HOME HEALTH
QUALITY REPORTING PROGRAM
PROVIDER TRAINING

PARTICIPANT QUESTIONS FROM IN-PERSON TRAINING ON NOVEMBER 6 AND 7, 2018

Current as of March 2019

Acronym List

Acronym	Definition
ADL	Activities of Daily Living (ADLs)
CASPER	Certification and Survey Provider Enhanced Reports
CMS	Centers for Medicare & Medicaid Services
CY	Calendar Year
HHA	Home Health Agency
IADL	Instrumental Activities of Daily Living
IMPACT Act	Improving Medicare Post-Acute Care Transformation Act
OASIS	Outcome and Assessment Information Set
PAE	Potentially Avoidable Event
QAO	Quality Assessments Only
QRP	Quality Reporting Program
QSOG	Quality, Safety & Oversight Group
RN	Registered Nurse
ROC	Resumption of Care
SOC	Start of Care

#	Category	Item If Applicable	Question	Response
1	Case Study	GG0130A. Eating	In the case study at end of training, GG0130A was scored as 05. This question specifically states, “Once the meal is placed before the patient.” Should the correct answer be 06, excluding setup?	This is the training example being referenced: • **Scenario:** Since her fall, Mark does the cooking and clean up for Mrs. S’ meals. He sets the table, prepares her plate, and fixes her tea for her. • **Rationale:** Mrs. S could feed herself but needed assistance from her son, Mark, to set the table, prepare her plate, and fix her tea. Mark also cleaned up after meals. • **Proposed Reply:** GG0130A assesses the ability to use suitable utensils to bring food and/or liquid to the mouth and swallow food and/or liquid. If any additional assistance is required before the patient starts to eat meal to allow the patient to safely eat or drink without assistance/supervision/cueing, code 05. Setup/clean-up. In the scenario provided, if the caregiver only needed to assist the patient preparing her plate and tea after the meal had been placed before the patient, but before the patient began eating, Code 05. Setup/clean-up."
2	Case Study	J1900. Number of Falls Since SOC/ROC	In the case study, Mrs. S was diagnosed with right femoral fracture. J1900 should be coded as major injury, not injury (except major) since any time there is a bone fracture major injury should be coded. Correct? But the speaker coded "1" for injury (except major) and coded "0" for major injury." Please clarify.	The right femoral fracture occurred prior to the most recent SOC/ROC and therefore would not be considered when coding J1900. The fall that was coded as a 1, Injury (except major) occurred after the SOC when the patient fell and sustained a bruise and abrasion.
3	Changes in Skin Integrity	M1311. Current Number of Unhealed Pressure Ulcers/Injuries at Each Stage	How would a pressure ulcer be coded at discharge if it did not form while the patient was receiving services from a HHA?	If the pressure ulcer was present Start of Care (SOC) and present on discharge at the same stage, it would not be counted as developing during a home health episode of care.

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4	Changes in Skin Integrity	M1311. Current Number of Unhealed Pressure Ulcers/Injuries at Each Stage	If a patient has a Stage 3 pressure ulcer at SOC but that pressure ulcer is covered with a nonremovable dressing at discharge, is the unstageable ulcer at discharge considered present at SOC?	The Stage 3 pressure ulcer covered with a dressing applied at the discharge visit is considered present at the most recent SOC.
5	Changes in Skin Integrity	M1311. Current Number of Unhealed Pressure Ulcers/Injuries at Each Stage	Will the new quality measure associated with M1311. Current Number of Unhealed Pressure Ulcers/Injuries at Each Stage result in worse outcomes than the quality measure currently associated with M1313. Percent of Residents or Patients with Pressure Ulcers that are New or Worsening?	You are correct that there are measure calculation (and therefore possible rate) differences between the two Improving Medicare Post-Acute Care Transformation (IMPACT) Act pressure ulcer measures. The new quality measure, Changes in Skin Integrity Post-Acute Care: Pressure ulcer/injury, is calculated from M1311 and includes unstageable pressure ulcers/injuries that worsen during the quality episode. Unstageable pressure ulcers that are new or worsened are not included in the Percent of Residents or Patients with Pressure Ulcers that are New or Worsening measure, which is calculated using M1313.

