Section GG Coding and Capturing Nursing Components

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Therapy that *exceeds expectations.*

Functional Pathways

Therapy that exceeds expectations.

25 YEARS

PDPM – Mastering Section GG and Nursing Coding

Objectives:

1. Understand MDS Section GG guidelines and scoring tips for
   - Admission assessment
   - Discharge goals
   - Discharge assessment

2. Be familiar with the scoring considerations that impact PT, OT and Nursing CMI

3. Have a good understanding of the clinical components and factors that determine nursing CMGs

4. Understand how Nursing CMGs are impacted by:
   - Isolation
   - PHQ-9 Interview
   - Restorative Nursing programs
   - Documentation of critical components

Section GG – General Guidelines

- It is required at Admission and at Discharge.
  - Section GG has a 3 day look back window
  - For admission that means day 1, 2 and 3 of the Medicare stay (admission date plus 2 days following the admission)
  - For discharge that includes the last 3 days of the Medicare stay. (D/C date plus previous 2 days)

- The assessment is based on
  - Direct observation
  - Patient self-report of performance during the 3 day look back
  - Family report of actual performance during the 3 day look back
  - Direct care staff reports documented in the medical record

Section GG – General Guidelines

- Utilizing a documentation tool for CNAs, nursing and therapy to capture the first 3 days of performance is helpful – especially for the 10 items related to CMI.
- Items coded on the MDS need to be supported by documentation in the medical record

Section GG Documentation Worksheet

Patient: _____

Admit Date: _____

MDS GG Items	Day 1	Day 2	Day 3
Eating: The ability to use suitable utensils to bring food to the mouth and swallow food once the meal is presented on a table/tray. Includes modified food consistency.			
Oral Hygiene: The ability to use suitable items to clean teeth. [Dentures (if applicable): The ability to remove and replace from and to the mouth, and manage the equipment for soaking and rinsing them.]			
Toileting Hygiene: The ability to maintain perineal hygiene, adjust clothes before and after using the toilet, commode, bedpan or urinal. If managing an ostomy, include wiping the opening but not managing the equipment.			
Sit to lying: The ability to move from sitting on side of bed to lying flat on the bed.			
Lying to sitting on side of bed: The ability to safely 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.			
Sit to stand: The ability to come safely to a standing position from sitting in a chair or on the side of the bed.			
Chair/bed-to-chair transfer: The ability to safely transfer to and from a bed to a chair (or wheelchair).			
Toilet Transfer: The ability to safely get on and off a toilet or commode.			
Walk 50 feet with 2 turns: Once standing, the ability to walk at least 50 feet with 2 turns.			

Section GG – General Guidelines

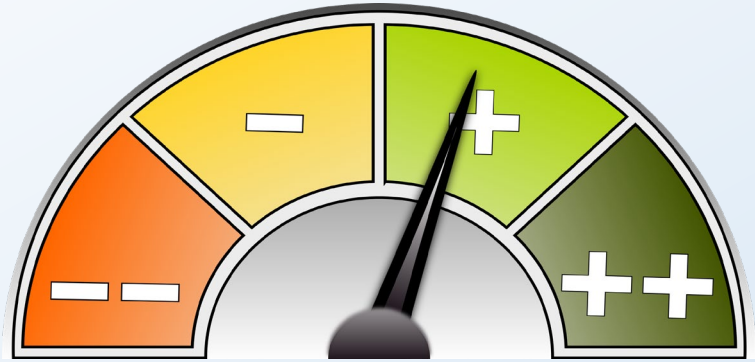
- Section GG comprises 20 Mobility items and 9 Selfcare items
  - 3 of the mobility items and 2 of the self-care items refer to PLOF status
  - The PLOF status items have a different scoring scale

- When assessing performance, only code actual performance of the task, not the staff's assessment of the patient's potential.

