Frequently Asked Questions:

[On-demand webinar] Taking GG from good to great: Capturing true baseline and discharge status

On Tuesday, April 21, 2020, SimpleLTC and QRM (Quality Rehab Management) held a live webinar on Section GG, covering how to document baseline and discharge data accurately and completely in order to improve quality measures and PDPM performance. This document contains answers to specific questions asked during the webinar.

1. **When assessing the GG's on the eval if a patient is unable to perform a task how do you recommend them to score?** If the patient is unable to perform the activity, the code used depends on the reason. (07) is used if the resident refused to attempt the task. (09) is used if the activity was not attempted and the resident did not perform the activity prior to the current illness, exacerbation, or injury. (10) is used if the activity was not attempted due to environmental limitations (lack of equipment, weather constraints). (88) is used if the activity was not attempted due to medical conditions or safety concerns.

2. **Prior level of function as state from the hospital are almost always different from the information we get from the patient and family when admitted to the SNF/Rehab. Is this an issue and how do we get the data to match?** The RAI instructs us to record the resident's usual ability to perform the everyday activities prior to the current illness, exacerbation, or injury. An attempt to find out who provided the PLOF information to the hospital may be beneficial. If the responses are vastly different the IDT should collaborate to determine what gets coded on the MDS. Do not forget to document your decision.

3. **If the resident does not walk without therapy help and just walks at a therapy session, how are we supposed to code it?** Usual performance prior to the benefit of intervention sounds like there was no walking. This would be a time to look at utilizing one of the not assessed options. For example, if it was due to a medical condition or safety concern, code 88.

4. **If therapy does a GG eval and nursing does a GG eval, which one is used to code the MDS?** The Section GG coding determination should be collaborative. We are looking at usual performance, not a snapshot in time according to each department. The RAI states “if the resident’s functional status varies, record the resident’s usual ability to perform each activity. Do not record the resident’s best performance and do not record the resident’s worse performance, but rather record the resident’s usual performance”.

5. **If therapy evaluates on day 2, does nursing still use day 3 of section GG documentation to code "usual performance"? Or does "usual performance" end once therapy has initiated intervention?** Usual performance includes assessment of each of the tasks prior to the benefit of intervention. The assessment of ‘usual’ ends when the benefit is noted and this is for each GG item which would logically be different - so assessment of some items GG performance may end on day 1 or 2, some on day 3.

6. **What about GG goals for residents that are LTC and we skill for Nursing only- is it OK to code discharge goals GG the same as Admission performance if that's their baseline?** The requirement is that we must have at least 1 goal within GG. It can be at the same or lower than baseline if that is what is anticipated due to the patient’s condition.

7. **As nurses and GNAs, we don’t see patients go upstairs or uneven surfaces or car transfers. How do we code those sections if we don’t see them?** Assess each individual based on their specific situation – example if a patient did not go upstairs previously (perhaps they are wheelchair bound) then this would be a time to utilize the not assessed option 09 – Not applicable. If they typically performed the task, it would be ideal to simulate for reason of baseline - but if unable – for example if you don’t have a car available or stairs – code 10 may be indicated – not assessed due to environmental limitations.

8. **What is the proper procedure for coding d/c GG when the patient d/c to acute care hospital? When this happens the pt typically has a decline in function 24-48 hours prior to the d/c. Do we code off of their performance before the rapid decline? Or the performance with the decline?** The answer to this question depends on if the resident's discharge was planned or unplanned. If the discharge is unplanned and the reason for the MDS assessment is coded as such, the discharge performance GG item set will be inactive.

9. **Are you recommending that therapy does not start treating until day 4?** Absolutely do not withhold the start of treatment for GG capture. Rather focus on gathering GG data from the admission through the time when the benefit of intervention is noted within those first 3 days.

10. **Do we code the GG section for HMOs?** This depends on your facility's individual contract with the insurance company and the manner in which they reimburse. I would encourage you to review your HMO contracts and determine their expectations in regards to billing/reimbursement.