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6	Changes in Skin Integrity	M1311. Current Number of Unhealed Pressure Ulcers/Injuries at Each Stage	Why is a Stage 3 pressure ulcer that worsens to become unstageable due to slough/eschar said to be present on SOC but yet a pressure ulcer Stage 3 that worsens and goes to Stage 4 is considered not present on SOC (it is the same ulcer, just worse)? It is very confusing.	Any numerically stageable pressure ulcer/injury observed at SOC/Resumption of Care (ROC) that is unstageable due to slough and/or eschar at discharge should be considered new and not coded as present at the most recent SOC/ROC for M1311X2.--(Ch.3 GM M1311).
7	Changes in Skin Integrity	M1311. Current Number of Unhealed Pressure Ulcers/Injuries at Each Stage	Why is it not acceptable to say unable to complete skin assessment at time of first visit for a device or nonremovable dressing when the dressing or device will be removed within the 5-day window? Is CMS saying that we should not open the case until the dressing or device needs to be changed?	The general standard of practice for patients starting or resuming care is that patient assessments are completed as close to the actual time of the SOC/ROC as possible. For example, if a pressure ulcer/injury that is identified on the SOC date increases in numerical stage within the assessment timeframe, the stage of the pressure ulcer/injury at the first skin assessment completed would be reported in M1311X1 at the SOC. (--Ch.3 GM M1311)

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8	General		What is needed in the documentation when proving interdisciplinary communication according to the Conditions of Participation?	The Quality, Safety & Oversight Group (QSOG) provided the following response: Home health agencies (HHAs) develop their own strategies and policies for interdisciplinary team meetings, and these are determined by each HHA. Evidence of interdisciplinary communication would consist of documentation of the periodic discussions that were held by the interdisciplinary team where all HHA staff involved in the patient's care is represented, as per agency policy. These discussions may be held in person or through virtual meetings. The State Operations Manual, Appendix B, contains two references to the interdisciplinary assessment and interdisciplinary team: • **§484.75(b)(1) Ongoing interdisciplinary assessment of the patient.** Interpretive Guidelines §484.75(b)(1). The term "interdisciplinary" refers to an approach to healthcare that includes a range of health service workers. "Ongoing interdisciplinary assessment" is the continual involvement of all skilled professional staff involved in a patient's plan of care from the initial assessment through discharge, which should include periodic discussions among the team regarding the patient's health status and recommendations for the plan of care. An interdisciplinary approach recognizes the contributions of various healthcare disciplines (medical doctors, registered nurses (RNs), licensed practical nurses/licensed vocational nurses, physical therapist, occupational therapist, speech language pathologists, Master of Social Work, home health aides) and their interactions to meet the patient's needs. • **§484.80(g)(4) Home health aides must be members of the interdisciplinary team, must report changes in the patient's condition to a RN or other appropriate skilled professional, and must complete appropriate records in compliance with the HHA's policies and procedures.** Interpretive Guidelines §484.80(g)(4). The term "interdisciplinary" refers to an approach to healthcare that includes a range of health service workers. The home health interdisciplinary team, which meets together, is composed of the disciplines including medical doctors, RNs, licensed practical nurses/licensed vocational nurses, physical therapists and physical therapist assistants, occupational therapists and occupational therapist assistants, speech language pathologists, Master of Social Work, and home health aides. During interdisciplinary team meetings, all HHA staff involved in the patient's care must be present for, and, where appropriate, should contribute to, any discussion regarding the patient's care. For other HHA survey-related questions, please send your questions via email to HHASurveyProtocols@cms.hhs.gov.
9	General		Will the Quality Assessments Only (QAO) expectation continue to ratchet up in future years?	The Centers for Medicare & Medicaid Services (CMS) announces changes in initiatives when they occur. The QAO threshold is currently 90 percent, and no plans to modify this have been announced.

