



5 STAR CONSULTANTS
HEALTHCARE SPECIALISTS



OASIS D: Be Prepared for New, Detailed Assessment Items

Presented by:

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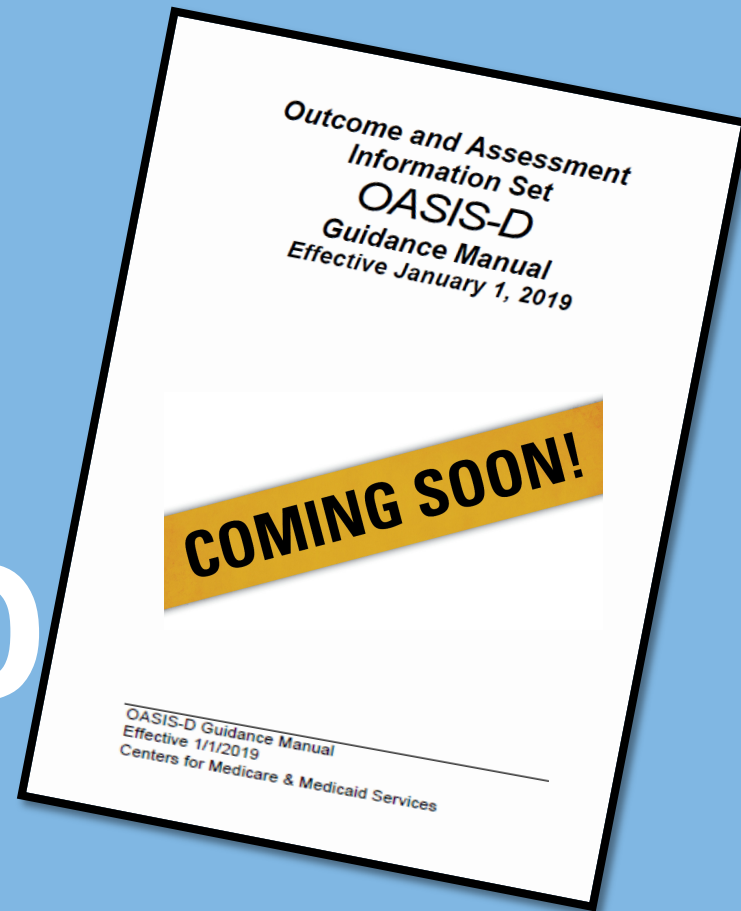


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OASIS D

Understanding the changes



OASIS D Time Points

- ▶ **March 2018**
 - ▷ Proposed OASIS D item set was released
- ▶ **July 2018**
 - ▷ OASIS D Guidance Manual
- ▶ **November 2018**
 - ▷ Final version of OASIS D is scheduled for release
- ▶ **January 1, 2019**
 - ▷ Implementation
 - Based on M0090: Date assessment was completed

OASIS D IMPACT ACT

- ▶ The Improving Medicare Post-Acute Care Transformation Act of 2014 (IMPACT Act)
- ▶ The purpose of the IMPACT Act is to standardize patient assessment data collected for Post-Acute Care (PAC) providers.
- ▶ The PAC providers are:
 1. Long-Term Care Hospitals (LTCHs)
 2. Inpatient Rehabilitation Facilities (IRFs)
 3. Skilled Nursing facilities (SNFs)
 4. Home Health Agencies (HHAs)

OASIS D IMPACT ACT

- ▶ The reason for standardization of data is to develop improved quality measure (QM).
- ▶ Utilize the data to compare all four PAC providers for quality.
- ▶ Improve coordination of care and discharge planning between the PAC providers.

OASIS D Changes

M - Items:

- ▶ Removing 28
- ▶ Abbreviating 1
- ▶ Adding:
 - ▶ 4 - GG items
 - ▶ 2 - J items
- ▶ CMS estimates an overall decrease in the time it takes to complete
- ▶ BUT...what we know is that not all OASIS items are equal

WHY IS OASIS BEING REVISED NOW?

- ▶ Currently the main reason for revising OASIS is to increase standardization across post-acute care (PAC) settings to enable calculation of standardized, cross-setting QMs, pursuant to the provisions of the IMPACT Act.
- ▶ Standardized patient assessment data elements (SPADEs) are questions and response options that are identical in all four PAC assessment instruments, and to which identical standards and definitions apply.

OASIS D Items Removed

- ▶ M0903: Date of Last / Most Recent Home Visit
- ▶ *M1011: Inpatient Diagnosis*
- ▶ *M1017: Diagnosis Requiring Medical or Treatment Regimen Change Within Past 14 Days*
- ▶ M1018: Conditions Prior to Medical or Treatment Regimen Change or Inpatient Stay Within Past 14 Days
- ▶ M1025: Optional Payment Diagnosis
- ▶ M1034: Overall Status
- ▶ M1036: Risk Factors
- ▶ M1210: Ability to Hear
- ▶ M1220: Understanding Verbal Content

OASIS D: Items Removed

- ▶ M1230: Speech & Oral (Verbal) Expression of Language
- ▶ *M1240: Pain Assessment*
- ▶ M1300: Assessment for Pressure Ulcer Risk
- ▶ M1302: Risk for Pressure Ulcers Identified
- ▶ M1313: Worsening in Pressure Ulcer Status
- ▶ M1320: Healing Status of Most Problematic Pressure Ulcer
- ▶ *M1350: Skin Lesion or Open Wound*
- ▶ M1410: Respiratory Treatments
- ▶ M1501: Symptoms in Heart Failure
- ▶ M1511: Heart Failure Follow-up

OASIS D: Items Removed

- ▶ M1615: When Does Urinary Incontinence Occur
- ▶ M1750: Psychiatric Nursing Services
- ▶ M1880: Ability to Plan and Prepare Light Meals
- ▶ M1890: Ability to Use the Telephone
- ▶ M1900: Prior Functioning ADL/IADL
- ▶ M2040: Prior Medication Management
- ▶ M2110: How Often Does the Patient Receive ADL or IADL Assistance from Caregiver
- ▶ M2250: Plan of Care Synopsis
- ▶ *M2430: Reason for Hospitalization*

