OASIS-D: WHAT DOES THIS MEAN?

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NO OASIS - NO Payment

MLN Matters® Number: MM9585  Related Change Request (CR) #: CR 9585
Related CR Release Date: October 27, 2016  Effective Date: April 1, 2017
Related CR Transmittal #: R3629CP  Implementation Date: April 3, 2017

• Submission of an OASIS assessment is a condition of payment for HH episodes of care. OASIS reporting regulations require the OASIS to be transmitted within 30 days of completing the assessment of the beneficiary. In most cases, this 30-day period will have elapsed by the time a 60-day episode of HH services is completed and the HHA submits the final claim for that episode to Medicare. If the OASIS assessment is not found in the QIES upon receipt of a final claim for an HH episode and the receipt date of the claim is more than 30 days after the assessment completion date, Medicare systems will deny the HH claim. (While the regulation requires the assessment to be submitted within 30 days, the initial implementation of this edit will allow 40 days.)

• In denying the claim, Medicare will supply the following remittance messages:
  • Group Code of CO
  • Claim Adjustment Reason Code 272
Compliance with the pay-for-reporting performance requirement can be measured through the use of an uncomplicated mathematical formula. We have titled this formula as the “Quality Assessments Only” (QAO) formula because only those OASIS assessments that contribute, or could contribute, to creating a quality episode of care are included in the computation. The formula based on this definition is as follows:

\[
QAO = \frac{\# \text{ Quality Assessments} \times 100}{\# \text{ Quality Assessments} + \# \text{ Non-Quality Assessments}}
\]

**OASIS Quality Data Reporting Requirement**

- For episodes beginning on or after July 1st, 2016 and before June 30th, 2017, HHAs must score at least 80 percent on the QAO metric of pay-for-reporting performance or be subject to a 2 percentage point reduction to their market basket update for CY 2018.
- For episodes beginning on or after July 1st, 2017 and thereafter, the required performance levels HHAs must score at least 90 percent on the QAO metric of pay-for-reporting performance or be subject to a 2 percentage point reduction to their market basket update for CY 2019 and thereafter.
The following items are currently on Home Health Compare, but these are proposed to be removed in the 2019 rule:

- Improvement in Status of Surgical Wounds
- Depression Assessment Conducted
- MultiFactor Fall Risk Assessment Conducted
- Diabetic Footcare and Pt/CG Education Implemented
- Pneumococcal Vaccine Ever Received

Data Collection begins with OASIS-D - 2019, but will be added to HHCompare 2021 for the following:

NEW! Changes in Skin Integrity Post-Acute Care: Pressure Ulcer/Injury

NEW! Application of % of Patients with an Admission and Discharge Functional Assessment and a Care Plan that Addresses Function

NEW! Application of % of Residents Experiencing One or More Falls with Major Injury
**OASIS-C2/D ITEMS**

**Clinical Domain - 2019**
- M1021 and M1023
- M1030 Therapies
- M1200 Vision**
- M1242 Pain
- M1311 & M1324 Pressure ulcer
- M1334 Stasis ulcers
- M1342 Surgical wounds
- M1400 Dyspnea
- M1620 Bowel incontinence
- M1630 Ostomy
- M2030 Injectable drugs

**PDGM - 2020**
- M1021 and M1023
- M1030 Therapies
- M1200 Vision
- M1242 Pain
- M1311 & M1324 Pressure ulcer
- M1334 Stasis ulcers
- M1342 Surgical wounds
- M1400 Dyspnea
- M1620 Bowel incontinence
- M1630 Ostomy
- M2030 Injectable drugs

**Functional Status**
- M1800 - Grooming - PDGM 2020
- M1810 - Dressing Upper Body
- M1820 - Dressing Lower Body
- M1830 - Bathing
- M1840 - Toilet Transferring
- M1850 - Transferring
- M1860 - Ambulation
- M1033 - Risk for Hospitalization - PDGM 2020