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10	General		Can you enter the rationales for the scenarios for staff education?	The rationales have been posted to the website with the scenarios and the slides. Presentations with answers to knowledge checks and scenarios are posted in the Downloads section of the Home Health QRP Training web page at https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HomeHealthQualityInits/Home-Health-Quality-Reporting-Training.html.
11	General		If the SOC assessment takes more than 1 day and the admitting clinician does a SOC visit on day 1 and returns on day 2 for more information, is it expected that a complete head-to-toe assessment be completed again on day 2 (i.e., vital signs, another skin check, respiratory status)?	The SOC OASIS items, which must be integrated into your agency's own comprehensive assessment, must be completed in a timely manner, but no later than 5 calendar days after the SOC date. The comprehensive assessment is not required to be completed on the initial visit; however, agencies may do so if they choose.
12	General		Where can I find written documentation that I may use for education of my staff? This is a requirement of my company.	If you are referring to the webinars and in-person training relative to Home Health QRP/OASIS-D, video recordings of presentations are all posted on YouTube and on the CMS website for that purpose. Additionally, the presentations themselves are posted on the Home Health QRP Training web page at https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HomeHealthQualityInits/Home-Health-Quality-Reporting-Training.html.
13	General		For the acute care hospital 60-day measure, will that measure be removed from Stars Quality and Value-Based Purchasing?	Per the CY 2019 Home Health Final Rule, the measure, Acute Care Hospitalization During the First 60 Days of Home Health (Claims-based), will continue to be used for the Quality of Patient Care Star Ratings and the Home Health Value Based Purchasing Model.

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14	Reports		Will the worksheet exhibit 285 be updated to reflect the new quality reports that are assessed pre-survey? It is getting confusing as to what surveyors are to assess.	QSOG provided the following response: The worksheet exhibit 285 is no longer necessary. The offsite preparation task has been refocused to optimize surveyor time in planning for the HHA survey and to shift the focus of the offsite review to PAEs. The number of CASPER HHA reports that are to be reviewed prior to the HHA survey is reduced from six to three reports. The three CASPER reports that surveyors will continue to review during Task 1 are: 1. **PAE Report (12 months).** Surveyors will continue to utilize the PAE Report to identify potential areas of concern for the survey. Review the report to identify all PAEs. It is no longer required that the surveyor analyze this report for statistical significance or to determine if the provider exceeded twice the national reference value for a particular concern. All incidents contained within the report time period should be used as the universe, in conjunction with the PAE: Patient Listing Report, from which the closed record sample for the survey is selected. The closed record sample is selected during the pre-survey preparation. If the reports do not contain a sufficient number of events, the sample may be augmented onsite. 2. **PAE: Patient Listing Report (12 months).** This report provides the names of the patients who experienced the events noted in the report above. Patients listed under multiple areas in the above report should be selected as a priority. If an insufficient number of patients are listed in the PAE Report to meet the number of closed records required for the survey sample, additional records may be added to the sample from the list of patients discharged from the agency for the 6 months prior to the survey. 3. **Agency Patient-Related Characteristics Report (12 months).** Surveyors will continue to review this report, which compiles several OASIS data elements into one report that provides a high-level overview of the HHA patient demographics, home care diagnoses, and agency statistics. Surveyors should identify potential focus areas of concern where the agency's indicators exceed the national reference in the areas of acute conditions, patient diagnostic information, and home care diagnoses. Select patients for review and home visits during the survey who be associated with these areas of concern. For the source document, please refer to Quality, Safety, and Oversight Memo 18-13-HHA, https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Downloads/QSO-18-13-HHA-.pdf. For other survey related questions, please send your questions via email to: HHASurveyProtocols@cms.hhs.gov.