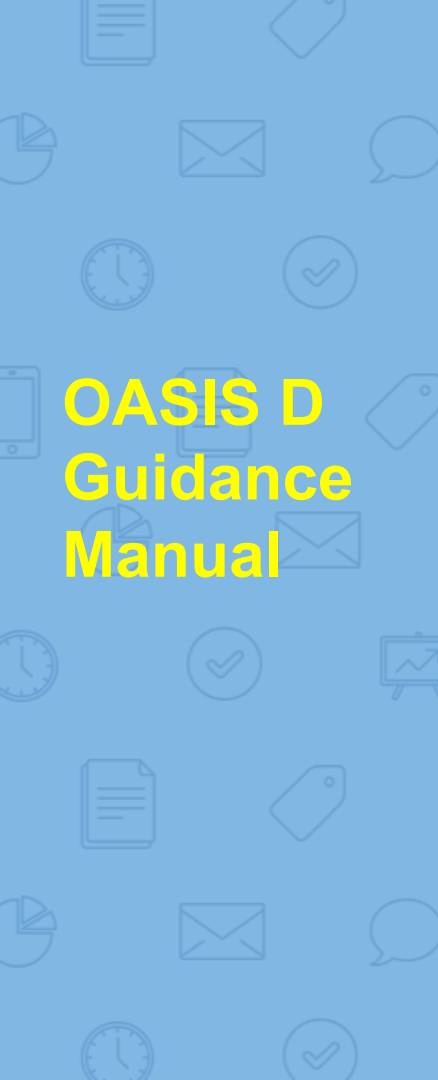
OASIS D Additions

Section GG: Functional Abilities and Goals

- ▶ GG0100: Prior Functioning: Everyday Activities
- ▶ GG0110: Prior Device Use
- ▶ GG0130: Self-Care
- ▶ GG0170: Mobility

Section J: Health Conditions

- ▶ J1800: Any Falls Since SOC / ROC J1900:
Number of Falls Since SOC/ROC



OASIS D Guidance Manual

- ▶ This manual provides guidance for home health agencies (HHAs) on how to ensure the collection of high-quality (accurate) OASIS data.
- ▶ It includes both general data collection conventions and item-specific guidance, as well as links to resources for agencies

WHAT'S NEW WITH THE OASIS-D GUIDANCE?

- ▶ Chapter 3, two new sections of standard guidance added: Section J – Health Conditions
- ▶ Section GG – Functional Abilities and Goals
- ▶ Chapter 4, Illustrative Examples are retired
- ▶ Removal of many items and their corresponding guidance
- ▶ Revisions to existing Guidance for some OASIS items to update or clarify information
- ▶ Appendix F - sample reports are not included in this version. Users may refer to the Casper Reporting User Manual, Section 6, OASIS Quality Improvement Reports, located at: <https://qtso.cms.gov/hhatrain.html>

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OASIS D

CHECK OUT WHAT'S NEW

SECTION GG: FUNCTIONAL ABILITIES AND GOALS

GG0100



NEW!

Prior Functioning: Everyday Activities

SECTION GG:
FUNCTIONAL
ABILITIES AND
GOALS

GG0100

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

Coding:

3. Independent – Patient completed the activities by him/herself, with or without an assistive device, with no assistance from a helper.

2. Needed Some Help – Patient needed partial assistance from another person to complete activities.

1. Dependent – A helper completed the activities for the patient.

8. Unknown

9. Not Applicable

↓ **Enter Codes in Boxes**

☐

A. Self Care: Code the patient's need for assistance with bathing, dressing, using the toilet, or eating prior to the current illness, exacerbation, or injury.

☐

B. Indoor Mobility (Ambulation): Code the patient's need for assistance with walking from room to room (with or without a device such as cane, crutch or walker) prior to the current illness, exacerbation, or injury.

☐

C. Stairs: Code the patient's need for assistance with internal or external stairs (with or without a device such as cane, crutch, or walker) prior to the current illness, exacerbation or injury.

☐

D. Functional Cognition: Code the patient's need for assistance with planning regular tasks, such as shopping or remembering to take medication prior to the current illness, exacerbation, or injury.

SECTION GG:
FUNCTIONAL
ABILITIES AND
GOALS

GG0100

Item Intent

- ▶ This item identifies the patient's usual ability with everyday activities, **prior to** the current illness, exacerbation or injury.

Time Points Item(s) Completed

- ▶ Start of Care
- ▶ Resumption of Care

Response-Specific Instructions

Interview patient or family or review patient's clinical records describing patient's prior functioning with everyday activities.

SECTION GG:
FUNCTIONAL
ABILITIES AND
GOALS

GG0100

Coding Instructions

- ▶ **Code 3**, Independent, if the patient completed the activities by him/herself, with or without an assistive device, with no assistance from a helper.
- ▶ **Code 2**, Needed Some Help, if the patient needed partial assistance from another person to complete activities.
- ▶ **Code 1**, Dependent, if the helper completed the activities for the patient. • **Code 8**, Unknown, if the patient's usual ability prior to the current illness, exacerbation or injury is unknown.
- ▶ **Code 9**, Not Applicable, if the activity was not applicable to the patient prior the current illness, exacerbation or injury.
- ▶ **A dash** is a valid response for this item. CMS expects dash use to be a rare occurrence.

Coding Tips

If no information about the patient's ability is available after attempt to interview patient or family and after reviewing patient's clinical record, code 8, Unknown

Example 1 - When to Code “Not Applicable”

- ▶ Mr. S ambulates with a walker around his home, and uses a stair lift to negotiate the stairs to the second floor, where his bedroom is located.
 - ▷ **Coding:** **GG0100C**, Stairs, would be coded 9, Not Applicable.
 - ▷ **Rationale:** Mr. S is not able to go up and down stairs; he uses a stair lift. So, he did not perform this activity.

SECTION GG:
FUNCTIONAL
ABILITIES AND
GOALS

GG0100

SECTION GG: FUNCTIONAL ABILITIES AND GOALS

GG0110



NEW!

Prior Device Use

**SECTION GG:
FUNCTIONAL
ABILITIES AND
GOALS**

GG0110

GG0110. Prior Device Use. Indicate devices and aids used by the patient prior to the current illness, exacerbation, or injury.

↓ Check all that apply

<input type="checkbox"/>	A. Manual wheelchair
<input type="checkbox"/>	B. Motorized wheelchair and/or scooter
<input type="checkbox"/>	C. Mechanical lift
<input type="checkbox"/>	D. Walker
<input type="checkbox"/>	E. Orthotics/Prosthetics
<input type="checkbox"/>	Z. None of the above

**SECTION GG:
FUNCTIONAL
ABILITIES
AND GOALS**

GG0110

Item Intent

- ▶ This item identifies the patient's use of devices and aids immediately prior to the current illness, exacerbation, or injury to align treatment goals.