11. **Can you use an ARD prior to day 3 to maximize reimbursement?** The RAI states "The SNF provider must set the ARD on days 1-8 to assure compliance with the SNF PPS PDPM requirements" and that the "functional assessment must be completed within the first three days of the Medicare Part A stay". It is up to the facility to select the ARD according to the technical requirements. No matter the ARD date, the GG coding is determined by the "usual" performance prior to the benefit of intervention from admission through 11:59 pm day 3 of the stay. Ex: If the benefit of therapy in walking was noted on day 3 – capture the usual performance as what happened on day 1 and 2. If the benefit of therapy or other intervention did not impact the other GG items – continue with the day 1-3 coding of usual performance.

12. **Is it a potential issue if we do not set a goal but a patient ends up with a decline in that ADL area we had no goal for?** Do the best we can to identify patient specific goals as needed for safe transitions to the next level of care.

13. **What do you recommend when there are no 12 steps? Reportedly some CMS MDS trainer said we can use the 4 steps x3. Your thoughts?** Yes, you can use the steps available x the # needing to be assessed.

14. **How do we rectify the information that the nurse is coding on the functional abilities assessment because they are saying that especially on the initial/admission funct. ability asst. they don't have the information.** It sounds like there may be potential for nurse training/education regarding functional abilities assessments. Are they answering 09 (not applicable)? What attempts were made by the nurse to gather the information? There may be snapshots in time where, for that nurse, the information was not able to be obtained (think late admission/night shift on day one of the stay). The IDT, as a whole, should be gathering information from all available sources and collaborating/deciding on the "usual performance" of the resident.

15. **Can we use what we see they do in therapy to use for GG?** What the patient is doing in therapy alone is not a representation of "usual" performance. We must gather GG performance throughout the completion of tasks each time performed from admission through 11:59pm on day 3.

16. **My facility rehab department gives me a completed GG section to input in the MDS, I review and complete section G after interview of the resident and staff. Should I be checking to be sure our data matches even though the data can be different? The G section and GG section sometimes don't match data.** The steps for assessment and coding of Section G versus Section GG are very different. With Section G we are focused on the "Rule of 3" and coding for the "most support provided", according to the RAI Manual. With Section GG we are determining the resident's "usual performance" during the first 3 days of the Medicare Part A stay. With that being said, the two sections do not have to match, as the assessments for each are very different.

17. **I am the GG reviewer for our company and I asked the last question because some clinicians were instructed to not use the 88's, 10's and so forth and to use 01, but issue with that is who honestly drags a patient up 12 steps at a dependent assist level or drags them 150 feet at 01? I feel we should use the 88 and put an explanation as to why the task could not be completed. Is this correct?** The Not Assessed options are to be utilized to present the true presentation of our patients' baseline upon admission.

18. **As far as doing GG ADL care plan, I need clarification on who what information is used and what about G ADL because the info is not the same. Which info do we use for the ADL care plan?** Care plan goals can be reviewed and updated now so that they may be measured using Section G or Section GG data. Using descriptive wording like "non-weight bearing assistance", "weight bearing support", or "verbal cueing" when setting goals is helpful because they can be measured using either section of the MDS.

19. **How do you suggest the team identify an appropriate discharge goal score? If we set a low goal, then we will meet or exceed it and it will look great on outcomes, but I feel this is cheating the system. What advice do you have to identify the appropriate goal? PLOF is not always realistic.** Involve the IDT in determining the DC location and prioritized goals required for safe transition to the next level – very likely won't be at PLOF.

20. **In relation to the idea that section GG goals should be set with the IDT: Assuming the PT eval is completed on day 2 and the IDT meeting does not happen until day 3. Do you have to go back and adjust the goals in the PT eval to meet the IDT GG goals? It seems it would be important that the goals in the therapy eval match the goals in section GG.** It is very important that ultimately the team is working towards the same ultimate goals. May require an update in the progress notes to clarify the anticipated DC location and expectations for a safe transition.

21. **Why complete section GG for patients not receiving therapy if that is an exclusion?** GG goals are critical for care planning and driving reimbursement for PT/OT and Nursing categories whether therapy is involved or not.

22. **Med A patient transitions to hospice. There will be a GG for the d/c from Med A. How does that become exempt from measures and not cause a negative impact on QMs?** Ensure all information is provided in the MDS, medical record and claim to capture all exclusions and co-variates. Subsequent assessments which should capture Hospice will exclude the patient from the QM.