**These 2 items are not currently on Follow-Up OASIS**
### TABLE 3: CY 2019 CASE-MIX ADJUSTMENT VARIABLES AND SCORES

<table>
<thead>
<tr>
<th>Episode number within sequence of adjacent episodes</th>
<th>1 or 2</th>
<th>1 or 2</th>
<th>3+</th>
<th>3+</th>
</tr>
</thead>
<tbody>
<tr>
<td>Therapy visits</td>
<td>0-13</td>
<td>14+</td>
<td>0-13</td>
<td>14+</td>
</tr>
<tr>
<td>EQUATION:</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
</tbody>
</table>

**CLINICAL DIMENSION**

| 1 | Primary or Other Diagnosis = Blindness/Low Vision | .      | .      | .  |
| 2 | Primary or Other Diagnosis = Blood disorders     | .      | 2      | .  |
| 3 | Primary or Other Diagnosis = Cancer, selected benign neoplasms | .      | 4      | .  |
| 4 | Primary Diagnosis = Diabetes                     | .      | 3      | .  |
| 5 | Other Diagnosis = Diabetes                       | 1      | .      | .  |
| 6 | Primary or Other Diagnosis = Dysphagia AND       | 2      | 14     | .  |
|    | Primary or Other Diagnosis = Neuro 3 – Stroke    | 2      | 14     | 10 |
| 7 | Primary or Other Diagnosis = Dysphagia AND       | .      | 5      | .  |
|    | M1030 (Therapy at home) = 3 (Enteral)            | .      | 5      | .  |

### TABLE 4: CY 2019 CLINICAL AND FUNCTIONAL THRESHOLDS

<table>
<thead>
<tr>
<th>Dimension</th>
<th>1st and 2nd Episodes</th>
<th>3rd+ Episodes</th>
<th>All Episodes</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0 to 13 therapy visits</td>
<td>14 to 19 therapy visits</td>
<td>0 to 13 therapy visits</td>
</tr>
<tr>
<td>Grouping Step</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Equations used to calculate points (see Table 2)</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Severity Level</td>
<td>Clinical CI</td>
<td>0 to 1</td>
<td>0 to 1</td>
</tr>
<tr>
<td></td>
<td>C2</td>
<td>2 to 3</td>
<td>2 to 7</td>
</tr>
<tr>
<td></td>
<td>C3</td>
<td>4+</td>
<td>8+</td>
</tr>
<tr>
<td></td>
<td>Functional F1</td>
<td>0 to 12</td>
<td>0 to 7</td>
</tr>
<tr>
<td></td>
<td>F2</td>
<td>13</td>
<td>8 to 12</td>
</tr>
<tr>
<td></td>
<td>F3</td>
<td>14+</td>
<td>13+</td>
</tr>
</tbody>
</table>
### TABLE 6: CY 2019 CASE-MIX PAYMENT WEIGHTS

<table>
<thead>
<tr>
<th>Pay Group</th>
<th>Description</th>
<th>Clinical and Functional Levels (1 = Low; 2 = Medium; 3 = High)</th>
<th>CY 2019 Weight</th>
</tr>
</thead>
<tbody>
<tr>
<td>10111</td>
<td>1st and 2nd Episodes, 0 to 5 Therapy Visits</td>
<td>CIF1S1</td>
<td>0.5468</td>
</tr>
<tr>
<td>10112</td>
<td>1st and 2nd Episodes, 6 Therapy Visits</td>
<td>CIF1S2</td>
<td>0.6791</td>
</tr>
<tr>
<td>10113</td>
<td>1st and 2nd Episodes, 7 to 9 Therapy Visits</td>
<td>CIF1S3</td>
<td>0.8115</td>
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<tr>
<td>10114</td>
<td>1st and 2nd Episodes, 10 Therapy Visits</td>
<td>CIF1S4</td>
<td>0.9438</td>
</tr>
<tr>
<td>10115</td>
<td>1st and 2nd Episodes, 11 to 13 Therapy Visits</td>
<td>CIF1S5</td>
<td>1.0761</td>
</tr>
</tbody>
</table>