- The patients should be allowed to perform activities as independently as possible, as long as they are safe

- Activities may be completed with or without an assistive device (AD) with no penalty or impact on the self- performance score

Section GG General Guidelines



- All Self-Care and Mobility item assessments should be attempted
- Avoid Using the “Did Not Do” codes when possible
- It's not just about therapy! Use documentation for all disciplines to capture usual performance
- Understand each component and what it is comprised of when assessing and scoring, i.e.:
  - Lower body dressing does not include donning and doffing socks and shoes
  - Toilet hygiene does not include the transfers
  - Ambulation does not include sit to stand
  - Donning socks and shoes includes AFOs, TED hose, or compression stockings
  - Eating does not include retrieving the tray or food
- If assistance is required for safety or quality reasons, there are restrictions on who can be considered a helper when coding section GG of the MDS

Section GG - Definition of Helper

When coding section GG – the term “Helper" refers to:

- Facility staff who are direct employees or facility-contracted employees (such as therapists, agency staff etc.)

- It does not include :
  - individuals hired by persons outside facility management and administration
  - hospice staff
  - family hired caregiver
  - nursing and/or therapy students
  - volunteers
  - friends or family

Section GG - Usual Performance

- Score section GG items based on usual performance, or baseline performance
  - Not the “best” performance or the “worst” performance but how the resident performs the activity the majority of the time.

- A resident’s functional status can be impacted by the environment or situations encountered at the facility. Observing the resident’s interactions with others in different locations and circumstances is important for comprehensive understanding of the resident’s functional status.
  - Factors such as fatigue, alertness levels, cognitive state, and pain, may influence performance

- Section GG coding should be a collaborative effort between all members of the direct care staff
  - Observe resident performance over the entire 3 days (all shifts)

Coding Section GG Discharge Goals

- Where does the interdisciplinary team expect the patient to be functioning at discharge? Consider:
  - Be realistic not idealistic
  - Patient motivation
  - Patient goals
  - Prior Level of function and level of care required
  - Length of stay – number of therapy treatments, clinical barriers such as wounds, pain, anxiety, etc.
- CMS requires that at least 1 goal be set for discharge.
  - Although this is the requirement, we encourage you to set goals for all items that will be addressed by therapy or nursing or areas that you anticipate to be at risk for decline.
  - This is a good habit for monitoring outcomes and for facilitating good care planning.
- Avoid using dashes (-) for coding current performance and discharge goals
  - Dashes mean there is no answer or information is not available.

Section GG – General Guidelines

- Even though there are 29 section GG items, only a subset of these items go into calculating the Functional status score for PDPM reimbursement.

- For OT and PT there are 10 items that go into determining Case Mix Group (CMG)

Self Care items

- Eating
- Oral Hygiene*
- Toileting Hygiene

Mobility Items

Sitting to lying
Lying to sitting on edge of bed
Sit to stand
Chair/Bed to chair transfers
Toilet transfers
Walking 50 feet with 2 turns *
Walking 150 feet *

*For Nursing there are 7 items (Oral Hygiene and the 2 walking items are excluded)

Scoring – Mobility and Self-Care

Code	Score Description
6	**Independent:** patient completes the activity by him/herself with no assistance from a helper.
5	**Setup or clean-up assistance:** helper **sets up** or **cleans up**; patient completes activity. Helper assists only prior to or following the activity, but not during the activity.
4	**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.

Functional Pathways
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Scoring – Mobility and Self-Care

Code	Score Description
3	**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.
2	**Substantial/maximal assistance:** helper does **more than half** the effort. Helper lifts or holds trunk or limbs and provides more than half the effort.
1	**Dependent:** helper does **all** of the effort. Resident does none of the effort to complete the activity, or the assistance of two or more helpers is required for the resident to complete the activity.

Functional Pathways
Therapy that exceeds expectations.

Scoring – Mobility and Self-Care

Code	Score Description
7	**Patient refused:** patient refused
9	**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 condition or safety concerns:** not attempted due to medical condition or safety concerns

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GG Scoring Cross Walk

GG	Therapy Functional Levels
06=Independent	Independent (I), Modified Independent (Mod I)
05=Set up or Clean up	Set Up Assist (SU)
04=Supervision or Touching Assistance (Helper provides verbal cues and/or touching/steadying and/or contact guard assistance	Contact Guard Assist (CGA) Stand By Assist (SBA) Supervision (S)
03= Partial/moderate assistance (Helper provides less than half of the effort)	Moderate Assist (Mod A) Minimal Assist (Min A)
02= Substantial/maximal assistance (Helper provides more than half of the effort)	Maximum Assist (Max A)
01=Dependent (Helper does all the effort OR two or more helper required)	Dependent (D) Any assist level with 2 or more people (ex.: Max A of 2)
07= Resident refused	Refused (R)
09=Not Applicable-Not attempted AND the resident did not perform this activity prior to current illness, exacerbation or injury	
10=Not Attempted due to environmental limitations (lack of equipment, weather constraints)	
88= Not attempted due to medical condition or safety concerns	