Time Points Item(s) Completed

- ▶ Start of care
- ▶ Resumption of care

Response-Specific Instructions

Interview patient or family or review the patient's clinical record describing the patient's use of prior devices and aids.

SECTION GG:
FUNCTIONAL
ABILITIES
AND GOALS

GG0100

Examples

2. Mobilized Wheelchair and/or Scooter

Mr. C has bilateral lower extremity neuropathy secondary to his diabetes. Prior to this current episode, he used a cane. Today, he is using a walker.

Coding: GG0110Z, None of the above, would be checked.

Rationale: A cane is not a device included as part of the item list above. Not all devices and aids are included in this item.

SECTION GG: FUNCTIONAL ABILITIES AND GOALS

GG0130



NEW!

Self-Care

SOC / ROC

SECTION GG: FUNCTIONAL ABILITIES AND GOALS

GG0130

GG0130. Self-Care

Code the patient's usual performance at SOC/ROC for each activity using the 6-point scale. If activity was not attempted at SOC/ROC, code the reason. Code the patient's discharge goal(s) using the 6-point scale. Use of codes 07, 09, 10 or 88 is permissible to code discharge goal(s).

Coding:

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

Activities may be completed with or without assistive devices.

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

If activity was not attempted, code reason:

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

SECTION GG: FUNCTIONAL ABILITIES AND GOALS

GG0130

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

Follow-up

SECTION GG: FUNCTIONAL ABILITIES AND GOALS GG0130

GG0130. Self-Care

Code the patient's usual performance at Follow-Up for each activity using the 6-point scale. If activity was not attempted at Follow-Up, code the reason.

Coding:

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

Activities may be completed with or without assistive devices.

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

If activity was not attempted, code reason:

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

Follow-up

SECTION GG: FUNCTIONAL ABILITIES AND GOALS GG0130

4. Follow-Up Performance	
↓ Enter Codes in Boxes	
<input type="text"/> <input type="text"/>	A. Eating: The ability to use suitable utensils to bring food and/or liquid to the mouth and swallow food and/or liquid once the meal is placed before the patient.
<input type="text"/> <input type="text"/>	B. Oral Hygiene: The ability to use suitable items to clean teeth. Dentures (if applicable): The ability to insert and remove dentures into and from the mouth, and manage denture soaking and rinsing with use of equipment.
<input type="text"/> <input type="text"/>	C. Toileting Hygiene: The ability to maintain perineal hygiene, adjust clothes before and after voiding or having a bowel movement. If managing an ostomy, include wiping the opening but not managing equipment.

Discharge

SECTION GG: FUNCTIONAL ABILITIES AND GOALS GG0130

GG0130. Self-Care

Code the patient's usual performance at Discharge for each activity using the 6-point scale. If activity was not attempted at Discharge, code the reason.

Coding:

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

Activities may be completed with or without assistive devices.

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

If activity was not attempted, code reason:

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

Discharge

SECTION GG: FUNCTIONAL ABILITIES AND GOALS GG0130

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

SECTION GG:
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GG0130

Item Intent

- ▶ This item identifies the patient's ability to perform the listed self-care activities, and discharge goal(s).

Time Points Item(s) Completed

- ▶ Start of care
- ▶ Resumption of care
- ▶ Follow-up
- ▶ Discharge from agency – not to an inpatient facility

Note

This item, GG0130, includes Performance assessment and Discharge Goal(s) at the SOC/ROC. Refer to sections for instructions, tips and examples for each.

**SECTION GG:
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GG0130**

Response-Specific Instructions – *Performance Assessment* (SOC/ROC, FU and DC)

- ▶ Licensed clinicians may assess the patient's performance based on direct observation (preferred) as well as reports from the patient, clinicians, care staff, and/or family.
- ▶ When possible, CMS invites a multidisciplinary approach to patient assessment.
- ▶ Patients should be allowed to perform activities as independently as possible, as long as they are safe. If helper assistance is required because patient's performance is unsafe or of poor quality, score according to amount of assistance provided.

SECTION GG:
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Response-Specific Instructions – *Performance Assessment* (SOC/ROC, FU and DC)

- ▶ Activities may be completed with or without assistive device(s). Use of assistive device(s) to complete an activity should not affect coding of the activity.
- ▶ Patients with cognitive impairments/limitations may need physical and/or verbal assistance when completing an activity. Code based on the patient's need for assistance to perform the activity safely (for example, choking risk due to rate of eating, amount of food placed into mouth, risk of falling).

Response-Specific Instructions – SOC/ROC Performance Assessment

- ▶ Code the patient's functional status based on a functional assessment that occurs at or soon after the patient's SOC/ROC. The SOC/ROC function scores are to reflect the patient's SOC/ROC baseline status and are to be based on observation of activities, to the extent possible. When possible, the assessment should occur prior to the start of therapy services to capture the patient's true baseline status. This is because therapy interventions can affect the patient's functional status.

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GG0130

SECTION GG:
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GG0130

- ▶ A patient's functional ability can be impacted by the environment or situations encountered in the home. Observing the patient in different locations and circumstances within the home is important for a comprehensive understanding of the patient's functional status.

DEFINITION

ASSESSMENT TIMEFRAME

- The assessment timeframe is the maximum number of days within which to complete the comprehensive assessment.

- ▶ If the patient's ability varies during the **assessment timeframe**, record their **usual ability** to perform each activity. Do not record the patient's best performance and do not record the patient's worst performance, but rather the patient's usual performance; what is true greater than 50% of the assessment timeframe.

**SECTION GG:
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Response-Specific Instructions – SOC/ROC Discharge Goal(s)

- ▶ Discharge goal(s) may be the coded the same as SOC/ROC performance, higher than SOC/ROC performance or lower than SOC/ROC performance.
- ▶ If the SOC/ROC performance of an activity was coded using one of the activity not attempted codes (07, 09, 10 or 88) a discharge goal may be submitted using the 6-point scale if the patient is expected to be able to perform the activity by discharge.

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Response-Specific Instructions – SOC/ROC Discharge Goal(s)

- ▶ Licensed clinicians can establish a patient's discharge goal(s) at the time of SOC/ROC based on the patient's prior medical condition, SOC/ROC assessment, self-care and mobility status, discussions with the patient and family, professional judgment, the profession's practice standards, expected treatments, patient motivation to improve, anticipated length of stay, and the discharge plan. Goals should be established as part of the patient's care plan.

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Response Specific Instructions

- ▶ ***Discharge Performance:*** The discharge ***time period under consideration*** includes the last 5 days of care.
- ▶ This includes the date of the discharge visit plus the four preceding calendar days.
- ▶ Code the patient's functional status based on a functional assessment that occurs at or close to the time of discharge.