### NON-ROUTINE SUPPLIES (NRS)

<table>
<thead>
<tr>
<th>Non-Routine Medical Supplies Severity Level</th>
<th>Points</th>
<th>2018 - FINAL Urban</th>
<th>2019 Final Urban</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>0</td>
<td>$14.31</td>
<td>$14.62</td>
</tr>
<tr>
<td>2</td>
<td>1 - 14</td>
<td>$51.66</td>
<td>$52.80</td>
</tr>
<tr>
<td>3</td>
<td>15 - 27</td>
<td>$141.65</td>
<td>$144.78</td>
</tr>
<tr>
<td>4</td>
<td>28 - 48</td>
<td>$210.45</td>
<td>$215.10</td>
</tr>
<tr>
<td>5</td>
<td>49 - 98</td>
<td>$324.53</td>
<td>$331.69</td>
</tr>
<tr>
<td>6</td>
<td>99+</td>
<td>$558.16</td>
<td>$570.48</td>
</tr>
</tbody>
</table>
INITIAL & COMPREHENSIVE ASSESSMENT

The purpose for Medicare patients is to determine eligibility for home health benefit including homebound status AND determine immediate care and support needs.

Patient Specific Assessments for all patients regardless of pay source and includes:
- Patient Status
- Info to demonstrate patient’s progress toward achievement goals & measurable outcomes
- Need for home care
- Medical, nursing, rehab, social & discharge planning needs
- Review of Meds
- Current OASIS data set, using the language & groupings of the OASIS items
- Primary caregiver, available support & legal representative (if applicable)

TIMING:

INITIAL ASSESSMENT - First Visit to the Patient - within 48 hrs of referral OR within 48 hrs of return home or ON physician ordered SOC date (must have this updated BEFORE the end or the 48 hour time frame or BEFORE expiration of previous ordered SOC date).

COMPREHENSIVE ASSESSMENT - Consistent with patient need - NO later than 5 calendar days after the SOC date, may NOT be started before the SOC date

Resumption of Care (ROC) - within 2 calendar days of the facility discharge, knowledge of the discharge or the ROC visit date (in case of a physician ordered ROC)

Who Conducts - RN if SN is ordered at SOC OR Qualifying therapist - IF therapy ONLY and need for the services establishes program eligibility

OTCANNOT establish program eligibility for Medicare, but may for other payers. OT are qualified to completed OASIS in those instances and MAY complete ALL OTHER OASIS for Medicare patients.
WHAT PATIENTS REQUIRE OASIS?

**REQUIRED:** Skilled Medicare & Medicaid – INCLUDING Medicare Advantage & Medicaid managed care patients AND ALL MUST be transmitted to the ASAP database.

**Exceptions:** Maternity Patients – Patients under 18 years old – Patients receiving ONLY personal care, homemaker or chore services – Patients for whom Medicare or Medicaid insurance is NOT billed

**MEDICARE SECONDARY PAYER** REQUIRES OASIS BE COMPLETED!!

SINGLE VISIT EPISODES **DO NOT** REQUIRE OASIS, BUT IF YOU ARE BILLING FOR A ONE TIME ONLY THERAPY ASSESSMENT YOU **MUST** COMPLETE AND SUBMIT OASIS

COLLABORATION

• Only one clinician is responsible for completing a comprehensive assessment!
  • Assessing Clinician may decide to use only data obtained from assessment visit OR
  • Assessing Clinician may obtain feedback from other agency staff (including contracted staff) acting within their scope of practice to complete ANY or all OASIS items integrated in the Comprehensive Assessment

