Functional Outcome Assessment, Compliance for SNF Therapists. Focus on the MDS: Section GG

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- [Fawn] Today's course is Functional Outcome Assessment Compliance For SNF Therapists. Focus on the MDS, Section GG, our presenter today is Kathleen Dwyer, she's an occupational therapist with over 20 years of experience in the healthcare industry, which includes professional leadership in the corporate setting. Following her graduation from Eastern Michigan university, she focused on earning her certification in hand therapy and also specializes in aquatic therapy. Her experience in therapy management began as the director of rehabilitation for a vast campus, which included a skilled nursing facility, a longterm acute care hospital, and an outpatient therapy center. Kathleen has also served as the director of operations for a chain of 56 skilled nursing facilities. She is certified in healthcare compliance and has also earned the RAC-CT, which designates her as an expert in the skilled nursing facility, prospective payment system and the minimum dataset assessment. She's currently working as the executive vice president for JMD healthcare solutions. Welcome Kathleen, so happy to have you.

- [Kathleen] Thanks, Fawn, so glad to be here and thank you everyone for joining on this topic today. Let's first review my disclosures here. So there they are. And now let's talk about our learning outcomes for today. So after this course, the goals are for you to be able to define the required functional outcome measurement reporting per the impact act and PDPM, the Patient Driven Payment Model. List RAI, Resident Assessment Instrument, rules for assessing for functional outcomes for section GG. And describe a plan of care supporting the assessment of section GG function items. So I will be using many acronyms today, like GG, RAI, PDPM. So I do have a PDF attachment in your handouts. So there's anything that I say that you're unfamiliar with that I don't describe, please reference that as I tried to include all the acronyms that I use regularly in this presentation. So today's focus is on Medicare guidelines that are in place for our skilled residents in our skilled nursing facilities. So remember that this is a

traditional part a patients and the requirements that are set forth by CMS or the centers for Medicare and Medicaid services In 1998, Medicare began paying skilled nursing facilities or SNFs, as I say, quite to shorten it, SNF short for SNF under a Prospective Payment System, PPS. The Prospective Payment System is a per diem rate based on the patient's condition. And it's determined through a CMS prescribed case-mix model and payment classification system. This classification system is done by the use of a clinical assessment tool. The minimum dataset or MDS as you might be more familiar if you work in a skilled nursing facility, I'm sure you've heard the term, the MDS.

So the MDS is required to be performed periodically, according to a very established schedule for purposes of Medicare payment, each MDS represents the patient's clinical status based on an assessment reference date, which has shortened to ARD. So the ARD creates an established look back period for the covered days associated with that MDS. And the RAI manual is the long term care facility, resident assessment instrument. And right now we're on version 3.0 1.17.1 from October of 2019. And this RAI manual provides us clear guidance of exactly how to use the minimum dataset or the MDS, the care assessment, which has also shortened to CAA, C-A-A and also the RAI utilization guidelines. So this is a very large document, it is over 1300 pages long published by a CMS, the centers for Medicare and Medicaid services. So the 1300 pages includes six chapters and eight appendices. It consists of three basic components, the MDS, the CAA, and the utilization guidelines. So we're not going to be going into the detail of the 1300 pages today, thankfully, but the reason why I bring this up is because there's no way for anyone, even the experts of the RAI manual to have everything memorized. So I will be referencing the RAI manual multiple times throughout today's presentation. And that way we know that the information is accurate based on the rules. So you will hear me reference the RAI manual many times today. So our focus is going to be on chapter three, which is the overview to the item by item guide of the MDS. So again, the MDS is a core set of screening, clinical and functional status. It's a standard communication about the residents problems and

conditions. And health professionals are certifying this information. So they have to sign off on this information and attest that it is entered and completed to the best of their knowledge and accurately reflects the residence status. So what I've done to start us off is I have for you a snippet here, we've got two slides of all of the sections of the MDS. And what I wanna do is just kind of lay down a little bit of groundwork because I am an occupational therapist and it really took many, many years before I was really knowledgeable of the MDS.

So I wanna take a moment and acknowledge that perhaps you've never even seen this document before. So let's walk through all of the sections of the MDS so you get kind of a grand scope of what this is, and then we'll hone in on our presentation today will be on section GG. So section A is basic identification information. So it talks about the date that they were admitted, key information like social security numbers, those kinds of identifying factors. Section B is on hearing speech and vision. So this is where nurses assess the patient for how are they doing, what they are hearing? How are they doing with their vision? How is their speech? Now, this is certainly an area where I feel that therapy could contribute to. As an OT I know that in our evaluations, we are always looking for how is their hearing? How is their speech? How is their vision? So any one of us, PTs, OTs speech could contribute to this. I don't see that happening very often, but I certainly think this is an area where therapists could contribute to based off of their evaluations. So C is cognitive patterns, and this is a very... It's an interview type assessment, it's called the bins that's within this cognitive section. A lot of speech therapists contribute in this area, I know some OTs have contributed in this area. So just another kind of point that this is an interdisciplinary assessment. Mood, so the mood is section D where a mood interview, PHQ nine is assessed with the patient. So this is typically done by social workers or nurses. E is behavior. So this is where the MDS captures those residents that might be having some distress or they're disruptive, sometimes with our residents with dementia, where they have some of those symptoms, the nurses will assess that and document it in section E. Section F is

preferences, I think this is another great area that therapy could contribute to 'cause it's about what do they like to do? What are their preferences? Do they like the window's wide open with the sun shining in, or do they like their drapes closed? Do they like it a little bit darker in their room?

So I think as therapists, we always are looking for what are their hobbies, leisure activities, what do they like to do? What do they like to spend their time? So again, very interdisciplinary and that's the point that I'm trying to make. Section G is typically for the nursing staff to assess the patient's functional status. So there's a little bit of a similarity between G and GG, but they are looking at different areas of assessments and so there's different rules to how we're assessing function in both of these areas. So section GG, we are going to go through all of the details today, but as a high level review, it's the assessment for the need of assistance for self-care and mobility activities. Okay, that's a little small, but section H is bowel and bladder. Section I is active diagnosis. So this is where the typically the MDS nurse in your facilities will pull together all of the active diagnosis of the patients. Anything that they're being treated for and monitoring for, they always get listed off in I. Section J is health conditions, so this might be something like a surgery that's happened in the past, that would be listed off in this section. Section K is swallowing and nutritional status. This is certainly an area where speech therapy needs to be involved in.

It's assessing their ability to swallow, what textures are they on? What alter diets are they on? What is their level four liquids? All of that gets included in there, as well as things like weight and height. L is oral and dental status so we know how can they... How is their ability to chew? Do they have dentures? Do they have teeth, et cetera. M is a very large section on skin. It's all about their wounds, any pressure areas, anything that is impaired with the large organ of the skin gets assessed and documented in M. And N is medications. So they list off every single injection, every single order for medications are listed in that area. And O, is special treatments, therapy minutes get

included in section O, if the patient has a restorative program that gets in O and then other things like chemo or radiations, any kind of special treatment that's gets captured in O, and our restraints and alarms are just that. So if the patient is on a restraint, they're gonna document it there and they talk about the reasons why. Q is participation in assessment and goal setting, so was the resident involved with this or did they bring in a family member? How did we assess this patient's kind of overall care plan and goal setting.

And then V is the care assessment. And that is kind of more like the nursing care plans. Where do they develop their plan for any area that has a concern or an impairment. And then X is a correction request, so it's not really clinical. And then Z is more about billing. And then again, it's just those signatures at the end of the assessment from those qualified professionals that have attested that this information is accurate. So I know that was a lot of information, but I think it's important for you to know that the MDS is a large document, lots of assessment, interdisciplinary and it really does look at every little corner of that patient's presentation. I don't think we've missed anything. So the MDS is quite the document. And I have a couple of pictures here, I'm gonna get my pointer out just to show you a few things. So you'll see over here on the right hand side, this is section GG, and it lists off some of the things that we're gonna be talking about today. This is the mobility section. And one of the things I just wanna start off by pointing out is in the MDS and the paper version, they do a nice job of giving us some color coding here. So where you see this green box, this indicates that these items relate directly to payment under PDPM.

So I think that that's great that this is clear and it's right there for us to understand that these are the sections that contribute to payment. So this page over here where I have the pointer is actually the self-care page. So these are the self-care items, which we'll get into in section GG. And then these are the three items that contribute to payment under PDPM. The other thing I wanna point out, if you can see very small little... They

look like dots here on this picture, but they're actually little, teeny, tiny hexagons, all these ones here, as well as all of these here. And the hexagon is an indication that these contribute to what's called the SNF quality reporting program, the QRP. And the QRP is something that we're going to be talking about today too, because this is what contributes to the outcome measurements that CMS looks at. So you've gotten a global overview of the MDS, this huge assessment. And now we're gonna tailor it down to section GG for our talk today, but understanding that we're gonna learn today about how we contribute to this section, how our evaluations can contribute to the section, but it's not just our documentation contributing to an assessment. Our documentation then translates to payment and it also translates to outcomes. So how does this make Medicare feel? Well, Medicare is expecting us to document and code, as they say, the supporting codes in the MDS that they're accurate.