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15	Reports		After the October 2019 report, when can we expect another quality outcome report? This is in reference to the freeze on quality reporting. Specifically, hospitalization.	Outcome reports are available on demand. The claims-based measures will be reported on an annual basis and will be updated annually each October.
16	Reports		The question was not answered yesterday about how to correct information on the "Review and Correct" report in CASPER. Can you discuss this?	For assistance with correcting inaccurate OASIS data, contact your State OASIS Automation Coordinator. A list of contacts by State is available at https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/OASIS/Downloads/OASISautomationcoordinators.pdf.
17	Section GG		For the new GG items, we noted that under guidance there are no data resources listed. What is the reason for this?	The data sources/resources listed for GG0100 and GG0110 include Patient Interview, Family Interview and Clinical Record. For GG0130 and GG0170, sources and resources for data collection are incorporated into the response-specific instructions (e.g., observation, interview, collaboration with other agency staff).
18	Section GG		For GG SOC, if there is a skip pattern, do you still fill out the discharge goal?	A discharge goal can be established for any activity, including an activity that is skipped due to a skip pattern. A dash is a valid response for any activity when a discharge goal is not established, including for an activity that is skipped due to a skip pattern

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19	Section GG	All items	In all your scenarios with these GG questions, you indicate the level of assistance by the physical therapist. Are you expecting that even though most OASIS evaluations are done by the RN that the information will be collaborated after the physical therapist has gone in?	In cases involving nursing, the RN is responsible for completing the comprehensive assessment document at SOC and may elicit input from the patient, caregivers, and other healthcare personnel to assist in the completion of any or all OASIS items. For those completing OASIS, a combination of observation, interview, collaboration with other agency staff and other relevant strategies should be used for OASIS data collection. OASIS items were designed to be discipline-neutral and have been tested and validated with clinicians from various disciplines.
20	Section GG	GG0100. Prior Functioning: Everyday Activities	Is there guidance if there is a list of activities? Should we instruct our staff to code to the lowest level of function, or is the guidance a majority of the task for GG 0100?	The “majority of tasks” convention that applies for the M1800 activities of daily living (ADLs)/instrumental activities of daily living (IADLs) items does not apply to the GG Prior Functioning, Self-Care, and Mobility items. For GG0100. Prior Functioning, if a patient completed all of the activities by him/herself, with or without an assistive device, with no assistance from a helper, code as “3. Independent.” If a patient needed partial assistance from another person to complete any of the activities, code as “2. Needed Some Help.” If a helper completed all of the activities for the patient because the patient could not assist, code as “1. Dependent.”
21	Section GG	GG0110. Prior Device Use	For GG0110, can you define what immediately prior timeframe would be?	Assessing clinicians must consider each individual patient’s unique circumstances and use professional clinical judgment to determine how prior functioning and prior device use applies for each individual patient. In responding to GG0100 Prior Functioning: Everyday Activities, the activities should be reported based on the patient's usual ability prior to the current illness, exacerbation, or injury. This is the patient’s functional ability prior to the onset of the current illness, exacerbation of a chronic condition, or injury (whichever is most recent) that initiated this episode of care. Clinicians should use clinical judgment within these parameters in determining the timeframe that is considered "prior to the current illness, exacerbation, or injury." The same approach should be used in determining Prior Device Use for GG0110.
22	Section GG	GG0110. Prior Device Use	Would a lift chair/power recliner-type chair be considered a mechanical device?	For GG0110C. Prior Device Use, a mechanical lift is defined as any device that a patient or caregiver requires for lifting or supporting the patient's body weight. Examples provided include a stair lift, Hoyer lift, and bathtub lift. Clinical judgment may be used to determine whether other devices, such as the electric lift chair described, meet the definition provided.