• Agency Policy & Procedure should be followed regarding staff communication and patient information to track and/or identify staff members contributing to the patient assessment information:
  • Comprehensive Assessment with OASIS items is a LEGAL DOCUMENT
  • Only One Clinician takes responsibility for completing
DATE ASSESSMENT IS COMPLETED

M0090 – DATE THE ASSESSMENT IS COMPLETED

• The last day the assessing clinician gathered or received any input to complete the comprehensive assessment document!
  • This could be the date that the physician returned a phone call to clarify questions
  • This could be the date that the therapist reports findings following their evaluation of the patient
  • This could be the date that the followup nurse reports new issues following visit on Day 3 of the episode

• Is the clinician allowed to begin the comprehensive assessment on the SOC date and complete later?
• When must the comprehensive assessment be completed in a therapy only case if RN is completing the comprehensive assessment/OASIS based on agency policy?

TIME PERIOD UNDER CONSIDERATION

• Most OASIS items use the DAY OF ASSESSMENT unless different time period is indicated in the item:
  • DAY OF ASSESSMENT = 24 hours immediately preceding the visit and the time spent in the home
  • OTHER TIME PERIODS:
    • At the time of or any time since the most recent SOC/ROC OASIS assessment
    • With the last 14 days
    • Day of assessment & recent pertinent past
    • Prior to this current illness, exacerbation or injury
    • This payment episode
    • Last 5 days visits received prior to planned and unexpected discharge
CONVENTIONS CONTINUED

- Minimize the use of NA or Unknown
- Avoid referring to prior OASIS assessments
- Document current status based on the observation of the patient’s condition and ability at the time of the assessment without referring back to prior assessments or documentation of status from a prior care setting
- Exception: Several process items require review of documentation of care that occurred “at the time of or at any time since the most recent SOC/ROC OASIS assessment”
- Direct observation is always preferred

ASSISTANCE – means assistance of ANOTHER PERSON – not limited to physical contact – does include verbal cues and/or supervision

INCLUDED & EXCLUDED – make sure to understand and apply to each question

MEDICAL RESTRICTIONS

ADHERE TO SKIP PATTERNS

SOME ITEMS ALLOW FOR A DASH (-)

- This should be rare – This indicates that no information is available and/or an item could not be assessed
UNPLANNED OR UNEXPECTED DISCHARGES

• THIS MEANS NO IN-HOME VISIT HAS HAPPENED AT DISCHARGE
• DISCHARGE COMPREHENSIVE ASSESSMENT IS REQUIRED
• DOCUMENTED BY LAST QUALIFIED CLINICIAN BASED ON LAST PATIENT ENCOUNTER
• COLLABORATION POSSIBLE
• CLINICAL RECORD MUST CONTAIN DOCUMENTATION THAT MATCHES THE ENCODED OASIS THAT IS TRANSMITTED
• OFFICE DISCHARGES - PHONE DISCHARGES - BY A CLINICIAN THAT DID NOT ENCOUNTER THE PATIENT ARE NOT COMPLIANT!!!

• LAST QUALIFIED CLINICIAN TO VISIT THE PATIENT MAY COMPLETE BASED ON INFORMATION FROM THE LAST VISIT AND
• MAY SUPPLEMENT THE OASIS ITEMS WITH INFORMATION DOCUMENTED FROM THE PATIENT VISITS THAT OCCURRED IN THE LAST 5 DAYS THE PATIENT RECEIVED VISITS
• FOLLOWING SHOULD BE DOCUMENTED:
  • M0090 – Date Assessment Completed – actual date the clinician is completing the assessment
  • M0903 – Date of the last (most recent) home visit (removed from OASIS D)
  • M0906 – Discharge Date – determined by agency policy – cannot be before the last visit
PHYSICIAN ORDERED START OF CARE/RESUMPTION OF CARE DATE