So I'm gonna read this quote here. "Medical review decisions are based on documentation provided to support the coding and medical necessity of services recorded on the MDS for the claim period billed. Medicare contractors focus on the unique individualized needs, characteristics and goals for each patient in conjunction with CMS payment policies to determine the appropriateness of case-mix classifier billed." Okay, and that's a little bit of a mouthful, but what we're saying here is that as we document and that documentation gets put forth towards the coding of the MDS, then what happens is Medicare comes in and they do a review of the documentation. And what they are saying here is that they expect that the documentation and the codes should support each other. And that does make sense, if you're documenting something, the code should be relatively accurate to that. And then they're looking for that to be accurate because they're paid based off of these codes, they're paid based off the data that's collected. So you can imagine if things aren't accurate that Medicare would likely take away some of the money or it could even create them to audit further if they find any inaccuracies here. So laying down that foundation, that it's really important from an integrity standpoint, that what we document and what we contribute

to these areas is very accurate because it relates to payment and of course outcomes. So let's talk first about the Medicare Quality Reporting. Medicare has requirements that are for skilled nursing facilities on how to report your quality outcomes.

In 2014, Congress passed the Impact Act, which stands for the improving Medicare Post-Acute Care Transformation Act. This act requires that standardized patient assessment, data elements also known as SPADES, can be collected across all of the post acute care, also known as the PAC, P-A-C. This is designed to be standardized and to allow for data to be exchanged across all of the post acute care and this way outcomes can be tracked at each level of care. So the SPADES are the required assessments to gather the data for all outcome measurements. And these are at the LTCHs, Longterm Acute Care Hospitals, SNFs, Skilled Nursing Facilities, Home Health Agencies, as well as Inpatient Rehab Facilities. Each level of this post acute care is required by the Impact Act to provide standardized patient assessment data to CMS. So furthermore, this Impact Act established a quality reporting program for the skilled nursing facilities and this is also shortened to QRP. The QRP tells our story about our outcomes of our patients to CMS.

So I bring this up because I think it's really important for us as therapists to understand, again, the documentation that we're providing will relate to these quality measurements or quality outcomes. And we need to be documenting that as accurately as possible to what these SPADES or standardized assessments tell us to do. CMS is looking at our outcomes now more than ever. So we wanna make sure that our outcome measurements are truly reflecting the care that we've given the patient, that care coordination, the decision making that we've done, the discharge planning that we've done, it all combines into this QRP and making sure that our plan of care is written to support this. So let's break it down and really get into the details. Now I get into the details, but I'm not gonna get into the weeds. So the Impact Act has a lot of different areas that they look at as far as you know, how the patient has progressed at

the skilled nursing facility. And I'm gonna hone in on just those areas that impact us as PTs and OTs. So there are three areas in the Impact Act that the therapists contribute to. And these are, change in self-care score, the change in mobility score and the change in cognitive functioning. So therapists are often gathering this functional status information at the time of our evaluations and then perhaps intermittent lane, a progress note, but then again at the time of discharge. So the information that's gathered at the eval and at the discharge, what the formula is here is they take the difference of those two measured outcomes.

So how was the patient doing on discharge compared to how the patient was doing on evaluation? And that change in the score is what is evaluated by the Impact Act. And the measures are scored from the performance areas that we are going to go through today. As a little side note, there are some patients who are excluded from this analysis, and there are also risk adjusters that get added to the calculation, but I'm not gonna get into those weeds today. I just think that for our benefit as PTs and OTs, it's best that we know and understand how, what we contribute in our evaluations and in our discharge summaries, how they play a role in the SNF quality reporting program. So, as I said earlier, therapists gather the functional outcomes scores on the evaluation and on the discharge summaries, those functional outcomes scores contribute to the quality reporting program of the SNF and the outcomes scores come from section GG. And so that's how we're gonna put this together today. The areas that we look at on our evaluation get translated into the MDS and then that data gets pulled from the government or CMS or Medicare and that data is looked at in section GG. Okay, so let's talk a little bit about what are these areas.

So I've broken them into the two areas that we contribute to, OT and PTs. So the first slide here are the OT areas, the left hand column here is the self-care areas. So on our evaluations, we're assessing eating, oral hygiene, toileting hygiene, shower, and bathing, upper and lower body dressing and putting on and taking off footwear. When

we assess these items in our evaluation, they can get translated over to section GG and then that is what the quality reporting program looks at for how they're doing in their self-care areas. Now, the one item kind of bridges us both, PTs can do this, OTs can do this. I've seen it both ways. Well, and actually we all can do any of these areas, but this is your typically OT based section, the mobility area of toilet transfers. So OTs, typically you're evaluating this on your initial assessment of the patient. And so we are looking at how the patient is doing with toilet transfers that again, from the time of about the time of discharge, how much progress did they make that goes towards that SNF quality reporting program. And then our next slide is on PT. So here we have the list of our PT areas, and we're gonna be talking a lot about these today.

So we've got rolling, sit to lying, lying to sitting, sit to stand, bed to chair, car transfers, walking, walking on uneven surfaces, steps and picking up objects. Every time that PTs assess this area on the evaluation, it can get translated over to section GG. And then these are the items that get pulled over into the quality reporting program. So this is what Medicare will be looking at as how did the patient make progress in the skilled nursing facility? Okay, so that is quality reporting. Let's talk now about payment, so as of October 1st of last year, 2019, PDPM replaced the formerly RUG-IV system as the Medicare payment system for skilled nursing facilities. And PDPM came into effect on October 1st as also a perspective payment system and it combines five different areas, they call them case-mix areas or case-mix components of PT, OT, speech, nursing, and non-therapy ancillary. They've added in also an interim payment assessment, which is also shortened as IPA for any substantial changes that happen in the patient's condition.

However, this is optional, so it is not a requirement. Here's your PDPM case-mix groups and we do have a learning opportunity, if you want to learn more about PDPM I would like to take this moment to kind of highlight a course I did on ot.com here. So in continued ed, you can look it up, it is a SNF primer, and there's a two part series and in

the first part, you'll learn a lot about PDPM. So if you're interested in knowing more of the details, I would suggest checking a look to that course. So this particular model represents how the sum comes together for how the payment per day for our patients at the Skilled Nursing Facility. What happens is you take into account the PT areas, the OT areas, speech areas, the nursing areas, this non-therapy ancillary area, and then a non case-mix score. And the non case-mix score is just basically a payment that comes based off of your location. This is how payment is drawn up upon for the skilled nursing facilities. So the areas that PT and OT kind of directly impact that payment based off of that model we just saw is actually what we put in our functional assessment that gets translated over to section GG.

So there's several things that we do in our evaluations that translate over to section GG in a Skilled Nursing Facility. So at this point in time, most evaluating therapists are being asked to gather this information at the time of their evaluations and then again, at discharge. So per the RAI manual section GG in the MDS, it's intent is to include items about the patient's functional abilities and their goals. It includes items that are focused on their prior function, their admission performance, what their discharge goals are, and then they're discharge performance. Functional status is assessed based on the need for assistance when performing their self-care and their mobility activities. So just to kinda see how this whole picture gets put together. So what happens is typically the PT and OT do their evaluation and the person at the facility who takes this information and applies it to section GG is typically the MDS nurse. So most skilled nursing facilities have a point person in charge of the MDS and that nurse is gathering and collecting the data that's needed for each of the areas of the MDS.

So whether they're gathering it from social workers or they're gathering it from the dietician, we all contribute to that large assessment, again, it's interdisciplinary, but the MDS's role is to really pull all of our information together and then apply it to the MDS or in, for our case section GG items. So that's why I think it's important for us as

therapists to really understand what are these rules behind section GG, because of what I'm putting in my eval is going towards payment eventually and going towards quality reporting. I'd really like to make sure that I'm giving accurate and correct information. So that's kind of why we put this course together is because many of us as PTs and OTs are contributing to these areas, the MDS nurses using our information, but do you know how this all works? I'll tell ya, it's evolving, it's always changing, it's hard to keep up with.