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GG0130

Coding Tips

- ▶ **B. Oral Hygiene**
 - ▶ If a patient does not perform oral hygiene during home visit, determine the patient's abilities based on the patient's performance of similar activities during the assessment, or on patient and/or caregiver report.

GG0130 Examples

GG0130A Eating – Food Consistency

- ▶ Mrs. H does not have any food consistency restrictions, but often needs to swallow two or three times so that the food clears her throat due to difficulty with pharyngeal peristalsis. She requires verbal cues to use the compensatory strategy of extra swallows to clear the food.
 - ▷ **Coding:** GG0130A, Eating, would be coded 04, Supervision or touching assistance.
 - ▷ **Rationale:** Mrs. H swallows all types of food consistencies and requires verbal cueing (supervision) from the helper. Code based on assistance from the helper. The coding is not based on whether the patient had restrictions related to food consistency.

GG0130B Oral Hygiene – Assistance to and from the Bathroom

- ▶ The helper provides steadying assistance to Mr. S as he walks to the bathroom. The helper applies toothpaste onto Mr. S's toothbrush. Mr. S then brushes his teeth at the sink in the bathroom without physical assistance or supervision. Once Mr. S is done brushing his teeth and washing his hands and face, the helper returns and provides steadying assistance as the patient walks back to his bed.
 - ▶ **Coding:** GG0130B, Oral hygiene, would be coded 05, Setup or clean-up assistance.
 - ▶ **Rationale:** The helper provides setup assistance (putting toothpaste on the toothbrush) before Mr. S brushes his teeth. Do not consider assistance provided to get to or from the bathroom to score Oral hygiene.

GG0130 Examples

GG0130 Examples

GG0130E1 Shower/Bathe Self

Discharge Goal Code is Higher than SOC/ROC Performance Code

- ▶ During SOC, functional assessment, Mr. M says he prefers to bathe himself rather than depending on helpers or his wife to perform this activity.
- ▶ The clinician assesses Mr. M's SOC/ROC performance for Shower/Bathe self, and determines the helper performs more than half the effort.
- ▶ The assessing clinician, using professional judgement, available information and collaboration as allowed, anticipates that by discharge Mr. M will require a helper for less than half of the activity Shower/Bathe self.

Coding: GG0130E1, Shower/Bathe self - continued

- ▶ **SOC Performance**, Coded 02, Substantial/maximal assistance.
- ▶ GG0130E2 Shower/Bathe self, **Discharge Goal**, would be coded 03, Partial/moderate assistance.
- ▶ **Rationale:** At SOC assessment, Mr. M participates in the activity Shower/bathe self, but a helper performs more than half the activity, the definition of substantial/maximal assistance.
- ▶ The assessing clinician expects Mr. M has the potential to improve in performance of this activity, to the extent that a helper needs to assist for less than half the activity, the definition for partial/moderate assistance.

GG0130
Examples

SECTION GG: FUNCTIONAL ABILITIES AND GOALS

GG0170

NEW!

Mobility

Timepoints : SOC/ROC, Follow Up, Discharge

GG0170. Mobility

Code the patient's usual performance at SOC/ROC for each activity using the 6-point scale. If activity was not attempted at SOC/ROC, code the reason. Code the patient's discharge goal(s) using the 6-point scale. Use of codes 07, 09, 10 or 88 is permissible to code discharge goal(s).

Coding:

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

Activities may be completed with or without assistive devices.













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- 05. **Setup or clean-up assistance** – Helper sets up or cleans up; patient completes activity. Helper assists only prior to or following the activity.
- 04. **Supervision or touching assistance** – Helper provides verbal cues and/or touching/steadying and/or contact guard assistance as patient completes activity. Assistance may be provided throughout the activity or intermittently.
- 03. **Partial/moderate assistance** – Helper does LESS THAN HALF the effort. Helper lifts, holds or supports trunk or limbs, but provides less than half the effort.
- 02. **Substantial/maximal assistance** – Helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs and provides more than half the effort.
- 01. **Dependent** – Helper does ALL of the effort. Patient does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the patient to complete the activity.

If activity was not attempted, code reason:

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

1. SOC/ROC Performance	2. Discharge Goal	
↓ Enter Codes in Boxes ↓		
<input type="text"/>	<input type="text"/>	A. Roll left and right: The ability to roll from lying on back to left and right side, and return to lying on back on the bed.
<input type="text"/>	<input type="text"/>	B. Sit to lying: The ability to move from sitting on side of bed to lying flat on the bed.
<input type="text"/>	<input type="text"/>	C. Lying to sitting on side of bed: The ability to move from lying on the back to sitting on the side of the bed with feet flat on the floor, and with no back support.
<input type="text"/>	<input type="text"/>	D. Sit to stand: The ability to come to a standing position from sitting in a chair, wheelchair, or on the side of the bed.
<input type="text"/>	<input type="text"/>	E. Chair/bed-to-chair transfer: The ability to transfer to and from a bed to a chair (or wheelchair).
<input type="text"/>	<input type="text"/>	F. Toilet transfer: The ability to get on and off a toilet or commode.
<input type="text"/>	<input type="text"/>	G. Car Transfer: The ability to transfer in and out of a car or van on the passenger side. Does not include the ability to open/close door or fasten seat belt.

GG0170: Mobility (Continued)

		I. Walk 10 feet: Once standing, the ability to walk at least 10 feet in a room, corridor, or similar space. <i>If SOC/ROC performance is coded 07, 09, 10 or 88 → skip to GG0170M, 1 step (curb)</i>
		J. Walk 50 feet with two turns: Once standing, the ability to walk 50 feet and make two turns.
		K. Walk 150 feet: Once standing, the ability to walk at least 150 feet in a corridor or similar space.
		L. Walking 10 feet on uneven surfaces: The ability to walk 10 feet on uneven or sloping surfaces (indoor or outdoor), such as turf or gravel.
		M. 1 step (curb): The ability to go up and down a curb and/or up and down one step .
		N. 4 steps: The ability to go up and down four steps with or without a rail.