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23	Section GG	GG0110. Prior Device Use	For GG0110C, if patient uses devices only as needed (e.g., walker which has only been used less than an hour in the past 6 months), would that be included as a response here?	Assessing clinicians must consider each individual patient's unique circumstances and use professional clinical judgment to determine how prior functioning and prior device use applies for each individual patient. In responding to GG0100 Prior Functioning: Everyday Activities, the activities should be reported based on the patient's usual ability prior to the current illness, exacerbation, or injury. This is the patient's functional ability prior to the onset of the current illness, exacerbation of a chronic condition, or injury (whichever is most recent) that initiated this episode of care. Clinicians should use clinical judgment within these parameters in determining the timeframe that is considered "prior to the current illness, exacerbation, or injury." The same approach should be used in determining Prior Device Use for GG0110.
24	Section GG	GG0110. Prior Device Use	For GG0110, are crutches considered as any of the devices?	The use of a cane or crutches is not captured in GG0110. Prior Device Use. If the patient was only using a cane or crutch prior to the current illness, exacerbation, or injury, check Z. None of the above.
25	Section GG	GG0130. Self-Care	For GG0130, please define the difference between maximal assistance and dependent.	For the six-point coding scale, substantial maximal assistance is defined as the helper doing more than half the effort. Dependent is defined as the helper providing all the effort and the patient contributes no effort to complete the activity or the assistance of two or more helpers is required for the patient to complete the activity.
26	Section GG	GG0130. Self-Care	What are the differences between the intent of items M1800–M1860 and items GG0130?	The implementation of Section GG is for the collection of quality data to meet the intent of the IMPACT Act. For quality purposes, the collection of Section GG quality data will expand measure development for the home health setting, allowing CMS to measure functional status and progress in some of the most complex cases treated in the home health setting. With the implementation of OASIS-D, CMS will continue to test/assess the current Section M and GG items. As stated, each item is used for a specific purpose, so the assessment of the data from the collection of those items is important.

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27	Section GG	GG0130. Self-Care/GG0170. Mobility	When selecting a goal level of GG0130 and GG0170, should the clinician take into consideration the ordered number of visits by physician, such as an orthopedic medical doctor that only orders four visits of home health physical therapy before the patient discharges to outpatient therapy?	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.
28	Section GG	GG0130. Self-Care/GG0170. Mobility	For GG0130/170, are there disadvantages (whatsoever) to a HHA when responses to these are any of the "not attempted"?	When completing GG0130 or GG0170, combine general observation, interview of patient/caregiver(s), collaboration with other agency staff, and other relevant strategies to complete any and all GG items, as needed. Use clinical judgement to determine which code best applies to your patient. Utilizing an "activity was not attempted" code does not negatively impact the calculation of the new quality measure, Percent of Patients with Admission and Discharge Functional Assessment and Care Plan that Addresses Function.
29	Section GG	GG0130. Self-Care/GG0170. Mobility	Do we use 06 if the patient is not safely performing the activity?	For GG0130 and GG0170, 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. (-- Ch. 3 GM)
30	Section GG	GG0130. Self-Care/GG0170. Mobility	Will selecting Code 10 (environmental limitation) on a GG question effect my outcomes at the end of the episode?	Utilizing an "activity was not attempted" code does not negatively impact the calculation of the new home health measure, Percent of Patients with Admission and Discharge Functional Assessment and Care Plan that Addresses Function.

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31	Section GG	GG0130. Self-Care/GG0170. Mobility	OASIS guidance has been to score SOC/ROC before any teaching or intervention.	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.
32	Section GG	GG0130. Self-Care/GG0170. Mobility	What is the estimated time burden on the clinician to complete GG0130 (seven performance observations) and GG0170 (nine performance observations)? Also would like to know the time reported from other settings (skilled nursing facility, inpatient rehabilitation facility, long-term care hospital)?	The home health calendar year (CY) 2018 Final Rule (CY 2018 FR), page 51,734, column 3, includes details of the calculations completed. CMS assumes that each data element requires 0.3 minutes of clinician time to complete. Considering the item removals, balanced with items added, this is determined to be a reduction in clinician burden per OASIS assessment of 11.4 minutes at SOC, 11.4 minutes at ROC, 0.6 minutes at follow-up, and 2.7 minutes at discharge. There is an increase in clinician burden per assessment of 0.9 minutes at death. In the Comment Responses 2018 (CMS 10545), CMS further clarified that the 0.3 minutes per item factor accounts for coding the items based on an assessment that takes place in the course of care. CMS' burden estimates are intended to reflect only the time needed to complete OASIS items and is independent of clinical time spent assessing the patient. CMS believes that burden estimates should not account for the time spent conducting a comprehensive assessment of the patient. Burden estimates are also not intended to reflect costs of training and operational processes; these are considered part of the operating costs for a HHA. CMS also points out that the Paperwork Reduction Act guide states, "Generally, estimates should not include burden hours for customary and usual business practices."
33	Section GG	GG0130. Self-Care/GG0170. Mobility	When a patient needs both verbal and touching, why does it not go to the lower one.	For the GG0130 and GG0170 items, if the helper provides verbal cues and/or touching/steadying and/or contact guard assistance as a patient completes activity, choose Code 04, Supervision or Touching Assistance. Assistance may be provided throughout the activity or intermittently. Touching does not infer lifting, holding, or supporting of trunk or limbs.
34	Section GG	GG0130. Self-Care/GG0170. Mobility	How will CMS use these data?	Effective January 1, 2019, select activities from GG0130 and GG0170 are used to calculate the quality measure Application of Percent of Patients with an Admission and Discharge Functional Assessment and a Care Plan that Addresses Function.