So what we've done today is try to break it down so that we can understand exactly, how this all works first and then what are the rules behind this section? Because if we understand how it's supposed to be assessed according to GG, then I think we'll have a better, more compliant assessment as therapists. Okay, I digressed a little bit, but let's get back on track here. So we are on now the breakdown of the OT areas, self-care, that impact payment. And we saw those earlier in that little picture I gave you of the MDS, it's eating, oral hygiene and toileting and then again, that toilet transfers. So our assessment of these four areas directly impact payment now in the Skilled Nursing Facility. Over here is the PT areas, so you're sit to lying, you're lying to sitting, you're sit to stand, you're chair to bed, to chair transfers, your walk 50 feet with two turns and your walk 150 feet. I'm guessing that you have some familiarity to these items because I'm finding and seeing, and most evaluations now are kind of targeting these areas that you have to do them on your eval. So perhaps now you're going, ah, now I know why but these are the areas that we contribute to, and these to directly relate back to that payment model. So it's really, really important again, from that integrity standpoint that we know we're doing a really accurate assessment of these areas.

So in summary, GG is critical to SNF reimbursement, it's critical to quality measures and PTs and OTs, probably having knowledge of the RAI manual guidelines of how section GG is supposed to be coded probably help us to get a better understanding of

how our documentation then gets translated over to section GG. I think it's also important to remember that our documentation is constantly being reviewed by auditors and probes. So it's important that when they read our documentation, it's consistent with what's being coded in section GG, payment could be denied. So any kind of discrepancy or inconsistency between the MDS and documentation, whether that be ours or nursing that would likely contribute to future audits probes, or denials even for the facility. So my point is that section GG needs to be an interdisciplinary assessment.

So it's just kind of an FYI if we are not in on the case, so let's say the patient comes in and doesn't need our services, this section of the MDS still needs to be completed. So nursing will have to assess this item, even though these are kind of our wheelhouse, our areas of expertise. If we're not seeing the patient, then the nurses will do that section and I think that that's important to know. And that's why I said earlier that if PT isn't in on the case, OT, you can assess bed mobility. It's perfectly fine and you might be asked to do that. So again, for both of disciplines that are on the call today, I think it's important for you both to know on both the mobility and the self-care side, as we are the professionals in the function of our patients. So dollars are still allocated under PDPM for PT and OT, even if we're not in on the case. And over 200 areas that impact payment are on the MDS, so you can tell that the MDS is a very, very important document in the skilled nursing facilities.

So we are going to take deep breath here, and we're gonna move on to the actual scoring of section GG. And I'm just going to say that, I'll use the term kind of coding a lot, like as you code the MDS in this section, and what I'm referring to is, again, that MDS nurse is responsible for taking the information from our evaluations and then putting in a code into section GG. What our goal here is today is that we're gonna make that job to that MDS nurse really easy, because now you're gonna learn how our documentation can really be a support and an adjunct to what that MDS nurse is

looking for. So a lot of details come in here. But section GG items that we talked about, we have on the far left column, that's the item number. So each section has its own breakdown in the MDS. So we have section GG01030, which is the self-care area. And then we have those three areas that impact payment, eating, oral hygiene, toilet hygiene, A, B, and C. And then we have section GG0170. B, C, D, E and F, which are all the mobility areas of bed mobility and transfers. And then sections J and K, which are mobility walking items. What happens here is that with each of these items, the MDS nurse is responsible for taking self-care, looking at our documentation, how we've assessed it, what level and then she puts in a score of zero to four.

We're gonna talk about what those scores are on the next slide, but I just want you to get a picture of what happens here. First eating, it's a standalone score, oral hygiene is standalone, toilet hygiene is standalone. These three directly impact how we score these impacts payment directly. Now these two in green, sitting to lying and lying to sitting, your scores in these areas get averaged and then that score gets applied towards the payment model. And then this light purple, these three scores get averaged together, and that gets one score impacts payment. And then your mobility walking, your two turns walking with 50 feet and your walk one 150, are averaged together and that impacts payment. We're gonna be talking a lot about these. So if that's a little overwhelming, don't worry, I'm coming back to it a couple more times. So like I said, each one of those areas has a zero through four score.

So what you should know is that how the patient's level of assist correlates to that function score. So if they're dependent, they get a zero. If they're substantial, maximal assists, they get a one. If they're partial or moderate assistance, they get a two. If they're supervision or touching assistance, they get a three. And if they're set up assistance are independent, they get a four. So this is in our MDS, the directions for this coding comes from the RAI manual. And so it's really important because if I just say dependent, max mod, touching supervision, independent kind of sounds like

therapy language, but then it kind of doesn't, right? 'Cause I was not trained with substantial or partial, moderate, in a traditional physical rehabilitation education. You and I were trained to assess our patients as independent, modified independent, maybe standby assist, supervision, contact guard, mean mod, max dependent. That's a different scale. And so that's what I really want you guys to grasp on. There's a bit of a translation problem here because our assessment from physical rehabilitation, doesn't exactly dot line over to how a section GG is supposed to be coded. So this is where in my job we've done a lot of audits to kind of have an understanding of this and we've seen conflict.

And so again, this is why we wanted to talk it through today, to see if we could kind of work out some of the conflict that others have had because of this translation issue. And it's important because it's impacting payment, it's impacting quality measures. So this is the scoring response for section GG items, again, according to that RAI manual and the MDS. Now, we also have these... They're all zeros, by the way, the function scores are zero, but these are scoring responses that CMS says should not be used all the time, but there are certainly some reasons why we would not be able to assess an area. So 07, represents that the resident has refused. we've all had that patient where it's just not gonna happen. They're just not gonna follow through with what we need them to do, so a refusal can happen. 09 is not applicable. So per the RAI manual, this means that the idea that you were going to assess, let's say it's toileting was not attempted and the resident did not perform the activity prior to the current illness. So again, let me say and it was not attempted. And the resident did not perform the activity prior to the current illness. This 09 not applicable means that the patient didn't do this before.

So I'm not gonna assess it now, 'cause it doesn't matter, they didn't do it. You can imagine that in our situations of our patients, that there's certainly a time where this is gonna happen. You're you're walking is a great example, if the patient was wheelchair

bound and has been in a wheelchair for 20 years, then you're not gonna be assessing walking, it's not applicable, make sense? Just remember that there's an and, so you didn't attempt it. But the key here is that the resident did not perform the activity prior to the illness that you're now treating them for. A 10 means that the activity was not attempted due to environmental limitations. So this would mean like the lack of equipment, maybe the staircase, isn't something you have, so stairs you can't test whether constraints is listed here because of the car transfer.

So if you're not able to do a car transfer outside because it's snowing, then that would be a good reason to use 10. An 88 means that it was not attempted due to the fact that this was either because of their medical condition or because of some safety concerns that you have. So I've seen 88 a few times where the patient is extremely sick. They're having blood pressure issues, there is just some medical reason that you're not going to be doing any kind of transfers with this patient on this state. So you're making that clinical decision that this is not a good time to be assessing that activity. And then finally, there's actually a dash. Now the dash would indicate that there is no information on this activity, but CMS expects that this would be very rare. However, some of the audits that we have done are showing dashes, particularly with mobility areas. So just as a little FYI, we should be avoiding using the dash and CMS would rather, we choose the actual reason why an activity was not done, okay.

So let's talk a little bit about clinical presentation, Let's wrap our heads around this as therapists. I'm gonna give you an example here. Our patient presents with the ability to independently feed self, she requires set up assist for oral hygiene. She is able to complete toilet hygiene with min assist. Bed mobility is min assist just for sit to lying, min assist for lying to sitting and max assist for sit to stand. Transfers to chair, bed to chair and toilet transfers are also max assist. And currently the patient is not able to walk 10 feet, but PT does indicate the goals are appropriate for walking later in this plan of care, what would be appropriate for the patient to be working towards. Now,

let's look at how that would translate into section GG. This is just a clip of an example of how section GG gets scored. So you can see here that we've scored section GG based on the presentation that I gave in the clinical representation of the patients. So we have, eating is represented now as a six independent, we have oral hygiene and toilet hygiene represented as set up or clean up assistance and partial moderate assistance. And then the bed mobility items you'll see are partial, moderate assistance and partial moderate assistance. And then sit to stand maximal assist and chair to bed, bed to chair transfers, maximal, and also for toilet transfers that substantial maximal. And then our goal indicating that patient is not walking now, but it is clinically indicated. So most of our companies have softwares that automatically kind of convert these to that payment. So our section GG levels get converted into the PDPM scoring.

So we're not gonna talk too much about how it translate into scoring, but I wanna just show you what happens. There's a calculation behind the scenes that happens with each of those areas and so now what it does is it breaks down into a score. So what that presentation of the patient I just gave you, actually gives her a score of 13 for GG and that 13, for both PT and OT here, translates to the PDPM case-mix group of TK. And that TK then translates into this case-mix index, which then translates into how much they get paid per day for that area of that component of PDPM. I remember we went back to that screen where there was the kind of the multiple components, on the circle, you add them all up and that's your total rate per day. So PT and OT, I mean, just for this example, you would be PT, you would be getting $107 a day for the patient and OT $101 a day for the patient. I hope I haven't lost you, but again, I feel it's important that if we're going to be gathering information for an assessment that contributes to payment, doesn't it kind of make sense for us to know like how that works. So this is, again, most softwares are doing all that calculation behind the scene as we are equipped with lots of different documentations systems. They all are now doing this, now that we're in PDPM. So the basics of this screen here is that as a PT and as an OT, you contribute to payment. That's the bottom line here. So why is it

important? I think I've said it already. It's really important for us to know how this all works, because we are the ones that are gathering the information. And I can tell you that, 'cause I've done a lot of chart audits. I've read therapy of ALS and then I've glanced over into the MDS and it's exactly what you said. The PT didn't , PT said max assist, section GG says max assist.