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<input type="checkbox"/>	<input type="checkbox"/>	P. Picking up object: The ability to bend/stoop from a standing position to pick up a small object, such as a spoon, from the floor.
		Q. Does patient use wheelchair/scooter? 0. No → Skip GG0170R, GG0170RR1, GG0170S, and GG0170SS1. 1. Yes → Continue to GG0170R, Wheel 50 feet with two turns.
<input type="checkbox"/>	<input type="checkbox"/>	R. Wheel 50 feet with two turns: Once seated in wheelchair/scooter, the ability to wheel at least 50 feet and make two turns.
		RR1. Indicate the type of wheelchair or scooter used. 1. Manual 2. Motorized
<input type="checkbox"/>	<input type="checkbox"/>	S. Wheel 150 feet: Once seated in wheelchair/scooter, the ability to wheel at least 150 feet in a corridor or similar space.
		SS1. Indicate the type of wheelchair or scooter used. 1. Manual 2. Motorized

SECTION GG:
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Item Intent

- ▶ This item identifies the patient's ability to perform the listed mobility activities, and discharge goal(s).

Time Points Item(s) Completed

- ▶ Start of care
- ▶ Resumption of care
- ▶ Follow-up
- ▶ Discharge from agency – not to an inpatient facility

Note: This item, GG0170, includes **Performance** assessment and **Discharge Goal(s)** at SOC/ROC. Refer to sections for instructions, tips and examples for each.

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Response-Specific Instructions – Performance Assessment (SOC/ROC, FU and DC)

- ▶ Licensed clinicians may assess the patient's performance based on direct observation (preferred) as well as reports from patient, clinicians, care staff, and/or family.
- ▶ *When possible, CMS invites a multidisciplinary approach to patient assessment.*
- ▶ Patients should be allowed to perform activities as independently as possible, as long as they are safe. If helper assistance is required because the patient's performance is unsafe or of poor quality, score according to amount of assistance provided.

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Response-Specific Instructions – Performance Assessment (SOC/ROC, FU and DC)

- ▶ Activities may be completed with or without assistive device(s). Use of assistive device(s) to complete an activity should not affect coding of the activity.
- ▶ Patients with cognitive impairments/limitations may need physical assistance and/or verbal assistance when completing an activity. Code based on the patient's need for assistance to complete an activity safely

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Response-Specific Instructions – SOC/ROC Performance Assessment

- ▶ Code the patient's functional status based on a functional assessment that occurs at or soon after the patient's SOC/ROC.
- ▶ The SOC/ROC function scores are to reflect the patient's SOC/ROC baseline status, and are to be based on observation of activities, to the extent possible.
- ▶ When possible, the assessment should occur prior to the start of therapy services to capture the patient's true baseline status. This is because therapy interventions can affect the patient's functional status.

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▶ A patient's functional ability can be impacted by the environment or situations encountered in the home. Observing the patient in different locations and circumstances within the home is important for a comprehensive understanding of the patient's functional status.

▶ If the patient's ability varies during the ***assessment timeframe***, record their ***usual ability*** to perform each activity. Do not record the patient's best performance and do not record the patient's worst performance, but rather the patient's usual performance; what is true greater than 50% of the assessment timeframe.

DEFINITION

ASSESSMENT TIMEFRAME

- The assessment timeframe is the maximum number of days within which to complete the comprehensive assessment.

DEFINITION

USUAL PERFORMANCE, ABILITY

- A patient's usual performance is his/her ability greater than 50% of the assessment timeframe.

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Response-Specific Instructions – SOC/ROC Discharge Goal(s)

- ▶ Discharge goal(s) may be coded the same as SOC/ROC performance, higher than SOC/ROC performance, or lower than SOC/ROC performance (See Examples).
- ▶ If the SOC/ROC performance of an activity was coded using one of the activity not attempted codes (07, 09, 10 or 88), a discharge goal may be submitted using the 6-point scale if the patient is expected to be able to perform the activity by discharge.

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Response-Specific Instructions – SOC/ROC Discharge Goal(s)

- ▶ Licensed clinicians can establish a patient's discharge goal(s) at the time of SOC/ROC based on the patient's prior medical condition, SOC/ROC assessment, self-care and mobility status, discussions with the patient and family, professional judgment, the profession's practice standards, expected treatments, patient motivation to improve, anticipated length of stay, and the discharge plan.
- ▶ Goals should be established as part of the patient's care plan.

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Coding Tips and Examples GG0170A, Roll Left and Right

- ▶ The activity includes the patient rolling to both the left and to the right while in a lying position,
- ▶ If at the time of the assessment the patient is unable to lie flat due to medical conditions or restrictions, but could perform this activity prior to the current illness, exacerbation or injury, code 88, Not attempted due to medical condition or safety concerns.
- ▶ For example, if a clinician determines that a patient's new medical need requires that the patient sit in an upright sitting position rather than a slightly elevated position, then code GG0170A, Roll left and right as 88, Not attempted due to medical or safety concerns.

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Coding Tips and Examples GG0170A, Roll Left and Right

- ▶ If at the time of the assessment the patient is unable to lie flat due to medical conditions or restrictions, and could not perform the activity prior to the current illness, exacerbation or injury, code 09, Not applicable.
- ▶ For GG0170A, Roll left and right, clinical judgment should be used to determine what is considered a “lying” position for the patient. For example, a clinician could determine that a patient’s preferred slightly elevated resting position is “lying” for that patient.

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Example: GG0170A, Roll Left and Right

At SOC, the physical therapist helps Mr. R turn onto his right side by instructing him to bend his left leg and roll to his right side.

He then instructs him 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 then return to lying on his back.

Mr. R completes the activity without physical assistance from a helper.

Mr. R was moving about in bed without difficulty prior to hospitalization. The therapist expects Mr. R will roll left and right by himself by discharge.

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Ex: GG0170A, Roll Left and Right - continued

- ▶ **SOC Performance** would be coded 04, Supervision or touching assistance.
- ▶ **Discharge Goal** would be coded 06, Independent.
- ▶ **Rationale:** At SOC, the physical therapist provides verbal cues (i.e., instructions) to Mr. R as he rolls from his back to his right side and returns to lying on his back.
- ▶ The physical therapist does not provide any physical assistance.
- ▶ After assessment & considering his current condition, the therapist expects Mr.R will be independently rolling left and right at discharge.

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GG0170D, Sit to Stand

Coding Tips and Examples GG0170E, Chair/Bed-to-Chair Transfer

- ▶ The activity begins with the patient sitting (in a chair, wheelchair, or at the edge of the bed) and transferring to sitting in a chair, wheelchair, or at the edge of the bed.
- ▶ Sit to lying and lying to sitting are not assessed as part of GG0170E.

