oral intake due to dysphagia. Would we code 05 - Setup or clean-up assistance based on initial ability or code 88 - Not attempted due to medical conditions or safety concerns because this is the new baseline following the decline?

A5. The intent of GG0130A - Eating is to assess the patient's 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 patient. At SOC/ROC, 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 agency staff. In the scenario provided, use Code 05 -Setup or clean-up assistance for GG0130A - Eating if this represents the patient's baseline status. Use of an "activity not attempted" code should only be used if the patient was not able to complete the 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.

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GG0130C- Toileting Hygiene
July 2020 Q&A #9

The Take-Away

GG0130C is based on the ability to maintain hygiene and adjust clothing. The "clothing" considered is based on all the items relevant and routinely worn by the individual patient being assessed. Guidance includes support devices are considered dressing items. (HHQRP Nov 2018 Provider Training #40 / #41)

Q9. We have a question about GG0130C - Toileting Hygiene. We have a patient who wears a Thoracic-Lumbar-Sacral Orthosis (TLSO) brace. She can pull down her underwear and pants without assistance. However, she insists on removing (or loosening) the brace while sitting on the commode prior cleaning herself and she requires assistance with the doffing/donning of the brace. She can then pull up her underwear/pants without assistance. How should we code GG0130C -Toileting Hygiene?

A9. 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. Code GG0130C- Toileting Hygiene based on the type and amount of assistance to complete the ENTIRE activity, including toileting hygiene, and adjusting any clothing relevant to the individual patient (in this case removing or loosening of the TLSO and managing her underwear and pants). If in the assessing clinician's clinical judgment, the patient requires a helper to provide less than half the effort to complete the entire activity, then code 03 - partial/moderate assistance, or if the patient

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GG0130E- Shower/ Bathe Self

October 2020 Q&A #6

The Take-Away

In order to choose the best response to GG0130E, when bathing is not completed in its entirety per the intent of the item and information from other sources is not available, clinical judgement may be required to determine if the simulation or completion of similar activities provides adequate information allowing a deduced response from the assessment.

Q6. Does the bathing/shower have to be an actual wet shower or bath, or can coding of GG0130E be based on a simulated performance?

A6. The intent of GG0130E – Shower/Bathe self is to assess the patient's ability to wash, rinse and dry self (excludes washing of back and hair). It does not include transferring in/out of a tub/shower, or onto or off of a tub bench. Coding of an activity may be based on observation, patient/caregiver report, collaboration with other agency staff, or assessment of similar activities. Use clinical judgment to determine if the situation of simulating the shower/bath allows the clinician to adequately assess the patient's ability to complete the activity of shower/bathe self (GG0130E). If the clinician determines that this observation is adequate, code based on the type and amount of assistance required to complete the shower/bathing activity.

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GG0170- Bed mobility ability related other items

January 2021 Q&A #6

The Take-Away

Each item should be assessed independently based on the guidance provided for that item. It is prefered that direct observation is the mode to assess functional items, however other relevant strategies should be used when that is not possible. This would include clinician judgement in relating similar activities within the constraints of the item's individual guidance. (As in the example that a patient must participate in order to complete walking activities)

Q6. If a patient is dependent for all GG0170 bed mobility activities, would it be acceptable to code the patient as dependent for all other GG0170 mobility activities even if those activities were not specifically assessed?

A6: At SOC/ROC, the mobility performance code is to reflect the patient's baseline ability to complete the activity, and is based on observation of activities, to the extent possible. Clinicians may assess the patient's performance based on direct observation (preferred) as well as reports from the patient and/or family, assessment of similar activities, collaboration with other agency staff, and other relevant strategies to complete all GG items. Each OASIS item should be considered individually and coded based on the guidance provided for that item. It is important to determine whether the appropriate code for each activity is a performance code (including code 01 -Dependent) vs. an "activity not attempted" code. It is also important to note that a helper cannot complete the walking activities for a patient. The walking activities cannot be considered completed without some level of patient participation that allows patient ambulation to occur the entire stated distance. For instance, if even with assistance a patient was not able to participate in walking a distance of 10 feet, an "activity not attempted" code (rather than 01 -Dependent) would be selected.

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GG0170F- Toilet Transfer

July 2020 Q&A #10 & January 2021 Q&A #8

The Take-Away

GG0170F coding does not include getting to and from the toilet/ commode. It ONLY includes assessing the ability to get on and off the toilet, with or without equipment, once the patient is there.

Q10. 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?

A10. No, in the scenario described the effort necessary to lift up off the bed does not count towards the toilet transfer in GG0170F – Toilet transfer. 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.