So I know with all the audits we've done, I know that what we put on our evals is being contributed to section GG, maybe whether you know it or not, I'll tell you right now, it's probably happening. So I just think it's important for us to be able to understand that what we gather contributes to the MDS. And I think it's critical that we're trained on how to assess and may I use this term lightly, code based on RAI gap guidelines, as payment is directly related to many of the areas that we are assessing and audits and probes are going to be looking at this information. And if our documentation doesn't support what's on the MDS, we're gonna have conflict and that might then lead to further probes or audits. So getting into the details a little bit more section GG. Now the very first area or item is 100 and this is the prior functioning. This is certainly an area that we all try to capture on our evaluation. So what was this patient's prior level of function? I'm sure you've seen this on your evals.

So you might be asked to be gathering this information, reporting it to the MDS nurse and now you know why, this is the very first question in section GG. They wanted to know what was this patient's usual ability prior to the current illness, exacerbation or injury. So self-care, for example, were they independent? Were they dependent? Or did they need some help? I mean, it's a very simple scale here. It's independent, needed some help, dependent or it's unknown or it's not applicable. But again, CMS is really hoping that we can assess this and not use that unknown or not applicable unless it's just a rare circumstance. So we need to know how they were doing with their self-care, how they were doing with their mobility, how are they doing with their stairs? And how were they doing with functional cognition? And the range for all those

items is right here. Just simple, very simple question. So you might be putting in, in your assessment, something much more specific, 'cause that's how we were trained, but all MDS is looking for is to know whether they were independent, needed some help or dependent. The very next question in section GG is to actually determine what type of device they used prior to this current illness, so it's immediately prior to this illness. And in the MDS manual, it says that we can ask the patient or the family members, or we can gather this information via a chart review.

So they wanna know, what was this patient using prior admission? Were they using a manual wheelchair, a motorized wheelchair or scooter, a mechanical lift? So that would be a sit to stand a stair lift, really any full body lift like a hoyer lift, a bath lift, were they using a walker? And this includes all types. So we are talking about four wheeled, knee walkers, pickup walkers, hemi walkers, rolling walkers, platform walkers, all we need to mention in this section is were they using a walker? So that's pretty clear. Were they using any kind of orthotic or prosthetic or the last option in this section is none. So absolutely this is something that we have on our evals and the MDS nurse, can certainly glance at the PT or OTL and find out what their prior device use was. So it's important that you gather that information and I know it's hard when we're all strapped for time and trying to get all these boxes checked, but I think it's good to know that that's one area that we can very easily contribute to for the MDS nurse. Okay, so now we move into the next item, which is 0130 self-care and 0170 mobility. And as it stands now, the requirements in the MDS for section GG is that we have an admission performance scored as well as a discharge goal set. The discharge goal, this should be a minimum of one self-care or mobility discharge. I'm sorry, with self-care or mobility, so it's one area. And the discharge goal is required to do at least one, but some facilities definitely complete more than one and you might be saying, Oh, I write like five on my evals and that's perfectly fine. But as the MDS stands, the facility is required to capture at least one discharge goal. Then we also have, as I mentioned earlier, this optional interim performance. So this is a new assessment that was added with PDPM,

it's called the IPA. So just one more acronym to learn. This one is something that the facility can choose to do, or they can opt out and they don't have to do one.

So you might be approached by an MDS nurse or someone at your facility and say, "Hey, I really need you to do a progress note and I need you to score section GG items." Well, now you know why, it's because they're choosing to do some sort of optional assessment. Typically they would choose to do that when the patient has had a significant change. So as an evaluating therapist, you know what? It might be appropriate anyhow for you to be getting in and checking in on that person, because an IPA isn't done for just no reason, it has to be done 'cause something's going on with the patient. And as an evaluating therapist, I think that, we can all agree that that would lead to believe that maybe an evaluating therapist should get in on the case. So just so you know, that's something else that you might be asked to do. And then finally we have a requirement for a discharge performance to be completed at the time of their discharge and we're gonna get into that a little bit more, so I'll talk more about that later.

So again, speaking about at the time of admission, so at the time of our initial assessments, the MDS nurses required to write at least one interdisciplinary goal. This is supposed to be the group determining what's best for this patient. So it could be discussed maybe at a weekly team meeting, maybe the nurse, the therapist, social worker, everyone should be agreeing upon that we're setting a goal that makes sense for this resident, this patient and if you are contributing to it, I think we just need to keep in mind the considerations. So that would be what is this patient's medical condition? What do we think is going to be appropriate for the time of discharge based on what the family and the patient have told us, are they gonna be able to be alone? Are they gonna need supervision? Another consideration, how motivated is this patient? What's the anticipated length of stay? How long will they be there? What's the discharge disposition? As I said, where are they going? How much help will they have?

So here's an example, Mrs. Smith was admitted to the SNF after a fall with femur fracture, prior to admission she used a walker and was modified independent with mobility and self-care. So the admission assessment for walking 150 feet would be coded at partial moderate assist. And the patient's goal was to return home at a Walker level. So the interdisciplinary team would set up that discharge goal as a 06 independent, because this would mean that the team agrees that the goal for this patient should be discharged as independently as possible.

So we're going to talk now about how the RAI manual explains how this assessment should be completed. And I think this is really key to those of us who are contributing the information that we provide on our evals goes over to section GG because per the RAI manual, CMS is anticipating that this is an interdisciplinary team of qualified clinicians that are involved with assessing the patient during the first and for the initial one, it's a three-day assessment period. So we are assessing self-care and mobility performance based on direct observation and in the RAI manual, that actually is defined as also being able to incorporate resident self reports and reports from qualified clinicians. So that would mean we could gather the information from other staff, nurses, care staff, even family. But again, the assessment that we do is supposed to be based on our own direct observation or gathering self reports. The patient in these assessments, and this is important because again, think about if you are coding or you're gathering information that gets coded right to GG. This is how the RAI manual is expecting us to assess the patient. They are asking us to allow the patient to be as independent as possible, as long as they are safe. So this means that we're looking at what the patient's doing truly at their own baseline without our interventions. And then they say that... They use the word helper throughout the RAI manual and I'm gonna be saying that word a lot today.

So how is the helper defined? And that is actually facility staff. So anytime assistance is required, that would mean that maybe the resident or patient isn't able to perform

the activity safely. So you're involved, or the facility staff have to get involved, you're considered the helper per the RAI manual. So again, that's defined as rehab staff. That would be anyone contract therapy, staff in house staff doesn't matter, nursing staff, again, same thing, even if they're agency staff, they are nursing staff, they are considered a helper. However, in the RAI manual, it does not include the hired help. So if someone has a private caregiver and they're the ones performing help or assistance to the patient, we can't consider their help when we're coding and when we're assessing, we cannot include hospice staff and we cannot include students. Steps for assessment continued on here, a couple more slides. Remember our evals are a point in time. So we are, as far as how this patient is doing right now as you're assessing and from the RAI manual and MDS is concerned, they also need to consider that our evaluations are a point in time and their job is to make sure that it is being assessed over that three-day period. So just a little kind of to remember that it's interdisciplinary and we are all looking at this patient maybe at different times with our different eyes, but the goal of this assessment is that we are all getting that usual performance of the patient within the first three days.

So when we are assessing, we are allowing the patient to use the device, whether or not they use one, a walker, a cane, it doesn't impact coding. And as I slightly mentioned earlier, this assessment should be conducted prior to them benefiting from our services or interventions. And I think that that's a tough one for us 'cause it kind of goes back to how to do an eval 101. You wanna really make sure that you're not giving them cues, you're not telling them to reach back. You're just... When you're assessing these areas, you really should try to look at that true baseline area. And if you do that, then you can use your assessment towards GG 'cause you're following the rules for it. And finally here we have usual performance and I did mention this. We have to record in the MDS, the patient's usual performance. And they're very clear that this is over the three days, the initial three days that the patient is in the facility, that we are not to record the patient's best, we are not to record the patient's worst performance, but

that we are responsible to assess the patient's performance, understanding that it could vary, especially if we've got sundowners or you've got deconditioning, they're gonna get tired late at night. So section GG is really looking for that resident's usual performance to be identified. We have three days so, and day one would be the first day that they are admitted into the facility.