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35	Section GG	GG0130. Self-Care/GG0170. Mobility	If only one goal is required for GG0130 or GG0170 for the quality measure, is it expected that goals would be set for all activities that are attempted? Would it be expected that goals would ever be left blank on the OASIS?	Agencies may choose to complete more than one self-care or mobility discharge goal, including reporting a discharge goal for all collected GG0130 and GG0170 items, including those skipped due to a skip pattern. A dash is a valid response for any activity where a discharge goal is not established, including for an activity that is skipped due to the skip pattern
36	Section GG	GG0130. Self-Care/GG0170. Mobility	Regarding the calculation of the quality measures for the GG items, it was said that the measure is calculated based on episodes where goals were identified for functional items. Does this mean the goals are not required? Is setting a goal for each item optional?	For the Home Health QRP, a minimum of one self-care or mobility goal must be coded. However, agencies may choose to complete more than one self-care or mobility discharge goal. Select activities from GG0130 and GG0170 are used to calculate the quality measure Application of Percent of Patients with an Admission and Discharge Functional Assessment and a Care Plan that Addresses Function. The activities utilized in the measure are: • GG0130. Self-care items (GG0130A. Eating, GG0130B. Oral hygiene, GG0130C. Toileting hygiene). • GG0170. Mobility Items (GG0170B. Sit to lying, GG0170C. Lying to sitting on side of bed, GG0170D. Sit to stand, GG0170E. Chair/bed-to-chair transfer, GG0170F. Toilet Transfer, GG0170J. Walk 50 feet with two turns, GG0170K. Walk 150 feet, GG0170R. Wheel 50 feet with two turns, GG0170S. Wheel 150 feet). Per the measure specifications, the numerator is met when, for a home health quality episode, valid codes are reported for the SOC/ROC performance and for the discharge performance for all of the listed functional activities and, at SOC/ROC, a valid numeric score is coded for a discharge goal for at least one of the listed self-care or mobility activities. (-- Ch. 3 GM GG0130 and GG0170; CMS Quarterly Q&A January 2019 Question 30)
37	Section GG	GG0130A. Eating	For GG0130A, please clarify answer as 05, set up assistance is not counted, so she should be independent with eating?	For GG0130A. Eating, examples of Code 05. Set-up or clean-up assistance would include cutting up food, pouring liquids, or opening containers, as long as the assistance is only required before or after the eating activity. (Ch 3, GG-10 HH QRP Training November 2018 Question 84)

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38	Section GG	GG0130C. Toileting Hygiene	Describe how a caregiver needing to retrieve incontinence products during toileting would affect coding for GG0130C? Is this setup or supervision or something else?	If the patient can complete toileting hygiene and clothing management tasks only after a helper retrieves or sets up supplies necessary to perform included tasks, code 05. Setup or clean-up assistance.
39	Section GG	GG0130E. Shower/bathe self	For GG0130E: Shower/bathe self, does this include the patient's ability to cover wounds/devices the patient has physician orders to not get wet when answering about his or her ability to bathe?	The ability to cover wounds or devices would be considered part of the setup or cleanup process.
40	Section GG	GG0130F. Upper body dress/GG130G. Upper body dressing	For self-care activities, does dressing include dress in usual clothing as with the M items?	Assess the patient based on the clothing the patient routinely wears.
41	Section GG	GG0130F. Upper body dress/GG130G. Upper body dressing	Do the upper and lower dressing items include TED hose, braces, slings, etc.?	For GG0130F and GG0130G Upper and Lower Body Dressing, support devices such has prosthetics, orthotics, braces, neck supports, elastic bandages, and knee braces should all be considered when coding.
42	Section GG	GG0130H. Putting on/taking off footwear	For GG0130H, - does the "majority of tasks" convention apply?	The "majority of tasks" convention that applies for the M1800 ADL/IADL items does not apply to the GG items. For GG items that include multiple activities (such as GG0130H. Putting on/taking off footwear for a patient wearing socks, shoes and an ankle foot orthosis), code using the six-point scale based on the patient's ability to complete all relevant tasks. (-- January 2019 Quarterly Question 8)