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Example: GG0170E, Chair/Bed-to-Chair Transfer

- ▶ Mr. L had a stroke and uses a wheelchair for mobility.
- ▶ When Mr. L gets out of bed at SOC, the family moves the wheelchair into the correct position and locks the brakes so that Mr. L can transfer into the wheelchair safely.
- ▶ Mr. L transfers into the wheelchair by himself without the need for supervision or assistance during the transfer.
- ▶ The family reports that Mr. L does transfer safely without the need for supervision, once the wheelchair is placed and locked.
- ▶ The nurse does not expect Mr. L's mobility status to change by discharge.

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GG0170E, Chair/Bed-to-Chair Transfer

- ▶ **SOC Performance** would be coded 05, Setup or clean-up assistance.
- ▶ **Discharge Goal** would be coded 05, Setup or clean up assistance.
- ▶ **Rationale:** A helper must provide setup assistance only. Once set up is provided, Mr. L transfers safely and does not need supervision or physical assistance during the transfer. The nurse expects Mr. L will continue to need wheelchair setup assistance for this transfer at discharge.

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Coding Tips and Examples GG0170F, Toilet Transfer

- ▶ The activity includes the patient getting on and off a toilet or commode.
- ▶ Use of assistive device(s) and adaptive equipment (for instance a grab bar or elevated toilet) required to complete the toilet transfer should not affect coding of the activity.
- ▶ If the only help a patient needs to complete the toilet transfer activity is for a helper to retrieve and place the toilet seat riser, and remove it after patient use, then enter code 05, Setup or clean-up assistance.
- ▶ Toileting hygiene and clothing management are not considered part of the toilet transferring activity.
- ▶ If the patient requires assistance from two or more helpers to get on and off the toilet or commode, then enter code 01, Dependent.

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Example: GG0170F, Toilet Transfer

- ▶ The assessing clinician notes that the home health aide visit note (documented on the afternoon visit on the SOC date) stated that the aide needed to steady Mrs. Z with a light contact when the patient lowers her underwear and then transfers onto the toilet.
- ▶ After voiding, Mrs. Z cleanses herself. She then stands up supporting her own weight as the aide steadies her.
- ▶ Mrs. Z pulls up her underwear as the aide steadies her to ensure Mrs. Z does not lose her balance.

GG0170F, Toilet Transfer

- ▶ **SOC Performance** would be coded 04, Supervision or touching assistance.
- ▶ **Rationale:** The aide provides steadying assistance only as the patient transfers on and off the toilet.
- ▶ Assistance with managing clothing and cleansing is coded under item GG0130C, Toileting hygiene, and is not considered when rating the Toilet transfer item.

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**SECTION GG:
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Coding Tips and Examples GG0170G, Car Transfer

- ▶ The activity includes transferring in and out of a car or van on the passenger side.
- ▶ Does not include opening or closing the car door, or fastening seat belt.
- ▶ If the patient is not able to attempt car transfers (for example because no car is available, or there are weather or other environmental constraints), and the patient's usual status cannot be determined based on patient or caregiver report, enter code 10 Not attempted due to environmental limitations.
- ▶ If at the time of the assessment the patient is unable to attempt car transfers, and could not perform the car transfers prior to the current illness, exacerbation or injury, code 09, Not applicable.

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GG0170, Car Transfer

- ▶ Mrs. W uses a wheelchair and ambulates for only short distances.
- ▶ At SOC, Mrs. W requires the physical therapist to lift most of her weight to get from a seated position in the wheelchair to a standing position.
- ▶ The therapist provides trunk support when Mrs. W takes several steps during the transfer turn. Mrs. W lowers herself into the car seat with steadying assistance from the therapist. Mrs. W moves her legs into the car as the therapist lifts the weight of her legs from the ground.

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GG0170, Car Transfer

- ▶ **SOC Performance** would be coded 02, Substantial/maximal assistance.
- ▶ **Rationale:** The therapist completed more than half the effort to transfer Mrs. W into the car by providing significant lifting assistance from the wheelchair, trunk support when taking steps toward the car seat, steadying when lowering into the car seat and lifting support when moving legs into the car.
- ▶ Mrs. W contributes less than half of the effort to complete the activity.

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Coding Tips and Examples GG0170I, Walk 10 Feet

- ▶ Starting from standing, the activity includes walking at least 10 feet in a room, corridor, or similar space.
- ▶ Use of assistive device(s) and adaptive equipment (for instance a cane or leg brace) required to complete the walking activity should not affect coding of the activity.
- ▶ If the only help a patient needs to complete the walking activity is for a helper to retrieve and place the walker and/or put it away after patient use, then enter code 05, Setup or clean-up assistance.

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Coding Tips and Examples GG0170J, Walk 50 Feet with Two Turns

- ▶ Starting from standing, the activity includes walking 50 feet and making two turns.
- ▶ The turns are 90 degree turns and may be in the same direction (two 90 degree turns to the right or two 90 degree turns to the left) or may be in different directions (one 90 degree turn to the right and one 90 degree turn to the left).
- ▶ The 90 degree turns should occur at the patient's ability level (i.e., not jeopardizing patient safety), and can include the use of an assistive device (for example walker or crutches) without affecting coding of the activity.

**SECTION GG:
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Example: GG0170, Walk 50 Feet with Two Turns

- ▶ At SOC, Mr. B is recovering from a recent stroke and now has difficulty walking.
- ▶ Even with assistance, he is able to walk only 30 feet.
- ▶ Mr. B's care plan includes muscle strengthening and gait training.
- ▶ The therapist expects Mr. B will be able to walk 50 feet with two turns safely with the assistance of a caregiver for verbal cues and contact guard for steadying on the turns at discharge.

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GG0170, Walk 50 Feet with Two Turns

- ▶ **SOC** -Walk 50 feet with two turns, would be coded 88, Not attempted due to medical condition or safety concerns.
- ▶ **Discharge Goal** would be 04 - Supervision or touching assistance.
- ▶ **Rationale: Mr. B** is ambulatory but was not able to walk the entire distance because of his new medical condition (stroke). Since the patient is unable to complete the activity at SOC, but was completing the activity prior to the recent stroke, Code 88 is appropriate.
- ▶ Although not able to complete the activity at SOC, the therapist anticipates Mr. B will be able to walk 50 feet with two turns safely with the assistance of a caregiver for verbal cues and contact guarding at discharge.