So by the end of the third day, that assessment needs to be gathered. As I've mentioned a couple of times, it's an interdisciplinary assessment, so it's not necessarily all on us here, but I think it's important that we understand the rules so that as we're gathering the information we can contribute to the MDS. So our assessment is our direct observation, what have we seen the patient do? Patients self report if that is a have good cognition and they can tell us how they have been doing with things, you can use that as gathering for your assessment. And you can also use what the family says, how the patient was doing or what was documented in the medical record. So just remembering that these are very specific multi-step areas of function that need to be gathered, looking for the language of the RAI manual to be used in gathering the levels of assist.

So what I've mentioned is that we have seen some kind of language translation issues because again, section GG's language is quite different than therapy language as we were all taught in school. So what I have done for us today is kind of talk wanna talk about how we at JMT healthcare solutions, the company I work for, how we have interpreted it, because what we've seen is that there is a disconnect here and we've seen some documentation that therapists have written that really doesn't flow well over to section GG, there's conflict. So what we've done is we've kind of made the assumption that we do speak different languages. We want therapists to be able to understand the guidelines of section GG. We want therapists to be able to understand the language that's in the RAI manual. And we wanna appreciate that it's not the same as what we were taught. So with that said, we created a little translation crosswalk that

we call it. And I'm sharing it with you today because I do think that it's important to have some sort of benchmark because it doesn't correlate exactly, this is our interpretation. I've added this in our handouts.

So you have a PDF of this, 'cause I know the slide is very small. So this is something we're gonna be talking through over the next several slides. But I want you to know you've got this resource from us and we're happy to share it with you, but again, a little asterisk there, it is what our interpretation of what we read in the RAI manual. And I'm gonna walk through it so all that information that was on that slide, we're gonna go through. This is a great decision tree, so we all think a little bit differently, so if our crosswalk doesn't kind of jive with how you think, I think this is another great way to learn how section GG language is written. I have pulled this information directly from the RAI manual, so this is there is I can't take any credit for it. So how it starts is that you have to ask yourself, does the patient complete the activity with, or without assistance devices by themselves with no assistance? And if the answer is yes, then you code them or they would be coded. I'm gonna just kind of say we code it. But I know the MDS nurse is probably the one coding it, they would be coded as a 06 independent. If that's the case, then we would say no and we would come down here and say, "Does the patient need only set up, clean up assist from one helper?" And if the answer is, yes, they get a 05 set up clean up. And if it's no, you come down here and you ask the next question, does the patient need only verbal, nonverbal queuing or steadying, touching, contact guard from one helper? And if the answer is yes, then we code them as supervision touching assistance. And if it's no, then we're going over here to the next question. T

his question says, does the patient need a physical assistance from one helper? And here's your key, providing less than half of the effort. If they're getting less than half of the effort of help, then you're gonna code them 03 partial moderate assistance. If that's not the case, then you go down here, does the patient need physical assistance from

one helper with the help of performing more than half of the effort. And if they're performing more than half of the effort, then we're gonna code them a 02 substantial maximal assistance. And if that's not the case, then you come down here to dependent, does the helper provide all of the effort to complete the activity or is the assistance of two or more helpers required. So at any time, if two helpers is required, then it is going to be dependent, that is clear in the RAI language. And that is something that we've seen missed where therapy or right model two, and then code them at mode assist 03. So anytime you have two helpers, we're gonna code it 01. I gave you the link there for the RAI manual and I know I have this later in the presentation, but the link is right there as well to CMS deck of, and then you just go right to that manual. Or I will tell you later in the presentation, another way you can get to it, but on the cms.gov website, you can always get the access to the most up to date RAI manual and like I said, that came directly from there.

So I've taken some quotes directly out of the RAI manual. And I wanna do just kind of a quick review on self-care and mobility. So we're assessing the patient or resident based on our direct observation, the patient should perform the activity as independently as possible. We're coding the usual performance at the start of the stay over that three day assessment period. We're coding the usual performance at the of this day, which is the three days, the last three days of the time in the facility and the assessment should be conducted prior to the resident benefiting from treatment. So that means any of our skills that we give to that patient they haven't benefited from them, we're getting a true baseline at that time of admission. I'm gonna just talk one slide here on IPA. I know we've talked about it, but just as a little recap, it is optional. It's that interim reassessment. And if you are being asked to do the interim assessment, if you're being asked to perform a progress note so that the MDS nurse can capture GG, what you would wanna do is know the reference date, know the assessment reference date ARD and your assessing that patient based on their performance from that ARD plus two days prior. So if you've seen the patient in that

three day window, you can assess them, write a progress note and do your section GG items for the MDS nurse if she asks you to, or he asks you to. Discharge assessments, these should be completed as close to the time of where the residents discharge from part A as possible. It is required to be an assessment of the last three calendar days of the Medicare, A stay. And this is an assessment that is required for planned discharges only, it's not something that they have to do on patients who get sent to the hospital as that is not a planned assessment. So just good tip to remember there.

Okay, coding instructions. Now I'm gonna just give you a little warning here, I loaded up these slides, I intentionally put them together with a lot of information because I really am trying to connect the dots now for you. And I also thought maybe if you ever wanna reference back to them, it might be helpful to have all of this information on one slide. So it's a little bit deeper dive into the coding instructions per the RAI manual and how that language compares to our rehabilitation textbooks. So let's go ahead and get started. We're gonna begin with the code for 06, which is independent per the RAI manual. The language in the RAI manual says that the individual completes the activity with, or without assistive device by themselves and with no assistance. This includes no physical, no verbal, nonverbal queuing, no setup, no cleanup, it is completely independent. And what I've done is I've taken the language out of Susan B O'Sullivan and Thomas J. Smith's book, "Physical Rehabilitation Assessment and Treatment." This is from the fourth edition copyright 2001. And according to them, the definition of independent is that the patient completes the activity with no assist, no supervision, no device, and is safe to complete the task freely or ab lib, so very similar. And then we have modified independent, which means that the completes the task with the device, walker or cane or grab bar, bedside commode, and requires extra time to complete the task.

So what we see here is that our language kind of that modified independent includes the use of a walker or cane or device that is also included in their RAI manuals version

06. So independent and modified independent are roughly equivalent to 06. Student example, Mr. R uses an electric wheelchair for longer distances. Once he is seated in the wheelchair, he does not need any help to mobilize himself. He is able to drive without any instructions up and down the hallway, at least 150 feet. So that would be coded 06 independent. Now let's compare the language in 05. The RAI manual says 05 setup or cleanup assistance is the patient completes the activity with only set up clean up assistance from one helper, helper only assists prior to, or following the activity, but not during the activity. So I didn't see anything in physical rehabilitation that really correlates to that, but I did find FIM.

So the uniform dataset for medical rehabilitation for adults, the functional independence measure describes supervision or set up as patient requires no more help than standby queuing or coaxing without physical contact or someone is needed to set up items or apply orthosis requires supervision and or verbal cues to complete the activity. And I said to myself, "Hmm, is this really the same." I don't think so. I mean, I think it's definitely a dilemma of our translation issues because we don't really have in our therapy language a set up that is just purely, go ahead, set up and then leave. As therapists, we always are kind of hanging around them, supervising them and making sure they're okay. And so that would be supervision, but just true setup. And so maybe this is something to kind of think through and I'll use this example so that we can kinda talk through what does this true 05 code set up mean? So the helper moves the wheelchair foot rests up so that Mrs. T can transfer from the wheelchair onto the toilet by herself safely. The helper is not present during the transfer because supervision is not required. Once Mrs. T completes the transfer from the toilet back to the wheelchair, she flips her foot rest back down herself. This is considered set up as the helper only moved the foot rest out of the way prior to the transfer.

So set up, clean up 05 is literally just that, all the helper is doing as either setting up the activity or putting the things away after the activity has been completed. There is no

needed supervision. There is no needed cues. So make sure you're aware of this, if you're choosing this level to pull over to your therapy documentation or to pull over from your therapy documentation to the MDS. 04 Supervision/Touching per the RAI manual reads the patient completes the activity with only verbal, nonverbal queuing or steadying and touching contact guard assist from one helper. Assistance may be provided throughout the activity or intermittently. And our language, we have that supervision/standby assist, no physical contact required from staff. However, staff should be close to maximize safety and then we have contact guard assist, which requires light physical touch from the staff but no actual assistance. Hand is lightly placed on the back to steady patient.

So again, I'm pointing this out, I put them on one slide here is 'cause I really don't think it's like a direct, dotted-line translation. We really have to kind of know both definitions and know that 04 per the RAI manual is that the patient is getting cues and that they're getting touching or maybe touching or maybe contact guard, maybe some steadying. That's what is 04 per the RAI manual. Let's do an example, we have Mrs. K suffered a stroke recently, and this resulted in cognitive decline. She brushes her teeth at the sink side, but is unable to initiate the task on her own, the cues Mrs. K receive from the OT, help her to get her toothpaste on the toothbrush, the OT cue sort of brush all areas of her teeth and rinse her mouth. The OT remains with Mrs. K during the task, providing verbal cues until the task was complete. So this is 04 supervision, touching assistance as the help provided both cues to come both physical and verbal cues for her to complete the task.

