

SECTION GG:

FUNCTIONAL ABILITIES AND GOALS

Intent: This section includes items about functional abilities and goals. It includes items focused on prior functioning admission performance, discharge goals and discharge performance. Functional status is assessed based on the need for assistance when performing self-care and mobility activities.

GG0100. Prior Functioning: Everyday Activities

GG0100. Prior Functioning: Everyday Activities. Indicate the patient's usual ability with everyday activities prior to the current illness, exacerbation, or injury.	
↓ Enter Codes in Boxes	
3. Independent - Patient completed the activities by him/herself, with or without an assistive device, with no assistance from a helper.	<input type="checkbox"/> 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.
2. Needed Some Help - Patient needed partial assistance from another person to complete activities.	<input type="checkbox"/> 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.
1. Dependent - A helper completed the activities for the patient.	<input type="checkbox"/> 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.
8. Unknown	<input type="checkbox"/> 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.
9. Not Applicable	

Item Rationale

Knowledge of the patient's functioning prior to the current illness, exacerbation or injury may inform treatment goals.

Steps for Assessment

Interview patient or family or review patient's medical records describing patient's prior functioning with everyday activities.

Coding Instructions

Complete during the 3 day admission assessment period.

- Code 3, Independent, if the patient completed the activities by him/herself, with or without an assistive device, with no assistance from a helper.
- Code 2, Needed Some Help, if the patient needed partial assistance from another person to complete activities.
- Code 1, Dependent, if the helper completed the activities for the patient.
- Code 8, Unknown, if the patient's usual ability prior to the current illness, exacerbation, or injury is unknown.

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- Code 9, Not Applicable, if the activity was not applicable to the patient prior to the current illness, exacerbation, or injury.

Coding Tips

- Record the patient's usual ability to perform self-care, indoor mobility (ambulation), stair and functional cognition prior to the current illness, exacerbation, or injury.
- If no information about the patient's ability is available after attempts to interview patient or family and after reviewing patient's medical record, code 8. Unknown.

Examples for Coding Prior Functioning: Everyday Activities

1. **Self-Care:** Ms. R was admitted to an acute care facility after sustaining a right hip fracture and subsequently admitted to the IRF for intensive rehabilitation. Prior to the hip fracture, Ms. R was independent in eating, bathing, dressing, and using the toilet. Ms. R used a raised toilet seat due to arthritis in both knee joints. The patient and family indicated there were no safety concerns when she performed these everyday activities in her home.

Coding: GG0100A Prior Functioning - Self Care would be coded 3 - Independent

Rationale: The patient completed the self-care tasks of eating, bathing, dressing, and using the toilet helper safely without any assistance from a helper. The patient may use an assistive device and still be coded independent.

2. **Self-Care:** Mr. T was admitted to an acute care facility after sustaining complex lumbar surgery and subsequently admitted to the IRF for intensive rehabilitation. Prior to the stroke, Mr. T was independent in eating, and using the toilet; however, Mr. T required assistance for bathing and putting on and taking off his shoes and socks. The assistance needed was due to severe arthritis lumbar pain upon bending and limited his ability to access his feet.

Coding: GG0100A Prior Functioning - Self Care would be coded 2- Needed Some Help

Rationale: Mr. T needed partial assistance from the helper to complete the activities of bathing and dressing. While Mr. T did not need help for all self-care activities, he did need some help. Code 2 is used to indicate that Mr. T needed some help for self-care.

3. **Self-Care:** Mr. J sustained a traumatic brain injury 3 years ago. He recently was hospitalized for surgery and has now been admitted for intensive rehabilitation. According to Mr. J's wife, Mr. J required complete assistance with self-care activities that included eating, bathing, dressing, and using the toilet. It is anticipated that the recent surgery and intensive rehabilitation may allow Mr. J to gain some self-care functioning.

Coding: GG0100A Prior Functioning - Self Care would be coded code 1- Dependent

Rationale: Mr. J's wife has reported that Mr. J was completely dependent in self-care activities that included eating, bathing, dressing, and using the toilet. The Code 1- Dependent is appropriate based upon this information.

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4. **Self-Care:** Mr. F was admitted with a diagnosis of stroke and a severe communication disorder. Mr. F is unable to communicate with staff using alternative communication devices. Mr. F had been living alone prior to admission and no family nor friends have not been successfully contacted by IRF staff. Mr. F's prior self-care abilities are unknown.