- **M0102** - ENTER DATE ONLY IF A DATE WAS SPECIFIED BY THE PHYSICIAN
  - RANGE OF DATES CANNOT BE CONSIDERED
  - HOSPITAL OR SNF DC PLANNER MAY COMMUNICATE ON BEHALF OF PHYSICIAN
  - PHYSICIAN MAY ORDER A ROC DATE PAST THE 2-DAYS POST DISCHARGE
  - IF ORIGINAL DATE IS DELAYED VIA PHYSICIAN ORDER, ENTER THE UPDATED DATE
  - IF THE DATE IS NOT GIVEN, AND A SPECIFIC DATE BEYOND 48 HOURS IS REQUESTED, ORDER MUST BE RECEIVED ON OR BEFORE THE END OF THE 48 HR INITIAL ASSESSMENT TIME FRAME.
  - SELECT NA IF NO SPECIFIC SOC/ROC ORDERED OR
  - REQUESTED OR REVISED SOC/ROC ORDER IS RECEIVED AFTER THE ORIGINALLY ORDERED SOC/ROC DATE
  - ORDER IS RECEIVED AFTER THE 48 HR TIME FRAME & THEN REPORT ORIGINAL REFERRAL DATE IN M0104

REFERRAL DATE

- **M0104** - DATE OF REFERRAL
  - REPORT THE MOST RECENT DATE THAT VERBAL, WRITTEN OR ELECTRONIC AUTHORIZATION TO BEGIN HOME CARE WAS RECEIVED BY THE AGENCY
  - IF NO SPECIFIC SOC IS GIVEN AND SOC IS DELAYED - DATE RECEIVED UPDATED/REVISED REFERRAL INFORMATION IS DATE USED
  - DOES NOT REFERENCE CALLS OR DOCUMENTATION FOR POTENTIAL REFERRALS OR DATE THAT YOU OBTAIN AUTHORIZATION FROM A PAYER
  - SKIPPED WHEN PHYSICIAN ORDERED SOC/ROC DATE IS IN M0102
  - IF HOSPITALIST/REFERRING PHYSICIAN WILL NOT FOLLOW THE PATIENT, THE REFERRAL DATE IS THE DATE AN ALTERNATE PHYSICIAN AGREES TO PROVIDE AN ONGOING PLAN OF CARE
1. M0903 – Date of Last/Most Recent Home Visit
2. M1011 – Inpatient Diagnosis
3. M1017 – Diagnoses Requiring Medical or Treatment Regimen Change within past 14 days
4. M1018 – Conditions Prior to Medical or Treatment Regimen Change or Inpatient Stay within Past 14 days
5. M1025 – Optional Diagnoses
6. M1034 – Overall Status
7. M1036 – Risk Factors
8. M1210 – Ability to Hear
9. M1220 – Understanding of Verbal Content
10. M1230 – Speech & Oral(Verbal) Expression of Language
11. M1240 – Pain Assessment
12. M1300 – Pressure Ulcer Assessment
13. M1302 – Risk of Developing Pressure Ulcers
14. M1313 – Worsening in Pressure Ulcer Status
15. M1320 – Status of the Most Problematic Pressure
16. M1350 – Skin Lesion or Open Wound
17. M1410 – Respiratory Treatments
18. M1501 – Symptoms in Heart Failure Ulcer
OASIS-D – ITEMS REMOVED COMPLETELY 2019

19. M1511 – Heart Failure Follow-Up
20. M1615 – When Does Urinary Incontinence Occur
21. M1750 – Psychiatric Nursing Services
22. M1880 – Ability to Plan & Prepare Light Meals
23. M1890 – Ability to Use Telephone
24. M1900 – Prior Functioning ADL/IADL
25. M2040 – Prior Medication Management
26. M2110 – How Often Does the Patient receive ADL or IADL Assistance from caregiver?
27. M2250 – Plan of Care Synopsis
28. M2430 – Reason for Hospitalization

OASIS-C2 CHANGES – IMPACT ACT

• Changes that occurred in 2017 leading toward OASIS-D

• Three Items added January 1, 2017
  • M1028 – Active Diagnoses
  • M1060 – Height & Weight
  • GG0170c – Mobility
M1028 – ACTIVE DIAGNOSES

(M1028) Active Diagnoses – Comorbidities and Co-existing Conditions – Check all that apply
See OASIS Guidance Manual for a complete list of relevant ICD-10 codes.