Okay, this is the one I see the most errors in. So moderate assist, I think in our therapy language is 50% help and that's not how this is described. 03 partial moderate assistance per the RAI manual is that the patient requires physical assistance, for example, lifting or trunk support from one helper with the help of providing less than half of the effort. So partial, moderate assistance helper does less than half of the effort

versus our physical rehabilitation language. We have min assist, which the patient requires at least 25% of support assistance or support to safely complete the task, the effort by the patient is 75% or less. And we have mode assist on the next slide, because truly by definition, mode assist should probably move over to maximal assist. But this is where it's challenging again. Our definition of min assist is that they require at least 25% and effort is less than 75%. The RAI manual says 03 is they require less than half of the effort. It's very difficult to understand you really need to take into consideration the presentation of your patient in front of you.

I have a another example here to help you. Mrs. S has multiple sclerosis affecting her endurance and strength. She prefers to feed herself as much as she is capable during all meals. After eating about 75% of her meal by herself she becomes extremely fatigued and request that the staff feed her the rest of her meal. So that would be an example of 03 as the helper is providing less than half of the effort of the task. And now we have 02 substantial maximal assist, per the RAI manual this one requires more than half of the effort. Patient requires physical assistance, for example, lifting our trunk support from one helper with help or providing more than half of the efforts. Our rehabilitation language says mode assist patient requires at least 50% assist from staff, effort by patient is 50% or less. And max assist requires 75% assist or support to safely complete the task, effort by patient is 25% or less. So a lot of confusion because of that language of moderate assist being in 03. But we really feel that mode assist should be kind of more translated to 02, providing more than half of the effort.

So again, your clinical judgment is imperative here. I think that you really need to code based on their usual performance. So do they normally need more than... Half of the time do they need help? Or less than half of the time do they need help? So let's do an example, Mr. T suffered a spinal cord injury that has affected both movement and strength in both upper extremities. He places his left hand into one third of his left sleeve of his shirt and requires assistance from the helper to complete the remaining

upper body dressing. This is an example of substantial, maximal assist as the helper has provided more than half of the effort of the task. And then finally, 01 dependent for the RAI help or provides all of the effort to complete the activity or the help of two people is required. Our language from therapy dependent requires 100% assistance or support from staff member to complete the task. So I think we finally have a direct translation. Mr. Z had a stroke that resulted in paralysis of his right side and he was recovering from cardiac surgery. He requires the assistance of two when rolling onto his right side and returning to lying. Also when rolling on his left side and returning to his back, this is coded as 01 dependent as it requires the assist of two helpers. Huh, okay, well, there were the details, I hope you enjoyed that.

Let's move on to some just tips and kind of understanding what these areas are supposed to be looking at. So I've broken it down each item in self-care and each item in our mobility sections. And we're just gonna kind of talk it through, so you know what eating means to the RAI manual, 'cause there's some things in here that might be different than what we assume. So eating per the RAI is bringing the food and liquid to the mouth and swallowing food. This includes modified food consistency and the administration of tube feedings and parenteral nutrition is not considered when coding this activity. So if they're on a tube feed, then it would be coded 88. A couple of examples, I pulled out of the RAI manual here.

So like I said, if the resident does not eat or drink by mouth and is 100% on tube feed or TPN because of a new condition, then that would be an ADA, not attempted. If the resident does not eat or drink by mouth and didn't prior to onset of illness, we code 09 not applicable. And if the resident eats by mouth by partially relies on tube feeding, we're gonna code based off the assistance needed to eat by mouth. The tube feed is not considered one coding eating. Oral hygiene is the next item. This is the ability to use suitable items to clean your teeth. This would include dentures, caring for the dentures, the ability to insert and remove the dentures. And it would also include if they

don't have teeth brushing their gums. So let's do an example here. If Mr. G has parkinson's disease resulting in tremors and incoordination, the helper has achieved all oral hygiene items for Mr. G and applies toothpaste to the toothbrush. He requires assistance to guide the toothbrush into his mouth and steady his elbow while he brushes his teeth. Mr. G is not able to finish the task without help. We would code this 02 maximal assist substantial as the helper provided more than half of the effort to complete the task.

Let's talk a little bit about toilet hygiene. So when we're assessing toilet hygiene, this includes managing undergarments and the clothing and performing perineal cleansing before and after avoiding or having a bowel movement. So they do clarify in the RAI manual that if they don't normally wear underwear, that's fine, just assess the lower body clothing and the perineal hygiene. Another important point here is that this is clarified in the RAI that we include their toilet hygiene, whether they're using a toilet, a bedside commode, a bedpan or urinal. So some people will say it's not applicable because they're not going to the toilet, they're only using a bedside commode. We wanna point out, toilet hygiene can be actually any one of those four areas. If they have a catheter, this is another good example. They have a catheter, but they do have bowel movements. Then we would code the toilet hygiene that's required for the bowel movement. Hey, we have item E here, shower, bathe itself includes the ability to wash, rinse and dry the face, the upper and lower body perineal area and feet. The only areas that this does not include are the back and doing hair, nor does this include the transfer to get in and out of that tub or shower. So I thought that that's kind of important. That might be a little bit different than as an OT would look at it 'cause we usually look at upper body bathing, lower body bathing, but this is both.

So that's key to remember when you're assessing for this area. They also clarify in the manual that you can assess this based off of the patient's ability to bathe and shower in a shower, in a bath or at the sink side or bedside. So you can do a full body sponge

bath with the patient and you can still use your assessment towards section GG area E here. According to that RAI manual, again, we're just quoting it, every other slide here, maybe every slide at this point. So I combined upper and lower body dressing, but these are two separate items. So we have area F item F, which is upper body dressing and item G, which is lower body dressing. So when coding these areas, helper assistance with buttons and fasteners, fasteners is considered touching assistance. So if they're able to get their pants on, but you have to do the button for them, then that would be a code for touching assistance. Hospital gowns, this is clarified in the RAI manual that you are not supposed to assess upper body dressing with a hospital gown. So you're supposed to have either a shirt, undershirt, buttoned down pull over, a dress, a sweatshirt sweater, a nightgown, a pajama top. Any of those are fine, but the RAI manual does say that a hospital gown is not to be used when assessing upper body dressing. So I know, again, as an OT, I didn't know that was a language in the RAI manual.

So if I'm being asked to contribute to section GG, I need to remember that when I'm assessing my patient to go find their sweater or their pajama top and really do my assessment using what the RAI manual is asking me to assess with. Lower body dressing, we have underwear, brief, slacks, shorts, pajama bottoms, capris skirts, pretty much anything below the waist counts. And then the footwear items would be socks, shoes, boots, and running shoes, that's what they clarified. I don't know how many of our patients are doing running, but that can count. Also with dressing, I wanna make sure we understand how the RAI manual considers any bandages orthotics stockings, so let's talk a little bit about that. For the upper body. we would consider any orthotic. So at TLSO, an abdominal binder, a back brace, or a stump soccer shrinker, or a hand or arm prosthesis, you would consider that and count that, as a piece of clothing when determining the need for help for upper body dressing and pretty much the same for lower body. If they've got a knee brace or a stump socks shrinker, or a lower limb prosthesis, you would count that when you're assessing the

lower body dressing. So if they can do everything, but they can't do their stump shrinker without your help, then you're gonna have to code it based off of that lower level of how much help they need. 'Cause remember this whole assessment is about how much help they need over the normal usual performance. So you would need to count that that help was needed for the shrinker. There is also an item H which is dawning footwear.

So this item again, when you're assessing it, you're looking at how are they able to put on their stockings? Those elastic stockings, the compression stockings, orthotics, AFOs, prosthetics. If it's around their foot, this is all going to count towards a piece of clothing. So again, you're looking at their level of assist on dawning footwear to include all those orthotics as well. So I think it's a great, just to have that knowledge point, again, if your information is being pulled over to section GG, then it's good for you to know this information. So that pretty much wraps up their self-care areas. We're gonna jump on over here now to mobility. So with the mobility areas, we've mentioned this before activities may be completed with, or without an assistive device that doesn't affect the coding of the activity at all.