Section GG Areas of Opportunity

Are you:

- Coding 88 on essential tasks such as eating, toileting, oral hygiene, and rolling
- Are we reviewing admission Functional Status Scores of 0 or 24 for accuracy in coding/scoring
- Are we using 88 vs. 10 vs. 9 vs 7. appropriately? Do we know the difference
- Are we reviewing and discussing Functional Status scores of 5 & 9 for therapy and 6 & 15 for nursing.
  - These cut points to the next category can impact reimbursement.
  - The more Independent – the higher the therapy CMI; the more Dependent – the higher the nursing CMI

Section GG – Calculating Function Score

Section GG Column 1	PDPM Function Score
05, 06	4
04	3
03	2
02	1
01, 07, 09, 10, 88, (-)	0

- The "Dependent", the "Did Not Do Codes" and the (-) = Zero points toward Function Score
- It is imperative to assess as many GG items as clinically appropriate across the 3 day assessment window

Section GG – Calculating Therapy Function Score

PT/OT:

Enter the Function Score for each item:		PT/OT FS		TOTAL
Eating	Eating Function Score:		→	
Oral Hygiene	Oral Hygiene Function Score:		→	
Toileting Hygiene	Toileting Hygiene Function Score:		→	
Bed Mobility	Sit to Lying Function Score:		Average → (sum scores and divide by 2)	
	Lying to Sitting on Side of Bed Function Score:			
Transfer	Sit to Stand Function Score:		Average → (sum scores and divide by 3)	
	Chair/Bed-to-Chair Function Score:			
	Toilet Transfer Function Score:			
Walking	Walk 50 Feet with Two Turns Function Score:		Average → (sum scores and divide by 2)	
	Walk 150 Feet Function Score:			
			Add 'total' column for the Total PT/OT Function Score.	

Section GG – Calculating Nursing Function Score

NURSING:

Enter the Function Score for each item:		**NURSING FS**		**TOTAL**
Eating	Eating Function Score:		→	
Toileting Hygiene	Toileting Hygiene Function Score:		→	
Bed Mobility	Sit to Lying Function Score:		Average → (sum scores and divide by 2)	
	Lying to Sitting on Side of Bed Function Score:			
Transfer	Sit to Stand Function Score:		Average → (sum scores and divide by 3)	
	Chair/Bed-to-Chair Function Score:			
	Toilet Transfer Function Score:			
			Add 'total' column for the Total NURSING Function Score.	

Nursing Case Mix Index (CMI)

Nursing coding is an area of great opportunity. It is imperative that we understand it well and know how to capture it accurately.

Two components go into determining the Nursing CMG

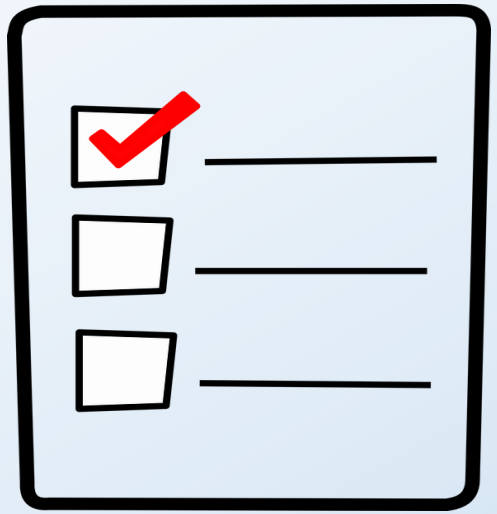
1. Functional Status score
2. Nursing clinical characteristics (RUGS)

There are 6 major clinical categories

- Extensive services
- Special Care High
- Special Care Low
- Clinically Complex
- Behavior and Cognitive Performance
- Physical Functioning Reduced

- The Pink categories are impacted by the presence or absence of depression (PHQ–9 (OV))
- The Blue categories are impacted by Restorative Nursing

Nursing Case Mix Index (CMI)