Coding: GG0100A Prior Functioning - Self Care would be coded 8- Unknown

Rationale: Attempts to seek information Mr. F's prior functioning were made; however, no information was available during the 3 day assessment period. This item is coded 8-Unknown. A "-" (dash) is *not* used as the information was sought but *unavailable*. Had there *not* been documentation that an attempt to seek information was made and not found a "-" (dash) would have been appropriate to use for this item.

5. **Indoor Mobility (Ambulation):** Mr. C. was admitted to an acute care hospital after experiencing a stroke. Prior to admission, he used a cane to walk from room to room. In the morning, Mr. C's wife would provide steadying assistance to Mr. C. when he walked from room to room due to joint stiffness and severe arthritis pain. Occasionally, Mr. C required steadying assistance during the day upon walking from room to room.

Coding: GG0110B. Prior Functioning - Indoor Mobility (Ambulation) would be coded 2, Needed Some Help.

Rationale: The patient needed some assistance (steadying assistance) from his wife to complete the activity of walking in the home.

6. **Stairs:** Prior to admission to the hospital for bilateral knee surgery followed by his recent admission for rehabilitation, Mr. V experienced severe knee pain upon ascending and particularly descending his internal and external stairs at home. Mr. V required assistance from his wife when using the stairs to steady him in the event his left knee would buckle. Mr. V's wife was interviewed about her husband's functioning prior to admission and the therapist noted Mr. V's prior functional level information in the medical chart.

Coding: GG0100C Prior Functioning - Stairs would be coded 2 – Needed Some Help

Rationale: Prior to admission Mr. V required some help in order to manage internal and external stairs.

7. **Stairs:** Mrs. E lived alone prior to her hospitalization for sepsis and has early stage Multiple Sclerosis. She has now been admitted to an inpatient rehabilitation facility for intensive rehabilitation due to deconditioning. Mrs. E reports that she used a straight cane to ascend and descend her indoor stairs at home and small staircases within in the community. Mrs. E reports that she did not require any assistance with the activity of using stairs prior to her admission.

Coding: GG0100C Prior Functioning - Stairs: would be coded 3 – Independent

Rationale: Prior to admission Mrs. E reported she was independent in using her internal stairs and the use of small staircases in the community.

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8. **Stairs:** Mr. P has continued to show signs and symptoms of possible delirium since admission to the IRF. The IRF staff has not received any response to their phone messages for Mr. P's family members requesting a return call. Mr. P has not received any visitors since his admission. The medical record from the prior facility does not indicate Mr. P's prior functioning. There is no information to code item GG0100C, but there have been attempts in locating this information.

Coding: GG0100C Prior Functioning - Stairs would be coded 8- Unknown

Rationale: Attempts to seek information Mr. P's prior functioning were made; however, no information was available during the 3 day assessment period. A "-" (dash) is **not** used as the information was sought but *unavailable*. Had there **not** been documentation that an attempt to seek information was made and not found a "-" (dash) would have been appropriate to use for this item.

9. **Functional Cognition:** Mr. K has mild dementia and recently sustained a fall resulting in complex multiple fractures requiring multiple surgeries. Mr. K has been admitted for rehabilitation. Mr. K's caregiver reports that when living at home Mr. K needed reminders to take his medications on time, manage his money, and plan tasks especially when he was fatigued.

Coding: GG0100D Prior Functioning – Functional Cognition would be coded 2 – Needed Some Help

Rationale: Mr. K required some help to recall, perform and plan regular daily activities due to cognitive impairment.

10. **Functional Cognition:** Ms. Z recently sustained a traumatic brain injury. Prior to her recent hospitalization she had been living in an apartment by herself. Ms. Z's cognition is currently impaired and her self-report has been determined as an unreliable source for the information required to code this activity. Ms. Z's cousin who had visited her frequently prior to her recent hospitalization indicated that Ms. Z did not require any help with taking her prescribed medications, planning her daily activities, and managing money when shopping.

Coding: GG0100D Prior Functioning – Functional Cognition would be coded 3 – Independent

Rationale: Ms. Z's cousin who frequently visited Ms. Z prior to sustaining a traumatic brain injury, reported that Ms. Z was independent in taking her prescribed medications, planning her daily activities, and managing money when shopping indicating use of memory and problem solving skills.