23. **What if therapy and nursing staff has a different assessment? What MDS code should be followed?** MDS must reflect "usual" performance. Therapy can provide input

but are not with patients at each meal, each time they toilet, etc. to be able to report 'usual' performance.

24. **What report do you use to see if your facility has completed the GG assessments within the required time frame?** Documentation within the medical record should indicate the IDT decision on usual performance.

25. **What impact does section G still have on Casper reports?** Short stay QM for 5 Star improvements in function still include Section G information. CMS delayed the removal of Section G on the MDS until further notice.

26. **How do we explain the low level of improvement in self-care?** The issue perhaps lies in capturing true baseline and DC GG scores.

27. **When is the best time for IDT team to meet regarding section GG for admission and discharge? Or is it something that just needs to happen prior to submission of MDS?** At least by day 4 for Admission assessments. For DC, the IDT needs to all be made aware of the planned DC date so that gathering of GG usual performance can begin the last covered day of the stay and 2 days prior.

28. **If companies are looking to study benchmarks, to look at initial and then discharge values, can we expect 75 % or better with a patient improvement? Or what is the national average for improvement?** The change in score is a point value and will be a positive or negative # based on improvement or decline. Best way to assess is to pull the building's SNF QRP Facility Level QM report.

29. **What about managed care/HMO A/insurance companies? We are doing GGs with them, but the insurance companies are telling us when to discharge. Or is this solely for traditional Med As?** If the patient is nontraditional Med A, the Part A PPS DC is not required and should not be submitted to CMS.

30. **What determines the expected discharge score? Is this based on goal or national data based on primary diagnosis?** This is a complex calculation and can be found in the SNF QRP Measure Calculations and Reporting Users Manual vs 3.0.

31. **When will G be eliminated and GG be the only item to input into the MDS?** CMS has delayed this until further notice – due to the COVID crisis.

32. **If ARD prior to day 3, is look back still ending with ARD? If ARD is day 1, is GG only day 1 usual performance?** Yes. The look back window is the ARD and 7 days prior unless specified otherwise in the RAI manual.

33. **Do all GG items that have a GG goal need to also then have a corresponding care plan?** 1 selfcare or performance goal is required to be documented and care planned.

34. **I feel like CNAs especially with high caseload don't give the patient opportunity to do bed mobility or toileting because of time, so that doesn't show a true or usual performance either. How can we make this more accurate as well?** Utilize the CMS training videos for all staff involved in gathering GG performance feedback and documentation. May require dedicated opportunities within the first 3 days.

35. **Since the Managed Care Medicare assessments are not sent to CMS, how accurate will the CASPER Reports be?** The QRP CASPER report will only capture traditional Med A Patients that are submitted to CMS.

36. **How do you code d/c performance if patient expires?** You don't, it is not included in the death in facility item set.

37. **If a resident is admitted to the facility and then discharged on or before day 3, like to the hospital, is it okay to complete a discharge and 5 day assessment together if they are a Medicare resident?** Yes.

38. **Would it be best to start PT on day three of patients stay?** No.

39. **GG section is grayed out in our MDS section when someone is discharged to the hospital. Is our computer wrong? It is unplanned discharge.** That is correct it is not a requirement in that item set if DC to hospital.

40. **How can you address a situation whereby Therapy's goals are nursing's baseline performance?** Regroup on patient's 'usual' performance and DC plans to ensure accuracy in baseline level and appropriate goals for the IDT.

41. **If your company requires you to complete goals for all categories how do you recommend care planning these? Would we just choose one for the care plan? Not sure how to care plan all the goals.** For QRP completion at least 1 self-care of mobility goal must be established, and care planned. If there is a goal set it should be care planned as best practice.

42. **Using Simple, can we pull the self-care and mobility outcome scores now in a report?** Yes, you can look at the assessment level detail for the residents on the QM detail page.

43. **Where can I get a color-coded MDS?** You can purchase a color-coded MDS here.

44. **Can the CMS reports be assessed through SimpleLTC?** To access the CMS reports in SimpleLTC, go to the MDS tab > CMS reports.

Helpful resources

- GG Scoring Calculator (QRM)
- Color-coded MDS (Briggs)
- Decision Tree tool (AANAC)
- GG Data Collection tool (AANAC)
- GG training videos (CMS)