#	Category	Item If Applicable	Question	Response
43	Section GG	GG0170. Mobility	In the GG section for mobility, if the patient is unable to ambulate/propel the distance within his or her home due to environmental hazards or outside due to inclement weather, how is it to be scored?	When completing GG0130 or GG0170, combine general observation, interview of patient/caregiver(s), collaboration with other agency staff, and other relevant strategies to complete any and all GG items, as needed. Use clinical judgement to determine which code best applies to your patient.
44	Section GG	GG0170A. Roll left and right	OASIS guidance has been to score SOC/ROC before any teaching or intervention. Why is Scenario 3 (slide 96) considering a score with a physical therapist providing cues? Why not score patient ability before the physical therapist's cues?	When coding GG0130 and GG0170 items, if the patient requires only verbal cueing to complete the activity, Code 04, Supervision or touching assistance would be the correct choice. Coding of the Section GG items should be based on the patient's actual performance prior to the start of therapy services to capture the patient's true baseline. The assessing clinician may need to use clinical judgement to differentiate between verbal cueing and therapeutic intervention.
45	Section GG	GG0170C. Lying to sitting on side of bed	What if a patient does not have a bed and sleeps on a recliner or couch?	If the patient uses a recliner, sofa, or mattress on the floor as the patient's "bed" (preferred or necessary sleeping surface), assess the patient's need for assistance using that sleeping surface when determining ability in GG0170C. Lying to sitting on side of bed.
46	Section GG	GG0170E. Chair/bed-to-chair transfer	On GG0170E, if the chair is across the room or in another room and the patient does not have a wheelchair but needs help with walking to the chair, do you grade the level of assistance based on the walking level of assistance?	The activity begins with the patient sitting (in a chair, wheelchair, or at the edge of a bed) and includes transferring to sitting in a chair, wheelchair, or at the edge of the bed. The activity may be assessed using a chair-to-chair transfer; therefore an environmental limitation restricting placement of a chair at the bedside would not need to affect the assessment or coding of this activity. The need for assistance with ambulation would not impact the code selected for GG0170E, which simply reflects the transfer between any two sitting surfaces.

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47	Section GG	GG0170I. Walk 10 feet	Will there be a skip pattern (similar to steps) for ambulation should a patient be unable to even walk 10 feet?	For the SOC/ROC performance, if GG0170I Walk 10 feet is coded with an “activity was not performed” code (07, 09, 10 or 88), the instruction is to skip to GG0170M, 1 step (curb).
48	Section GG	GG0170J. Walk 50 feet with two turns	Please explain why an “activity was not attempted” code is used for GG0170J 50 feet, when a patient can only walk 30 feet. The patient is attempting, so “activity was not attempted” seems inconsistent.	In the scenario described, the patient was able to walk 30 feet, but not able to complete the 50-foot walk. Assuming that the patient's usual status cannot be determined based on patient or caregiver report, use "activity was not attempted" codes when the patient does not complete the activity and a helper does not complete the activity for the patient. (--Ch. 3 GM GG0170)
49	Section GG	GG0170J. Walk 50 feet with two turns/GG0170K. Walk 150 feet	What if there is not 50 or 150 feet of space to assess in? Sometimes 10 feet can be a challenge!	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 six-point scale.
50	Section GG	GG0170M. 1 step (curb)	We can only use what we have to derive the answers for the question for curb/one step. If the patient has one step to enter the home with no rails but his or her stairs have two rails and he or she can do those well because of the rails, but the curb they cannot do because there is no rail, how would we code that?	If a patient's performance going up/down a curb is different than his performance going up/down one step with a railing, code GG0170M 1 step (curb) based on the activity with which the patient needs the most assistance.