Q8. A patient completes a toilet transfer with supervision only. As he was ambulating with contact guard assistance back to his bed, he lost his balance and required assistance to steady himself. Would the contact guard assist and assistance to steady himself be considered when determining the performance code for GG0170F -Toilet transfer?

A8. 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 assistance provided while ambulating to the bed should not be considered when coding the GG0170F -Toilet transfer activity.

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GG0170F- Toilet Transfer

January 2021 Q&A #9

The Take-Away

The intent of GG0170F is to assess the patient's ability to get on and off a toilet or commode. The toilet transfer activity can be assessed and coded regardless of the patient's need to void or have a bowel movement in conjunction with the toilet transfer assessment.

Q9. If my patient does not need to void during my assessment, does this mean an "activity not attempted" code must be used for GG0170F - Toilet transfer?

A9. The intent of GG0170F -Toilet transfer is to assess the patient's ability to get on and off a toilet or commode. The Toilet transfer activity can be assessed and coded regardless of the patient's need to void or have a bowel movement in conjunction with the toilet transfer assessment. Use the appropriate "activity not attempted" code, only if the patient was not able to transfer on/off the toilet or commode and the performance code cannot be determined based on patient/caregiver report, collaboration with other agency staff, or assessment of similar activities.

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GG0170E- Chair/ Bed-to-Chair Transfer

October 2020 Q&A #8

The Take-Away

In allowing the patient to complete the activity as safely and independently as possible, score based on ability. Ability is not caregiver dependent. As previous guidance has referenced, use clinical judgement to differentiate between therapeutic intervention leading to a more independent level of ability and routine assistance allowing safe performance of an activity.

Q8. We have a patient who required substantial to max assistance to perform a transfer during the assessment, so is coded 02 for this activity. This maximal assist transfer is not safe for the elderly family to complete, so two family members will be using a Hoyer lift to transfer the patient from bed to chair. Would the correct code for Chair/bed-to-chair transfer be 02, based on the maximal assist transfer required when the therapist transfers the patient; or would the correct code be 01, because the transfer will be carried out by 2 family members?

A8. The intent of GG0170E – Chair/bed-to-chair transfer is to assess the patient's ability to transfer to and from a bed to a chair (or wheelchair). 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. If the patient performed the activity during the assessment period, code based on that assessment. Use the 6-point scale codes to identify the patient's baseline performance on the assessment. If when allowed to complete the activity as independently as possible, the patient was able to complete the transfer activity with substantial to max assist safely, code 02-Substantial/maximal assistance.

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GG0170G- Car Transfer

January 2021 Q&A #10

The Take-Away

It is preferred that direct observation is the mode to assess functional items, however other relevant strategies should be used when that is not possible (e.g.when specific equipment is not available – vehicle). This would include clinician judgement in relating similar activities within the constraints of the item's individual guidance.

Q10. When coding GG0170G -Car transfer based on a simulation, what equipment or environmental setup would we need to have in order to make the activity similar enough to the car transfer?

A10. The intent of GG0170G -Car transfer is to assess the patient's ability to transfer in and out of a car or van seat on the passenger side. The performance code is to reflect the patient's baseline ability to complete the activity, and is based on observation of activities, to the extent possible. The assessing clinician may, as needed, combine general observation, assessment of similar activities, patient/caregiver report, collaboration with other agency staff, and other relevant strategies to complete all GG items. In situations where specific equipment may not be available (e.g., 12 steps, a vehicle), the assessing clinician may determine that assessment of a similar activity adequately represents the patient's ability to complete the activity. This practice will serve to minimize the use of an "activity not attempted" code in favor of a performance code determined to represent the patient's status in the given self-care or mobility activity. While CMS does not provide specific parameters or a complete list of what is and is not an acceptable proxy activity, providers are expected to use clinical judgment in determining if the "similar activity" meets the intent of the target activity to make it a reasonable substitute when making a coding determination. Use of an "activity not attempted" code should occur only after determining that the activity is not completed, and that the performance code cannot be determined based on patient/caregiver report, collaboration with other agency staff, or assessment of similar activities, in conjunction with all current assessment findings. If, using clinical judgment, simulating the car transfer adequately represents the patient's ability to transfer in and out of a car, code GG0170G -Car transfer based on the type and amount of assistance required to complete the activity.

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GG0170M- 1 step (curb)
July 2020 Q&A #11

The Take-Away

If a patient can complete one step either assessed by observation or report with a rail, GG0170M should be answered based on this ability even if the patient is not able to do a curb step (without a rail) safely. This will allow responses in GG0170N and GG0170O to be collected.

Q 11. Regarding the GG0170M - 1 step or curb item, when we initiate the assessment to code this item with a curb and the patient is not able to perform due to medical/safety reasons, are we then required to assess using a single step (i.e. the bottom step of a set of practice steps)?