- Use the Hierarchical Classification System to determine which category the patient falls into:
  - The first category the resident qualifies for, based on the clinical characteristics of the resident, is the nursing clinical category
  - Begin at the top of the clinical category hierarchy, identifying if the resident meets criteria in that category. If not, move on down the hierarchy to the next clinical category. The process continues until the resident characteristics meet criteria in the category

Nursing Clinical Category Hierarchy

Nursing Category	Extensive Services	Clinical Conditions	Depression	Restorative	Function Score	Nursing Case Mix Group	Nursing Case Mix Index
Extensive Services	Trach & Vent				0-14	ES3	4.06
	Trach or Vent				0-14	ES2	3.07
	Infection	Infection Isolation			0-14	ES1	2.93
Special Care High		**Serious Medical Conditions** (Comatose and Completely Dependent, Septicemia, Diabetes w/ Insulin Injections & 2 or more days of Insulin Order Changes, Quadriplegia, Asthma or COPD with SOB while lying flat, Fever with Pneumonia or Vomiting, Parental/IV Feedings, Respiratory Therapy)	Yes		0-5	HDE2	2.40
			No		0-5	HDE1	1.99
			Yes		6-14	HBC2	2.24
			No		6-14	HBC1	1.86
Special Care Low		**Serious Medical Conditions** (CP, MS, Parkinson's Disease, Respiratory Failure & O2 Therapy, Pressure Ulcers, Foot Infection, Diabetic Foot Ulcers, Radiation Therapy, Dialysis)	Yes		0-5	LDE2	2.08
			No		0-5	LDE1	1.73
			Yes		6-14	LBC2	1.72
			No		6-14	LBC1	1.43
Clinically Complex		**Conditions Requiring Complex Medical Care** (Pneumonia, Hemiplegia/Hemiparesis, Surgical Wounds, Burns, Chemotherapy, Oxygen Therapy, IV Medications, Transfusions)	Yes		0-5	CDE2	1.87
			No		0-5	CDE1	1.62
			Yes		6-14	CBC2	1.55
			Yes		15-16	CA2	1.09
			No		6-14	CBC1	1.34
			No		15-16	CA1	0.94
Behavioral Symptoms or Cognitive Performance		**Behavioral Symptoms or Cognitive Performance** (BIMS score of 9 or less and Function Score of ≥ 11, Hallucinations, Delusions, Wandering, Behaviors directed at Others)		2 or More	11-16	BAB2	1.04
				0-1	11-16	BAB1	0.99
Reduced Physical Function		**Assistance with Daily Living and General Supervision** (Residents who do not meet the conditions of any previous categories or who would meet the criteria of Behavior Symptoms and Cognition Performance but have a Function Score less than 11)		2 or More	0-5	PDE2	1.57
				0-1	0-5	PDE1	1.47
				2 or More	6-14	PBC2	1.22
				2 or More	15-16	PA2	0.71
				0-1	6-14	PBC1	1.13
				0-1	15-16	PA1	0.66

Nursing Opportunities - Documentation

Skilled Nursing Documentation Recommendations

Respiratory	Urinary	Integumentary	Diabetic Teaching	Pain Control	Orthopedic
Respiratory rate/pattern	Document S/S of infection	Wound location Wound measurements Wound stage Appearance of wound Presence of drainage S/S infection	Performing/reading blood sugars	Type Location Severity Frequency Time of day Activity related to pain	ADLs affected and amount of assist needed for ADLs
Lung sounds	Burning, pain, bloody, cloudy, pus in urine, odor	Nutritional intake	Determining/drawing insulin	Medications and response	Assist with transfers
Cough/congestion	Urgency	Skin integrity interventions	Self-injections	Pain rate before and after medication	Assist with ambulation
Oxygen use/O2 sats	Confusion	Current treatment and response	Rotating sites	Non-therapeutic interventions: turning down lights, quiet environment, position change, massage, therapy, etc.	Pain: (see pain control section)
Meds and response	Behavior	Dressing type and change orders	Diabetic diet		Positioning/safety devices
Activity tolerance	Fever	Pain with dressing changes	Diabetic foot care		Surgical Incision appearance/care
SOB cause; SOB while lying flat	Medications ordered and response				Precautions/contraindications
Sore throat	Change in S/S				
Fever					