#	Category	Item If Applicable	Question	Response
51	Section GG	GG170L. Walking 10 feet on uneven surfaces	Regarding Practice Scenario12 for, GG170L. Walking 10 feet on uneven surfaces, are clinicians able to "take the patient/caregiver's verbal information only" to determine the correct code for that item?	Patients should be allowed to perform activities as independently as possible as long as they are safe. Direct observation is preferred to assess a patient's performance. However, if a patient does not attempt an activity and a helper does not complete the activity for the patient, the patient's usual status may be determined based on reports from the patient, clinicians, care staff, and/or family.
52	Section J: Health Conditions	J1800. Any Falls Since SOC/ROC/J1900. Number of Falls Since SOC/ROC	With Home Health Compare, are all falls or only major falls counted as the 20 who qualify?	The new quality measure, Application of the percent of residents experiencing one or more falls with major injury, will report only falls with major injury. The measure will be calculated for home health quality episodes ending with a discharge, transfer, or death during the reporting period, other than those covered by generic or measure-specific exclusions. The measure is expected to be publicly reported starting January 2021 for all agencies that have 20 or more episodes eligible for measure calculation during the reporting period.
53	Section J: Health Conditions	J1800. Any Falls Since SOC/ROC/J1900. Number of Falls Since SOC/ROC	When will this measure be reported?	The Application of the percent of residents experiencing one or more falls with major injury quality measure will be reflected in the Certification and Survey Provider Enhanced Reports (CASPER) Review and Correct report in April 2019, on CASPER quality measure reports starting January 2020, and publicly reported on Home Health Compare starting January 2021.
54	Section J: Health Conditions	J1800. Any Falls Since SOC/ROC/J1900. Number of Falls Since SOC/ROC	Does the fall and intercepted fall definition pertain to M items also or just the J items?	The definitions for fall and intercepted fall are for the Section J: Health Conditions Items J1800 and J1900.
55	Section J: Health Conditions	J1800. Any Falls Since SOC/ROC/J1900. Number of Falls Since SOC/ROC	So the fall question will only be reported on Home Health Compare January 2020? Not Five Star?	The Application of the percent of residents experiencing one or more falls with major injury quality measure will be on Home Health Compare starting January 2021 and CASPER reports starting January 2020. The measure is not included in the Home Health Star Rating at this time.

#	Category	Item If Applicable	Question	Response
56	Section J: Health Conditions	J1800. Any Falls Since SOC/ROC/J1900. Number of Falls Since SOC/ROC	Will the fall with major injury be reported as a Potentially Avoidable Event (PAE) on CASPER reports?	Application of the percent of residents experiencing one or more falls with major injury will be reported on the Outcome Report, not on the PAE Report.
57	Section J: Health Conditions	J1800. Any Falls Since SOC/ROC/J1900. Number of Falls Since SOC/ROC	Will Outcome and Assessment Information Set (OASIS) data collection for 2020 reporting of the new fall quality measure begin in January?	Data collection for the new quality measure Application of the percent of residents experiencing one or more falls with major injury began January 1, 2019.
58	Section J: Health Conditions	M1060. Height and Weight	Regarding obtaining the weight in the patient's home, how can the weight be obtained for bedbound, morbidly obese patients or patients that cannot stand without risk of falling?	If a patient cannot be weighed, for example, because of extreme pain, immobility, or risk of pathological fractures, the use of a dash is appropriate. Document the rationale on the patient's medical record.
59	Section J: Health Conditions	M1060. Height and Weight	Why can we not use a height from a medical doctor office, etc.? This is much more accurate than a clinician attempting to measure the height in the home. Also using a weight 30 days later could be extremely inaccurate. It does not make sense to use a weight 30 days later.	As a standardized item, the height/weight data must be obtained by a HHA clinician in the home setting. (-- CH. 3 GM)