



PROPRIETARY STATEMENT

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MDS Section GG Coding Policy

I. Policy Statement and Purpose

The purpose of this policy is to ensure that coding professionals apply accurate, complete, and consistent coding practices to produce accurate healthcare data and to ensure all entries coded in section GG of the MDS have supporting documentation in the clinical record. This is to be achieved by the interdisciplinary team adequately assessing the resident in a collaborative and multidisciplinary manner as required. Assessment information will be reported on the PPS 5-day assessment, optional Interim Payment assessment, and PPS Discharge assessment.

II. Scope

This policy applies to patient care in nursing facilities regarding documentation and selection of proper GG coding following RAI reporting procedures.

III. Procedures

1. General rules for Section GG Coding accuracy will include, but are not limited to:
 1. Section GG items will be completed for all Medicare Part A residents as follows:
 - a. PPS 5-day assessment
 - Assessment period: First three days of the Part A stay (including day of admission as day 1)
 - b. Optional Interim Payment assessment
 - Assessment period: Assessment Reference Date (ARD) and two days prior (for a total of 3 days)
 - c. Part A PPS Discharge assessment
 - Assessment period: Last three days of the Part A stay (including day of discharge as day 3)
 2. A system for collecting patient usual performance data and tracking coding performance for the resident during the observation period shall be clearly defined (such as submission to the charge nurse, as will be defined in this policy).
 3. Section GG coding status shall be documented for each observation period. Charge nurses completing the ADL tracking shall discuss usual performance status with nurses/nurse aides from each shift as well as therapy staff and document performance status over the 24-hour period on the tracking tool. Documentation must reflect usual episodes over each 24-hour period during the observation period while a resident.

- a. Assessment involves talking with direct care staff from each shift that has cared for the resident to learn what the resident does for himself or herself during each episode of each performance activity definition as well as the type and level of staff assistance provided.
- b. Facility staff coding section GG shall be trained in proper coding of section GG Performance items, which measures how much of the activity the resident did for himself or herself (not what he or she might be capable of doing), and indicates the support provided, which measures how much facility staff support is needed for the resident to complete the activity.
 - For the purposes of completing section GG, “facility staff” pertains to direct employees and facility-contracted employees. Thus, does not include individuals hired, compensated or not, by individuals outside of the facility’s management and administration. Therefore, facility staff does not include, for example, hospice staff, Nursing/CNA students, etc.
4. The MDS Coordinator will monitor evaluation coding assigned by staff to ensure accurate coding of section GG items based on interviews and medical record documentation. The MDS coordinator will also keep staff informed of updates related to section GG coding set forth by payers including Medicare.

2. Section GG Supporting Documentation Requirements

1. The section GG key for performance must include all the MDS key options and be equivalent to the intent and definition of the MDS key.
2. The self-care and mobility key for performance must be understood and readily available to staff, and included in the electronic or hard copy collection tool.
3. Coding descriptions must include all tasks and components related to the specific section GG activity as specified in the RAI Manual.
 - a. Example – “eating – the ability to use suitable utensils to bring food and/or liquid to the mouth and swallow food and/or liquid once the meal is placed before the resident.
 - b. A care plan must address the underlying cause(s) based on an accurate assessment and include tailored interventions focusing on improving or maintaining function when possible, and preventing additional decline when improvement is not possible.

APPROVALS	Printed Name	Signature	Date
Executive Leadership			
Chief Compliance Officer			
REVIEW and REVISIONS			
Version #: Date:			
Summary of changes:			
Version #: Date:			
Summary of changes:			

Source Documents & References	
Federal Regulations	CMS Long Term Care Facility Resident Assessment Instrument 3.0 User's Manual https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/MDS30RAIManual.html
OBRA Regulations	
Related Documents	