Let's talk about rolling. So rolling left and right is item A here, the ability to roll from lying on back to the left and right side and return to lying on the back of the bed. So I'm gonna give you an example here. Let's say the physical therapist helps Mr. K turn onto his right side by instructing him to bend his left leg and roll onto his right side. He then instructs him on how to position his limbs to return to lying on his back and then to repeat a similar process for rolling onto his left side and returning to his back. Mr. K completes the activity without physical assistance from the PT. So we would code this as 04 supervision or touching assistance. As the PT provide verbal cues, gave instructions and the patient was able to complete the activity without any other physical assistance. So the physical therapist did not provide any help. So 04 supervision touching. Item B here is sit to lying, which is the ability to move from sitting

on the side of the bed to laying flat on the back. So I think this is another area where we see a lot of, so I was just gonna give you another example. Mrs. F requires assistance from the helper to get from sitting position to lying flat on the bed because of a post-surgical O-R-I-F healing fractures of her right hip and left and right wrist, the helper cradles and supports her trunk and her right leg to transition her from sitting at the side of the bed to laying flat on the bed. Mrs. F assist herself a small amount by bending her elbows and left leg while pushing her elbows and left foot into the mattress only to straighten her trunk while transitioning into a lying position. So I think that is a great example of a 02 substantial maximal assist. The helper is certainly providing more than half of the effort for this patient to complete the activity. Lying to sitting on side of bed, this is section G.

So this activity includes the patient transitioning from lying on their back to sitting on the side of the bed. They are supposed to have their feet flat on the floor and the ability to sit upright on the bed without back support. So that is the key here on this one, the lying to sitting on the side of the bed is that they are supposed to have their feet flat on the floor, and they're supposed to be able to sit upright and you're assessing them in how they're doing what those tasks. I know that we've all been there where the patient gets up and their feet are dangling, two feet from the floor. So you might need to bring the floor to the feet, whether it's pull over that wastebasket or bring a step with you from, the therapy department or somehow assist them with lowering that bed so that you can be fair in assessing them, in this area with their feet on the floor. 'Cause we all know that does make a difference on how they're do. All right, the next two sections are D and E we have sit to stand and then we have the chair/bed-to-chair transfers. So sit to stand. It's pretty self explanatory, begins with patients sitting in a chair or wheelchair sitting up right at the edge of the bed and then returning to sitting in a chair or wheelchair or sitting up right at the edge of the bed. So it's very straightforward. The chair to bed to chair transfers is also very straightforward. They're transferring from a chair to a bed and that chair can be a wheelchair. So if at any time they need two

helpers or a mechanical lift, then of course this would be a dependent situation. So those two, I think, are very common for PT to be doing on eval. And I think that's a great opportunity for you, 'cause those are pretty much the same way that we would assess them. There's not much of a difference between our therapy language and the language in the RAI. All right, so item F is our toilet transfer. And like I said before, this is certainly one of those areas that is interdisciplinary. I do see PTs addressing this one and I do see OT is addressing this one.

So let's really dive into this example. Toilet transfers, according to the RAI are the ability to get safely on and off a toilet or commode. So you can assess the patient bedside commode here. Here's our example, Mrs. W has PVD and sepsis, lower extremity, pain and weakness. She uses a bedside commode when having a bowel movement, the helper raise the bed to a height that helps with transfer. Mrs. W initiated lifting her buttocks from the bed, in addition requires some of her weight to be lifted by the helper. Mrs. W then reaches and grabs onto the arm rest of the bedside commode to steady herself to helper provides assistance by lowering her to the bedside commode. Hopefully by now you can answer this question. How would we code this? The answer is 02 substantial maximal assist. The helper is providing more than half of the effort. So the key with toilet transfers that I learned when reading the RAI was that you can use a commode.

So I have seen some OT vowels where they write not applicable because the patient didn't make it to the toilet. And wanna make sure we all know that you can use that bedside commode and you can address that item. Car transfers, certainly an area where I don't see many of us assessing on admission, but it is definitely an area that we should be assessing in those last three days of our planned discharged med A patients. So I understand being an OT that this is probably not an area that you're gonna get done on an initial evaluation. And CMS also understands that, but they do have this in the initial admission assessment. So you can at least start your

documentation on it and work towards it. Car transfers are very important for our home going residents. So if you're doing a car transfer, you can use an indoor car. So if you're fortunate enough to have that simulation in your therapy department, you can use the simulation cars, they clarify that in the RAI manual saying that it can be done in a simulation just as long as that simulation is truly similar to getting in inside of a regular car. So a car seat within a car cabin is how they clarify it. So even if it's a half car, that's fine. As long as there's a car seat within a car cabin, then you can use that to assess the patient. You don't have to take them outside and do it if you have the ability to have that wonderful car simulator in your therapy department, which would be great if we all did, but the car transfer item does not include transfers into the driver's seat. So I think that's a good kind of point to clarify. It does not include opening and closing the door and it does not include fastening or unfastening the seatbelt. The car transfer item includes the ability to transfer in and out of the passenger seat of a car or car simulators, that's it. I think that's also just good clarification for us all to know on that one. Walking items, walking is lots of items here, so we have I through L.

Let's talk about I first. That's walk 10 feet, once standing the ability to walk at least 10 feet in a room, corridor or similar. And if this section is coded that the patient is unable or refused, or it's not applicable, or you're saying it's not attempted due to a medical reason, then the rest of these that I'm gonna go over are skipped until we get to curb. So that's sort of an algorithm that happens, so if the patient is unable to walk 10 feet, or if you're saying it's not safe for them, then you're not gonna have to answer these other questions. However, if the patient can walk 10 feet, then the next question is J, and can the patient walk 50 feet with two turns? So the two turns are described as they can be in the same direction that was clarified in the RAI. They are two 90 degree turns to the right or two 90 degree turns to the left, or they may be in different directions. One 90 degree turn to the left and one 90 degree turn to the right. The 90 degree turn should occur at the person's ability level and of course this can include a device. So that is good clarification for item J. Item K is walk 150 feet. And if you were

assessing this on a evaluation there are probably a very high level patients. So lots of times, we're just seeing this one done at discharge, but the clarification for this is that once you're standing, it's the ability to walk at least 150 feet in a corridor or a similar place. And then item L is walking 10 feet on uneven surfaces. So this would include indoor or outdoor, anything uneven or sloping, which I know again, can be difficult in the skilled nursing facility to assess. So those are your walking items.

Before I move on to the steps, I just want to say that when coding section GG0170 walking items. So this I through L, we do not consider the resident's performance within parallel bars. So parallel bars are not a portable assistive device. So therefore they should not be used when you're assessing this section if you're assessing for GG. If the patient does not walk, then these items are skipped and you are prompted to go into the wheelchair level questions in the MDS. So these are only for our patients who are walking. Okay, we are at curb. So the curb is one step and it is just the ability to go up or down one step, pretty self explanatory. Again, if they're unable to do the one step, then you're gonna skip the next few slides, which are the four steps and the 12 steps. So let's just do an example here. Mrs. Z had a stroke. She must be able to step up and down one step to enter and exit her home. The PT provides standby assist as she uses her quad cane to support her balance and stepping up one step. The physical therapist provides steadying assistance as Mrs. Z uses her cane for balance and steps down one step. So how would we code this?

Okay, that would be 04 supervision or touching assistance as the PT provided that touching assistance as she completed the activity. The next item is N which has four steps, the ability to go up and down four steps with or without a rail. And again, if you're coding that they're unable to do this, it's not safe or they refused. Then you skip the next, which is 12 steps and you move forward to picking up objects. So 12 steps, very self explanatory here, the ability to go up and down 12 steps with or without a rail. I know this is another kind of challenging one with an environmental standpoint. So we

just have to do with what we have in our facilities. Item P is the ability to bend, stoop from a standing position to pick up a small object, such as a spoon from the floor. Now, one area that I found when reading about this in the RAI manual that I was surprised is that you also can assess this, if the resident upright in a wheelchair. So I thought that was good information to pass along because I think we just assume that this picking up object is from standing, but the RAI manual does say it could also occur if the resident is upright in the wheelchair.

Okay, so now we've got a few slides here on wheelchair items. And so I just wanna start by saying that the intent for wheelchair items are for the patients who are actually... They need to learn how to self mobilize and use a wheelchair because that's the end goal. They're not gonna walk again. Or if this patient didn't walk before and they're going home at the wheelchair as they were prior to admission, that's the intent for this section. So this area is not supposed to be just because they get transported between their room and therapy department, because they walk so slow, they wouldn't be able to physically make that distance. That's not what this item is designed for. It is truly designed for the patient to be able to use their wheelchair once they're home going. So I thought that that's pretty much, what I felt was needed to be clarified if you are coding this section at all. So this is R and S, which are our wheelchair items. And we also have to code in this section, what type of wheelchair, whether a wheelchair or scooter was used. So that's where that algorithm happens. Does the resident use a wheelchair or scooter? Again, the intent is prior to admission, was that their prior level of functioning. So if no, then this section is done and there's no more assessment. If the answer is yes, then we have to answer the items for the next couple slides here of section GG that includes wheeling 50 feet with two turns.

So we're coding the patient based on their performance once they're seated in the wheelchair and then their ability to wheel at least 50 and make two turns. So we do need to indicate what type of chair they're in, whether it's a manual or a motorized.