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Coding Tips and Examples GG0170K, Walk 150 Feet

- ▶ Starting from standing, the activity includes walking 150 feet in a corridor, or similar space.
- ▶ If the patient's environment does not accommodate a walk of 150 feet without turns, but the patient demonstrates the ability to walk with or without assistance 150 feet with turns without jeopardizing the patient's safety, code using the 6-point scale.
- ▶ Use of assistive device(s) and adaptive equipment (for instance a rolling walker or quad cane) required to complete the walking activity should not affect coding of the activity.
- ▶ If the only help a patient needs to complete the walking activity is for a helper to retrieve and place the assistive device and/or put it away after patient use, then enter code 05, Setup or clean-up assistance.

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Coding Tips and Examples- GG0170L, Walking 10 Feet on Uneven Surfaces

- ▶ Once standing, the activity includes walking 10 feet on uneven or sloping surfaces (indoor or outdoor), such as turf or gravel.
- ▶ If the patient is not able to attempt walking on uneven surfaces (for example because no uneven surfaces are available, or there are weather or other environmental constraints limiting access), and the patient's usual status for walking 10 feet on uneven surfaces cannot be determined based on patient or caregiver report, enter code 10 Not attempted due to environmental limitations.
- ▶ Use of assistive device(s) and adaptive equipment (for instance a rolling walker or quad cane) required to complete the walking activity should not affect coding of the activity

SECTION GG:
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Ex: GG0170L, Walking 10 Feet on Uneven Surfaces

- ▶ Mrs. N has severe joint degenerative disease and is recovering from sepsis.
- ▶ When walking on the uneven driveway was attempted yesterday when Mrs. N came home from the hospital, she reports that her neighbor had to hold her belt and help lift her a little during a few steps. The neighbor also provided help to advance the walker across the gravel driveway as the patient walked.
- ▶ **Coding:** 03, Partial/moderate assistance.
- ▶ **Rationale:** Per patient report, Mrs. N requires help provide some weight-bearing support, and assist in advancing the walker as she walked 10 feet on uneven surfaces. The helper does less than half the effort for walking 10 feet on uneven surfaces.

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Coding Tips and Examples GG0170M, 1 Step (curb)

- ▶ The activity includes the patient going up and down a curb and/or one step.
- ▶ Use of assistive device(s) and adaptive equipment (for instance a railing or cane) required to complete the activity should not affect coding of the activity.

Coding Tips and Examples GG0170N, 4 Steps

- ▶ The activity includes the patient going up and down four steps with or without a rail.

Coding Tips and Examples GG0170O, 12 Steps

- ▶ The activity includes the patient going up and down 12 steps with or without a rail.

**SECTION GG:
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Coding Tips and Examples GG0170P, Picking up Object

- ▶ The activity includes the patient bending/stooping from a standing position to pick up a small object, such a spoon, from the floor.
- ▶ Use of assistive device(s) and adaptive equipment (for instance a cane to support standing balance and a reacher to pick up the object) required to complete the activity should not affect coding of the activity.
- ▶ If at the time of the assessment the patient is unable to complete the activity (for instance is unable to stand), and could not stand to perform this activity prior to the current illness, exacerbation or injury, code 09, Not applicable.

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Example: GG0170P, Picking up Object

Ms. C has recently undergone a hip replacement. At SOC, she walks with a walker without assistance. When she drops a hair brush from her walker basket, she asks her daughter to locate her long-handled reacher and bring it to her. Using the reacher, Mrs. C is able to bend slightly, and safely pick up the hair brush with the reacher, without need of additional assistance or verbal cues.

- ▶ **Coding:** GG0170P, Picking up object would be coded 05, Set-up or clean-up assistance.
- ▶ **Rationale:** The daughter provides set-up assistance only by retrieving the reacher and then the patient is able use the device to pick up the hairbrush safely.

**SECTION GG:
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Coding Tips and Examples GG0170Q, Does the Patient Use a Wheelchair/Scooter?

- ▶ The intent of the wheelchair mobility item is to assess the ability of patients who are learning how to self-mobilize using a wheelchair or patients who used a wheelchair prior to admission.
- ▶ Use clinical judgment to determine if the patient's use of a wheelchair is for self-mobilization due to the patient's medical condition or safety.
- ▶ If the patient is ambulatory and is not learning how to mobilize in a wheelchair, and only uses a wheelchair for transport within a larger living facility (assisted living facility or apartment complex), or for community mobility outside the home (for instance to a physician appointment or to dialysis), enter code 0 – No for GG0170Q Does the patient use a wheelchair/scooter, and skip all remaining wheelchair questions.

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Mobility

Coding Tips and Examples GG0170R, Wheel 50 Feet with Two Turns, and GG0170RR, Indicate the Type of Wheelchair or Scooter Used

- ▶ Once seated in the wheelchair or scooter, the activity includes wheeling at least 50 feet and making two turns.
- ▶ Indicate whether the wheelchair or scooter used is manual or motorized.
- ▶ The turns are 90 degree turns and may be in the same direction (two 90 degree turns to the right or two 90 degree turns to the left) or may be in different directions (one 90 degree turn to the right and one 90 degree turn to the left).
- ▶ The 90 degree turns should occur at the patient's ability level (i.e., not jeopardizing patient safety).

**SECTION GG:
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Coding Tips and Examples GG0170S, Wheel 150 Feet and GG0170SS, Indicate the Type of Wheelchair/Scooter Used

- ▶ Once seated in the wheelchair or scooter, the activity includes wheeling at least 150 feet in a corridor or similar space.
- ▶ Indicate whether the wheelchair or scooter used is manual or motorized.
- ▶ If the patient's environment does not accommodate wheelchair/scooter use of 150 feet without turns, but the patient demonstrates the ability to mobilize the wheelchair/scooter with or without assistance 150 feet with turns without jeopardizing the patient's safety, code using the 6-point scale.

SECTION J: Health Conditions

J1800



NEW!

Any Falls Since SOC / ROC, whichever is more recent

SECTION J: Health Conditions

J1800

J1800. Any Falls Since SOC/ROC, whichever is more recent	
Enter Code <input type="checkbox"/>	Has the patient had any falls since SOC/ROC, whichever is more recent? 0. No → Skip J1800 1. Yes → Continue to J1800, Number of Falls Since SOC/ROC, whichever is more recent

SECTION J:
Health
Conditions
J1800

Item Intent

- ▶ This item identifies if the patient had any witnessed or unwitnessed falls since the most recent SOC/ROC.