Nursing CMI - Extensive Services: Isolation

Isolation is an area that is misunderstood and often miscoded

- To qualify for isolation, the patient must:
  - Have a physician diagnosis of **active** infection that is documented
  - Be placed in strict isolation
    - They cannot be cohorted or have a roommate
    - Must be confined to their room (cannot be moving around the facility)
    - They must require over and above standard precautions
- Isolation does not have to have occurred during the **entire** 14 day look back, just at some point during the lookback
- Observe and document disease symptoms every shift
- Include positive lab results in medical record
- Address isolation and include symptom observation and/or monitoring in the care plan

The PHQ-9 Interview

- CMS utilizes the Patient Health Questionnaire to assess mood distress which is known to be underdiagnosed and undertreated in nursing facilities

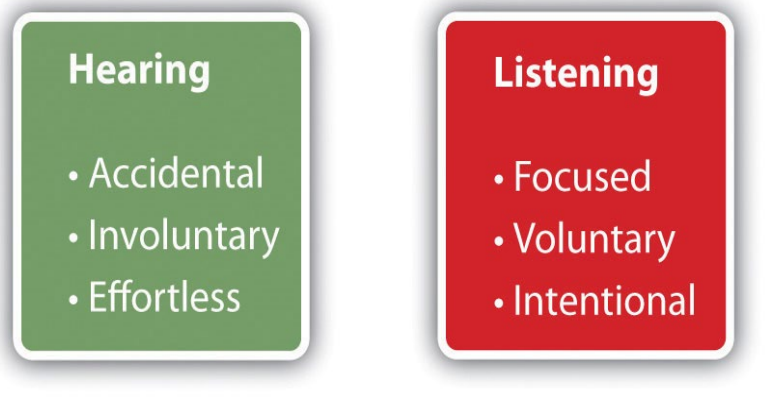
- Mood distress and depression can cause:
  - Poor adjustment to the nursing facility, increased sensitivity to pain, exacerbation of chronic illness
  - Decreased participation in activities and daily tasks
  - Decreased functional status and resistance to daily care
  - Decreased appetite and cognitive status

- How much do we truly focus on patient feelings and how they affect care?

Intent of the PHQ-9

- Presence of indicators on the PHQ-9 do not automatically mean the resident has or should have a diagnosis of depression
- The person administering the PHQ-9 does not assign a diagnosis of depression or mood disorder – only record the presence or absence of the indicators
- A score of 10 or higher triggers as the presence of depression for the Nursing CMI
- Findings of indicator/symptoms of mood distress should lead us to:
  - Identify causes and contributing factors for the symptoms
  - Identify interventions that may address the symptoms such as personal support, environmental modification, or treatment
  - Ensure resident safety
  - Develop an individualized care plan to address affects the symptoms have on the patient's care

Considerations for the Interview



- Resident vs Staff Interview considerations:
  - Attempt the interview on ALL residents – even if they are coded as rarely/never understood on B0700 – Makes Self Understood
  - Most residents who can communicate can answer questions about how they feel
  - Perform the interview during the ARD lookback – RAI states “preferred” on or day before the ARD – but is not required (14 day lookback period)
  - “Hearing the resident’s voice” – more reliable than staff/family observation alone
  - Determine if resident needs an interpreter, or needs the questions given in writing or sign language

Tips for Administering

- Conduct the interview in a private setting – many residents in the elder population may find it embarrassing or difficult to discuss their feelings on these items.
- Be sure the resident can see and hear you clearly
- Minimize background noise
- Be an active listener – the items in this interview are sensitive topics – be attentive to the resident
- Explain the reason for doing the interview prior to asking the questions.
  - **Suggested language:** "I am going to ask you some questions about your mood and feelings over the past 2 weeks. I will also ask about some common problems that are known to go along with feeling down. Some of the questions might seem personal, but everyone is asked to answer them. This will help us provide you with better care."

PHQ-9 Questions

D0200. Resident Mood Interview (PHQ-9©)

Say to resident: *"Over the last 2 weeks, have you been bothered by any of the following problems?"*

If symptom is present, enter 1 (yes) in column 1, Symptom Presence.
If yes in column 1, then ask the resident: "*About **how often** have you been bothered by this?*"
Read and show the resident a card with the symptom frequency choices. Indicate response in column 2, Symptom Frequency.