A11. There is no requirement to assess a patient going up and down both a curb AND a step. However, coding GG0170M – 1 step or curb with a 07, 09, 10 or 88 when a patient is unable to go up and down a curb results in skipping GG0170N – 4 Steps and GG0170O – 12 Steps. Providers may want to consider assessing the patient's ability to go up and down 1 step in order to capture performance codes of 06 through 01 for one or more of the stair items if the patient can complete the activities with a railing.

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GG0170M and not attempted codes
October 2020 Q&A #9

The Take-Away

Continue to follow the coding guidance for the not attemted codes as follows: 88- the patient completed the activity prior to the most recent injury/ illness but is no longer able due to medical issue or safety concern. 09- Not applicable indicates the patient did not perform the activity prior to the most recent injury/ illness and does not perform the activity at the time of assessment. IF the patient can be observed to safely complete the activity or additional information allows for determination of ability at the time of assessment code accordingly.

Q9. A question has come up regarding when it is appropriate to use code 09 – Not applicable for functional tasks such as curb step and stairs. If a patient has a ramp that he uses to enter his home due to his past medical issues, would we use the code 09? Or do we use code 88 – Not attempted due to medical conditions or safety concerns?

A9. The intent of GG0170M – 1 step (curb) is to assess the patient's ability to go up and down a curb and/or up and down one step. If, at the time of the assessment, the patient is unable to complete the activity and the performance 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. Code 88 - Not attempted due to medical conditions or safety concerns indicates the patient performed the activity prior to the current illness, exacerbation or injury, but does not perform the activity at the time of assessment due to a medical issue or safety concern. Code 09 - Not applicable indicates that the patient did not perform the activity prior to the current illness, exacerbation or injury and the patient does not perform the activity at the time of assessment.

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GG0170Q – Wheelchair or Scooter Use

July 2020 Q&A #12

The Take-Away

GG0170Q should be answered "Yes" if at the time of the assessment, the patient uses a WC or scooter for any reason (April 20 Q&A #15) and no if the patient does not use a WC or scooter under any condition. If a correct response was reported at the SOC, do not update the SOC document if a change occurs after the assessment period.

Q12. A patient does not use a wheelchair at SOC and GG0170Q - Does the patient use a wheelchair/scooter? is coded as "No." Then, during the episode, the patient does use a wheelchair. Would it be appropriate to go back to the SOC assessment and change the response to "YES" and add the corresponding goals, even though the wheelchair use occurred after the SOC assessment time period has ended?

A12. The intent of GG0170Q – Does the patient use a wheelchair/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 SOC, GG0170Q is answered "no" correctly and following the SOC assessment period the patient begins to use a wheelchair under any condition, there is no need to update the SOC performance and/or discharge goals for GG0170 activities on the SOC assessment. The gateway wheelchair item (GG0170Q1 and GG0170Q3) might not be the same on SOC and discharge assessments. If, at the time of SOC, GG0170Q was answered incorrectly then corrections to the assessment should be made following Federal, State, and facility policy guidelines.

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CMS Risk Adjustment Updates

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Risk Adjustment Technical Steps and Risk Factor Specifications

Take-Aways

- OASIS-based home health outcome measures are risk adjusted using OASIS items that are statistically significant and clinically relevant predictors of the outcome.
- This update effective with quality episodes beginning Jan 1, 2021 reruns the prior risk adjustment models after removing voluntary items (Follow-Up Assessment Optional) :
  - M1030 (Therapies)
  - M1242 (Frequency of Pain Interfering)
  - M2030 (Management of Injectable Medications)
  - M2200 (Therapy Need)
- The next major update of the risk adjustment models is planned for the release of OASIS-E. During that update, the risk adjustment models will be based on refreshed data and all risk factors will be re-tested for inclusion.

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Risk Adjustment Technical Steps and Risk Factor Specifications

Take-Aways

- The OASIS-based outcome measures for which the updated risk adjustment models apply starting January 1, 2021 are:
  - Improvement in Ambulation/Locomotion
  - Improvement in Bathing
  - Improvement in Bed Transferring
  - Improvement in Bowel Incontinence
  - Improvement in Confusion Frequency Improvement in Dyspnea
  - Improvement in Lower Body Dressing
  - Improvement in Upper Body Dressing
  - Improvement in Management of Oral Medications
  - Improvement in Toilet Transferring
- Two measures are no longer risk adjusted and reported (Improvement in Pain Interfering with Activity [CY2020 HH Rule] and Improvement in the Status of Surgical Wounds [CY 2019 HH Rule]).

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Thank you

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