Time Points Item(s) Completed

- ▶ Transfer to an inpatient facility
- ▶ Death at home
- ▶ Discharge from agency – not to an inpatient facility

DEFINITION

FALL

- Unintentional change in position coming to rest on the ground, floor, or onto the next lower surface (such as a bed or chair). The fall may be witnessed or unwitnessed, reported by the patient or an observer, or identified when a patient is found on the floor or ground. Falls are not a result of an overwhelming external force (such as, a person pushes a patient).
- An **intercepted fall** occurs when the patient would have fallen if he or she had not caught him/herself or had not been intercepted by another person—this is still considered a fall.
- CMS understands that **challenging a patient's balance** and training him/her to recover from a loss of balance is an intentional therapeutic intervention and does not consider anticipated losses of balance that occur during supervised therapeutic interventions as intercepted falls.

SECTION J:
Health
Conditions

J1800

Response-Specific Instructions

- ▶ Review home health clinical record, incident reports and any other relevant clinical documentation (for example, fall logs)
- ▶ Interview patient and/or caregiver about occurrence of falls

Coding Instructions

- ▶ **Code 0, No**, if the patient has not had any fall since the most recent SOC/ROC.
- ▶ **Code 1, Yes**, if the patient has fallen since the most recent SOC/ROC.
- ▶ **A dash** is a valid response for this item. CMS expects dash use to be a rare occurrence.

SECTION J:
Health
Conditions

J1800

Examples

Example: Unwitnessed Fall

The discharging RN reviews the clinical record and interviews the patient and caregiver, Mrs. K and her daughter Susan, determining that a single fall occurred since the most recent SOC/ROC. The fall is documented on a clinical note from an RN home visit in which Susan reported her mother slipped from her wheelchair to the floor the previous day.

- ▶ **Coding:** J1800, Any Falls since SOC/ROC, would be coded 1, Yes.
- ▶ **Rationale:** This item addresses unwitnessed as well as witnessed falls.

SECTION J:
Health
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J1800

Examples

Example: Intercepted Fall

An incident report describes an event in which Mr. S appeared to slip on a wet spot on the floor during a home health aide bath visit. He lost his balance and bumped into the wall, but was able to steady himself and remain standing.

- ▶ **Coding:** J1800, Any Falls since SOC/ROC, would be coded 1, Yes.
- ▶ **Rationale:** An intercepted fall is considered a fall.

SECTION J:
Health
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J1800

Examples

Example: Unanticipated Fall During Therapy

A patient is ambulating with a walker with the help of the physical therapist. The patient stumbles and the therapist has to bear some of the patient's weight in order to prevent a fall.

- ▶ **Coding:** J1800, Any Falls since SOC/ROC would be coded 1, Yes.
- ▶ **Rationale:** The patient's stumble was not anticipated by the therapist. The therapist intervened to prevent a fall. An intercepted fall is considered a fall.

SECTION J: Health Conditions

J1900



NEW!

Any Falls Since SOC / ROC, whichever is more recent

SECTION J:
Health
Conditions

J1900

J1900. Number of Falls Since SOC/ROC, whichever is more recent		
CODING:	↓ Enter Codes in Boxes	
0. None	<input type="checkbox"/>	A. No injury: No evidence of any injury is noted on physical assessment by the nurse or primary care clinician; no complaints of pain or injury by the patient; no change in the patient's behavior is noted after the fall
1. One	<input type="checkbox"/>	B. Injury (except major): Skin tears, abrasions, lacerations, superficial bruises, hematomas and sprains; or any fall-related injury that causes the patient to complain of pain
2. Two or more	<input type="checkbox"/>	C. Major injury: Bone fractures, joint dislocations, closed head injuries with altered consciousness, subdural hematoma

SECTION J:
Health
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J1900

Item Intent

- ▶ This item identifies the number of falls a patient had since the most recent SOC/ROC, and fall-related injury.

Time Points Item(s) Completed

- ▶ Transfer to an inpatient facility
- ▶ Death at home
- ▶ Discharge from agency – not to an inpatient facility

DEFINITIONS

INJURY RELATED TO A FALL

Any documented or reported injury that occurred as a result of, or was recognized within a short period of time (e.g., hours to a few days) after the fall and attributed to the fall.

NO INJURY

No evidence of any injury noted on assessment; no complaints of pain or injury by the patient; no change in the patient's behavior is noted after the fall.

INJURY (EXCEPT MAJOR)

Includes skin tears, abrasions, lacerations, superficial bruises, hematomas, and sprains; or any fall-related injury that causes the patient to complain of pain.

MAJOR INJURY

Includes bone fractures, joint dislocations, closed head injuries with altered consciousness, subdural hematoma.

SECTION J:
Health
Conditions

J1900

Response-Specific Instructions

- ▶ Review the home health clinical record, incident reports and any other relevant clinical documentation, such as fall logs.
- ▶ Interview the patient and/or caregiver about occurrence of falls.
- ▶ Determine the number of falls that occurred since the most recent SOC/ROC, and, code the level of fall-related injury for each.
- ▶ Code falls no matter where the fall occurred.
- ▶ Code each fall only once.
- ▶ If the patient has multiple injuries in a single fall, code the fall for the highest level of injury.

SECTION J:
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J1900

Example: Two Falls Since the Most Recent SOC/ROC, One with Injury (except major), One with No Injury

- ▶ Review of the patient record, incident reports and patient and caregiver report identify that two falls occurred since the most recent SOC/ROC. The falls are documented on clinical notes.
- ▶ The first describes an event during which Mr. G tripped on the bathroom rug and almost fell, but caught himself against the sink. The RN assessment identified no injury.
- ▶ The second describes an event during which Mr. G, while coming up the basement stairs with the laundry, fell against the stair and sustained a bruise and laceration on his left knee.

SECTION J:
Health
Conditions
J1900

EX: Two Falls Since the Most Recent SOC/ROC, One with Injury (except major), One with No Injury (cont...)

Coding:

- ▶ J1900A, No injury, would be coded 1, one non-injurious fall since the most recent SOC/ROC.
- ▶ J1900B, Injury (except major), would be coded 1, one injurious (except major) fall since the most recent SOC/ROC.
- ▶ J1900C, Major injury, would be coded 0, no falls with major injury since the most recent SOC/ROC.

Rationale: The first fall is an intercepted fall, which is considered a fall. The patient sustained no injury as a result of this fall. The second fall resulted in a laceration and bruising, considered injury, but not major injury.

Conclusion

- ▶ IMPACT Act felt with OASIS D as post-acute entities are effected
 - ▷ Ensuring good continuum of care
 - ▷ Standardizations
 - ▷ Identifying “On Whose Watch” did this occur
- ▶ Start OASIS D education early
- ▶ Ensure that **All OASIS clinicians** understand the assessment responsibilities for the new items
 - ▷ Ensure consistency among clinicians

Any Questions?



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THANKS!

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