1. **Symptom Presence**
   0. **No** (enter 0 in column 2)
   1. **Yes** (enter 0-3 in column 2)
   9. **No response** (leave column 2 blank)

2. **Symptom Frequency**
   0. **Never or 1 day**
   1. **2-6 days** (several days)
   2. **7-11 days** (half or more of the days)
   3. **12-14 days** (nearly every day)

	1. Symptom Presence	2. Symptom Frequency
	↓ Enter Scores in Boxes ↓	
A. *Little interest or pleasure in doing things*	☐	☐
B. *Feeling down, depressed, or hopeless*	☐	☐
C. *Trouble falling or staying asleep, or sleeping too much*	☐	☐
D. *Feeling tired or having little energy*	☐	☐
E. *Poor appetite or overeating*	☐	☐
F. *Feeling bad about yourself - or that you are a failure or have let yourself or your family down*	☐	☐
G. *Trouble concentrating on things, such as reading the newspaper or watching television*	☐	☐
H. *Moving or speaking so slowly that other people could have noticed. Or the opposite - being so fidgety or restless that you have been moving around a lot more than usual*	☐	☐
I. *Thoughts that you would be better off dead, or of hurting yourself in some way*	☐	☐

Nursing CMI Opportunities - Depression

PDPM RUG	End Splits	Function Score	Nursing Case-Mix Group	Nuring Case-Mix Inderx
Special Care High	Depression	0 - 5	HDE2	2.40
Special Care High	Depression	6 - 14	HBC2	2.24
Special Care High	No Depression	6 - 14	HBC1	1.86
Special Care High	No Depression	0 - 5	HDE1	1.99

Nursing CMI Opportunities - Depression

CMG		CMI	Nursing Rural Rate Unadjusted	Nursing Daily rate
HDE2	Depression	2.4	$101.88	$244.51
HDE1	No Depression	1.99	$101.88	$202.74
Difference		0.41		$41.77

$41.77 per day x 20 days = $835.42

Nursing Opportunities - Restorative

- Restorative Nursing also affects the nursing CMI
  - Must have 2 programs
  - 15 minutes each, per day
  - 6 days per week
  - Service must be provided by a trained person
  - Services must be recorded and documented

- There needs to be a specific plan that is individualized to the resident

- The services need to be recorded and coded on the MDS

NOTE: Restorative Nursing impacts both PDPM and LTC case mix

Restorative Programs

H0200C, H0500** Urinary toileting program and/or bowel toileting program

O0500A, O0500B** Passive and/or active range of motion

O0500C Splint or brace assistance

O0500D,O0500F** Bed mobility and/or walking training

O0500E Transfer training

O0500G Dressing and/or grooming training

O0500H Eating and/or swallowing training

O0500I Amputation/prostheses care

O0500J Communication training

** Means that both programs on this line can only count as one program

Nursing Opportunities - Restorative

Nursing Category	Extensive Services	Clinical Conditions	Depression	Restorative	Function Score	Nursing Case Mix Group	Nursing Case Mix Index
Reduced Physical Function		**Assistance with Daily Living and General Supervision** (Residents who do not meet the conditions of any previous categories or who would meet the criteria of Behavior Symptoms and Cognition Performance but have a Function Score less than 11)		2 or More	0-5	PDE2	1.57
				0-1	0-5	PDE1	1.47
				2 or More	6-14	PBC2	1.22
				2 or More	15-16	PA2	0.71
				0-1	6-14	PBC1	1.13
				0-1	15-16	PA1	0.66

Nursing Opportunities - Restorative

CMG		CMI	Nursing Rural Rate Unadjusted	Nursing Daily Rate
PBC2	Restorative	1.22	$101.88	$124.29
PBC1	No Restorative	1.13	$101.88	$115.12
Difference		0.09		$9.17

$9.17 per day
x 20 days =
$183.38

Important Take-Aways

- Remember that Section GG affects the Case Mix Index (CMI) for PT, OT AND Nursing
- Ensure nursing is documenting critical components using a documentation checklist
- Any 2-person assist should be documented and coded
- The PHQ-9 - When and how it is being administered
- Consider having a dedicated person in restorative for both skilled and LTC patients
- Special consideration should be made when setting the ARD
- Review orders and ensure all medications have an associated diagnosis

If you have questions or would like further resources, contact:

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