☐ 1 - Peripheral Vascular Disease (PVD) or Peripheral Arterial Disease (PAD)
☐ 2 - Diabetes Mellitus (DM)
☐ 3 - None of the above

Item Intent
This item identifies whether two specific diagnoses are present and active. These diagnoses influence a patient’s functional outcomes or increase a patient’s risk for development or worsening of pressure ulcer(s).

Time Points Item(s) Completed
Start of care
Resumption of care

M1060 – HEIGHT & WEIGHT

(M1060) Height and Weight – While measuring, if the number is X.1 to X.4 round down; X.5 or greater round up

a. Height (in inches). Record most recent height measure since the most recent SOC/ROC

b. Weight (in pounds). Base weight on most recent measure in last 30 days; measure weight consistently, according to standard agency practice (for example, in a.m. after voiding, before meal, with shoes off, etc.)

Item Intent
These items support calculation of the patient’s body mass index (BMI) using the patient’s height and weight.

Time Points Item(s) Completed
Start of care
Resumption of care
OASIS-D ADDITIONS

**Section GG:** Functional Abilities & Goals
- Introduced in 2017 with GG0170 – Mobility
- Now fully expanded to include:
  - GG0100 – Prior Functioning: Everyday Activities
  - GG0110 – Prior Device Use
  - GG0130 – Self Care
  - GG0170 – Mobility

**Section J:** Health Conditions
- New with OASIS-D
  - J1800: Any Falls Since SOC/ROC
  - J1900 – Number of Falls Since SOC/ROC

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**GG0100: Prior Functioning: Everyday Activities**

<table>
<thead>
<tr>
<th>Coding:</th>
<th>Enter Codes in Boxes</th>
</tr>
</thead>
<tbody>
<tr>
<td>3. Independent – Patient completed the activities by him/herself, with or without an assistive device, with no assistance from a helper.</td>
<td>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.</td>
</tr>
<tr>
<td>2. Needed Some Help – Patient needed partial assistance from another person to complete activities.</td>
<td>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.</td>
</tr>
<tr>
<td>1. Dependent – A helper completed the activities for the patient.</td>
<td>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.</td>
</tr>
<tr>
<td>8. Unknown</td>
<td>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.</td>
</tr>
<tr>
<td>9. Not Applicable</td>
<td></td>
</tr>
</tbody>
</table>

**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
GG0110: Prior Device Use

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

Check all that apply

- A. Manual wheelchair
- B. Motorized wheelchair and/or scooter
- C. Mechanical lift
- D. Walker
- E. Orthotics/Prosthetics
- Z. None of the above

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

GG0130 Self-Care

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 himself/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
### GG0130 – SELF-CARE

**• ALSO SEE GUIDANCE MANUAL INSERT FOR FOLLOWUP, TRANSFER & DISCHARGE VERSIONS OF GG0130**
GG0170 – MOBILITY – SOC/ROC

GG0170 Mobility
SOC/ROC

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).

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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/mild 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.
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1. SOC/ROC Performance

<table>
<thead>
<tr>
<th>Enter Codes in Boxes</th>
</tr>
</thead>
</table>

2. Discharge Goal

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.

B. Sit to lying: The ability to move from sitting on side of bed to lying flat on the bed.

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.

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.