Tryna see if there's anything else. Nope, let's just move on to the next slide here 'cause I know we're getting close to the end of the presentation here. So hang on , GG0170 section S, it's the last item, it's wheel 150 feet. So code performance once seated to mobilize self down a corridor or hallway, at least 150 feet. So we again have to indicate whether that's a manual or a motorized chair. So if the patient was using a motorized wheelchair prior to their admission, then that would be perfectly applicable that we would be assessing how they're doing now, going up to 150 feet and how they're doing in the facility with that. So that is the end of all those items that are in section GG. And so I just have a couple little tidbits of information here 'cause I thought it was interesting. The rules for section GG are 67 pages long.

So I tried my best to condense this information for you today, but I do appreciate that this is a lot of information and if you're eager to learn more, you can download the RAI manual from the CMS website. So that's www.cms.gov, G-O-V. And then there's a little search box at the top of the webpage. If you just put in our RAI and hit, Okay or a Search that manual will pop up for you and you can download the most recent manual. Another just kind of wrap up point, and I understand that this is not our responsibility to code, it is the responsibility of the MDS nurse. And that's a rule go figure. They've mentioned that to an RAI manual. It has to be an RN who codes it, but the whole intent of the MDS is this interdisciplinary assessment. So when we are bringing forward our OT or PT evaluations, and those are getting translated into the MDS, I think it is our job to really understand it and understand these little nuances that we pointed out today. Like the bedside commode, I mean, that's simple. OTs, PTs, we can assess the patient on toilet transfers with a bedside commode. I can't tell you how many times I've read the OT eval and it had bedside commode transfer, it had max assist. And then I look at section GG and the OT was the contributor to it and it says not tested or not applicable. So I think that that's what the whole point of the last 20 slides were, was that we can just really appreciate the information that's inside the RAI manual so that when we do contribute to payment and quality measures, we're knowledgeable, we're

educated. And yet knowing that MDS nurses, it is their job to make sure that it's all coded correctly. I also have a couple YouTube videos for you. Now you can really find anything you want on YouTube, who would have thought that section GG training is on YouTube, but it is. So I thought, I watched a couple of these videos and they're done really well. This is straight from CMS. So these are our rule makers and they have some YouTube videos. So there's a couple of links there, just some of the ones that I found helpful gave me some information I didn't know otherwise. So I thought I would just pass those along to you.

So to finish up our lesson today, we're gonna just kind of flip this around now and think about how our plan of care can be written. So that a reviewer, someone from the outside who looks at it can see that we're supporting the information that we've provided and given to section GG. Again, since CMS is looking at our outcome measurements, they're looking at these quality reporting measures. This is federal level, this is very important information. I think that it would be helpful for us to start thinking about how our plan of care can support it. And I think our facilities who are the ones that are paying us to do the therapy and they're getting paid for the therapy that we provide, I think that they would appreciate knowing that our plan of care is supporting what they've coded in GG. So couple of thoughts here, what level of care does your therapy documentation display? What level of care does that section GG score display? And do these coincide or do these conflict? And let me just point out where this is coming from. We've done audits where we look at the therapy documentation and we'll see clearly that the OT has assessed their ability to dress themselves and it says, mode assist. And then you look at the section GG, which this particular software would allow the OT to just kind of do section GG at the end of her evaluation. And in there she had that partial/moderate assist. And now today we've learned that really mode assist in our language really should translate more to that substantial maximal assist. So there's where that conflict lies and sure, it's not always gonna be perfect 'cause it's a three day assessment and it needs to be the usual

performance. So there certainly can be a little bit of a discrepancy between documentation and the coding, but it shouldn't be like this drastic conflict. And I've got so many examples of drastic conflict, I could get way off on tangents. So we've seen PT evals where the evaluations are clear, they're transferring, they're walking, there's all kinds of data in the eval. And then we jump over to section GG and the PT had put an A, not apical down the whole column. And it's things like that that make me go, "Hmm, why is this happening?" Well, I think it's just the lack of us understanding how important it is that we do contribute to section GG and that our contribution is valid 'cause we're professionals and we're experts in these levels in assessing these levels.

So let's go through some examples, let's test your knowledge, see how you're doing with this. OTs, we're gonna look at toileting. You assess the patient as max assist times two with toileting, and you wrote a plan of care goal for the patient to be modified independent with toileting longterm goal. Going over to section GG, and you scored it as substantial maximal 02. And you wrote your discharge goal to support what you wrote on your plan of care. Discharge GG goal, patient will be independent 06 with toileting. Is that correct? Now, I do, do, do, do. Okay, we'll move on. Is that correct? Well, partially. Section GG scoring, we learned earlier, anytime you have two people helping it is automatically coded as 01 dependent. So on this example, we would say 01 dependent for their status of section GG score on admission. And then you're discharge GG goal being 06, that is correct. As we can learn today, modified independent kind of falls into that independent category in GG world. So that is accurate. Okay, PTs, you're up. Is this correct? Max assist, bed mobility, status on eval is max assist for bed mobility. You wrote your plan of care for your patient to be independent with bed mobility at the time of their discharge, longterm goal. Now we look at section GG. We have role side to side, you have 02 substantial maximal assist. And you wrote your discharge goal GG, patient will be independent 06 with bed mobility. Is this correct? Yes, both the PT eval status and the GG code reflect the same

level of assist. And again, GG goal independent with bed mobility at the time of discharge equals independent 06. So that is correct.

Okay, and now one for both the PTs and the OTs, is this correct? We're looking at toilet transfers. The OT status eval said they are mode assist with their toilet transfers. The OT plan of care was written, modified independent with toilet transfers. We have our GG score as partial, moderate assists 03. And we have our discharged GG goal as independent 06 toilet transfers. Okay, where are we at? Is this correct? So no, and this was the example I gave earlier. It is the number one error that we see in our audits, just because 03 has the word moderate assist. We are seeing a lot of translation issues. We really think that by the definitions of these two things, that when someone is a moderate assist in their OT or PT eval, that that would equate more to that substantial maximal assist by definition as the helper is providing more than half of the effort. I think we've talked this one through quite a bit. So hopefully by now you understand it. And of course we have 06 as the equivalent to our modified independent. So that would be correct independent for the discharge goal.

Okay, so I just have a couple of final comments to wrap us up today. I really appreciate you choosing to review this topic today. I know that this is not the most exciting of topics, but I think it's important. I think it really is our responsibility now as clinicians to really understand how impactful our documentation can be. Our documentation does not need to be identical to what nursing is writing, but the big picture of the patient should make sense alongside their documentation. What we're seeing and what they're seeing should paint the same picture. I've had the pleasure or not so much the pleasure of defending many, many cases at the administrative law judge and Medicare appeals and denials. And once the auditor or the judge sees discrepancies, that's when they really start kind of nitpicking on why doesn't this documentation reflect the same patient? So it makes sense if we're a little bit off from each other because our professional skills are different. So some things would make sense if they're just a

slightly off. So if we were, PT, we were able to walk them, but nursing is saying it wasn't medically safe to do so. Maybe that makes sense because PTs are the experts with this and you feel more comfortable or confident with taking someone who might be low level and walking with them. So it's just the whole picture here is that what we do as therapists can support what's in GG, not conflict with what's in GG. It's important that we're knowledgeable, that the information we're giving to these facilities, to the nurses, to the MDS nurse gets into an assessment tool that is being looked at from the CMS, the centers for Medicare and Medicaid services level. I mean, that's the top dog right there. So if CMS is looking at, if they want information, they're asking for it, they're gonna look back and make sure that what we're providing them is accurate and is capturing the patient's unique characteristics. And I think that my last soap box I'll get on today, is that our jobs here is that we are painting the picture for Medicare to know the story of our patients. What did they look like when they came in? How did they do in therapy? Did they make progress? If they didn't, why didn't they? And what did they look like at that discharge disposition? How much progress did they make? And they understand that not everyone's gonna be a perfect painted picture and that people are gonna have problems and there's going to be barriers, but our documentation needs to support that. So even in coding of section GG, it's important that we recognize we might not have that progress, but there needs to be a reason why.

So try not to take the shortcuts and use those not tested or not applicable because we really should be trying to paint the picture of the patient, the best we can 'cause we're contributing to payment and we're contributing to quality measures. So that's my kind of my last two cents there. I think if you're contributing to the section of the MDS at your facility, I hope now that you have a greater understanding of the rules and now you can design your plan of care in a way that will support how you document in this area. I appreciate your time and your interest in this topic. And here is my email address. Feel free to email any questions. Thank you so much.

- [Fawn] Thank you, Kathleen, for such a great talk today. I appreciate it. It's packed full of information that I think will be very helpful to our learners. I hope everyone has a great rest of the day. You joined us again on continuedandoccupationaltherapy.com. Thanks everyone.