E. Chair/bed-to-chair transfer: The ability to transfer to and from a bed to a chair (or wheelchair).

F. Toilet transfer: The ability to get on and off a toilet or commode.
### GG0170 – MOBILITY – SOC/ROC

<table>
<thead>
<tr>
<th>1. SOC/ROC Performance</th>
<th>2. Discharge Goal</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Enter Codes in Boxes</td>
</tr>
</tbody>
</table>

- **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.
- **I. Walk 10 feet:** Once standing, the ability to walk at least 10 feet in a room, corridor, or similar space. If SOC/ROC performance is coded 07, 09, 10 or 88, skip to GG0170M. 1 step (curb)
- **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. If SOC/ROC performance is coded 07, 09, 10 or 88, skip to GG0170P. Picking up object.
- **N. 4 steps:** The ability to go up and down four steps with or without a rail. If SOC/ROC performance is coded 07, 09, 10 or 88, skip to GG0170P. Picking up object.

### GG0170 – MOBILITY – SOC/ROC

<table>
<thead>
<tr>
<th>O. 12 steps: The ability to go up and down 12 steps with or without a rail.</th>
</tr>
</thead>
<tbody>
<tr>
<td>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.</td>
</tr>
</tbody>
</table>

- **Q. Does patient use wheelchair and/or scooter?**
  0. No → Skip GG0170R, GG0170RR1, GG0170S, and GG0170SS1.
  1. Yes → Continue to GG0170R, Wheel 50 feet with two turns.

- **R. Wheel 50 feet with two turns:** Once seated in wheelchair/scooter, the ability to wheel at least 50 feet and make two turns.

- **S. Wheel 150 feet:** Once seated in wheelchair/scooter, the ability to wheel at least 150 feet in a corridor or similar space.

- **RR1. Indicate the type of wheelchair or scooter used.**
  1. Manual
  2. Motorized

- **SS1. Indicate the type of wheelchair or scooter used.**
  1. Manual
  2. Motorized
GG0170 – MOBILITY – SOC/ROC

• ALSO SEE GUIDANCE MANUAL INSERT FOR FOLLOWUP, TRANSFER & DISCHARGE VERSIONS OF GG0170

J1800 – J1900 – HEALTH CONDITIONS – TRANSFER/ DISCHARGE

<table>
<thead>
<tr>
<th>Section J</th>
<th>Health Conditions</th>
</tr>
</thead>
<tbody>
<tr>
<td>J1800. Any Falls Since SOC/ROC, whichever is more recent</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Enter Code</th>
<th>Has the patient had any falls since SOC/ROC, whichever is more recent?</th>
</tr>
</thead>
<tbody>
<tr>
<td>0. No → Skip J1900</td>
<td>1. Yes → Continue to J1900</td>
</tr>
</tbody>
</table>

| J1900. Number of Falls Since SOC/ROC, whichever is more recent |
| CODING: |
| 0. None |
| 1. One |
| 2. Two or more |

<table>
<thead>
<tr>
<th>Enter Codes in Boxes</th>
</tr>
</thead>
<tbody>
<tr>
<td>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</td>
</tr>
<tr>
<td>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</td>
</tr>
<tr>
<td>C. Major Injury: Bone fractures, joint dislocations, closed head injuries with altered consciousness, subdural hematoma</td>
</tr>
</tbody>
</table>
INTEGUMENTARY ITEMS

DELETED ITEMS FROM INTEGUMENTARY ITEMS FOR OASIS-D

- M1300-M1302 – PRESSURE ULCER RISK
- M1313 – WORSENING IN PRESSURE ULCER STATUS
- M1320 – STATUS OF THE MOST PROBLEMATIC PRESSURE ULCER
- M1350 – OTHER SKIN LESIONS

PRESSURE ULCER ITEMS THAT REMAIN

- M1306 – PRESSURE ULCERS/INJURIES
- M1307 – OLDEST STAGE 2 PRESSURE ULCER
- M1311 – CURRENT NUMBER UNHEALED PRESSURE ULCERS/INJURIES EACH STAGE
- M1322 – CURRENT STATE 1 PRESSURE ULCERS
- M1324 – MOST PROBLEMATIC PRESSURE ULCER/INJURY STAGE
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