11. **Functional Cognition:** Mrs. R had a stroke. Since hospitalization and continuing during her rehabilitation stay she has had a severe communication disorder. Her family members have not returned phone calls requesting information about Mrs. R's prior functional status. Her medical records do not contain information about her functional cognition prior to the stroke.

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Coding: GG0100D Prior Functioning – Functional Cognition would be coded 8-Unknown

Rationale: Attempts to seek information regarding Mrs. R's prior functioning were made; however, no information was available during the 3 day assessment period. A “-” (dash) is **not** used as the information was sought but *unavailable*. Had there **not** been documentation that an attempt to seek information was made and not found a “-” (dash) would have been appropriate to use for this item.

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	
<input type="checkbox"/>	A. Manual wheelchair
<input type="checkbox"/>	B. Motorized wheelchair or scooter
<input type="checkbox"/>	C. Mechanical lift
<input type="checkbox"/>	D. Walker
<input type="checkbox"/>	E. Orthotics/Prosthetics
<input type="checkbox"/>	Z. None of the above

Item Rationale

- Knowledge of the patient's use of devices and aids immediately prior to the current illness, exacerbation, or injury may inform treatment goals.

Steps for Assessment

- Interview patient or family or review the patient's medical record describing the patient's use of prior devices and aids.

Coding Instructions

- Complete during the 3 day admission assessment period. Check all devices that apply.
- Check Z, None of the above, if the patient did not use any of the listed devices or aids immediately prior to the current illness, exacerbation, or injury.

Coding Tips

- For GG0110 Prior device use, walkers refer to all types of walkers (for example, pick-up walker, hemi-walker, rolling walker, platform walker, etc.).

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GG0130. Self-Care (3-day assessment period)

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Code the patient's usual performance at admission for each activity using the 6-point scale. If activity was not attempted at admission, code the reason. Code the patient's discharge goal(s) using the 6-point scale. Do not use codes 07, 09, or 88 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. <i>Activities may be completed with or without assistive devices.</i> 06. Independent - Patient completes the activity by him/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 or TOUCHING/STEADYING 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 88. Not attempted due to medical condition or safety concerns		
1. Admission Performance	2. Discharge Goal	
↓ Enter Codes In Boxes ↓		
<input type="text"/>	<input type="text"/>	A. 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.
<input type="text"/>	<input type="text"/>	B. Oral hygiene: The ability to use suitable items to clean teeth. [Dentures (if applicable): The ability to remove and replace dentures from and to the mouth, and manage equipment for soaking and rinsing them.]
<input type="text"/>	<input type="text"/>	C. 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 equipment.
<input type="text"/>	<input type="text"/>	E. Shower/bathe self: The ability to bathe self in shower or tub, including washing, rinsing, and drying self. Does not include transferring in/out of tub/shower.
<input type="text"/>	<input type="text"/>	F. Upper body dressing: The ability to put on and remove shirt or pajama top; includes buttoning, if applicable.
<input type="text"/>	<input type="text"/>	G. Lower body dressing: The ability to dress and undress below the waist, including fasteners; does not include footwear.
<input type="text"/>	<input type="text"/>	H. Putting on/taking off footwear: The ability to put on and take off socks and shoes or other footwear that is appropriate for safe mobility.

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Item Rationale

- Patients in IRFs may have self-care limitations on admission. In addition, patients may be at risk of further functional decline during their stay in the IRF.

Steps for Assessment

1. Assess the patient's self-care status based on direct observation, the patient's self-report, family reports, and direct care staff reports documented in the patient's medical record during the 3-day assessment period.
2. Patients should be allowed to perform activities as independently as possible, as long as they are safe.
3. If helper assistance is required because patient's performance is unsafe or of poor quality, score according to amount of assistance provided.
4. Activities may be completed with or without assistive device(s). Use of assistive device(s) to complete an activity should not affect coding of the activity.
5. If the patient's self-care performance varies during the assessment period, report the patient's usual status, **not** the patient's most independent performance and **not** the patient's most dependent episode.
6. Refer to facility, Federal, and State policies and procedures to determine which IRF staff members may complete an assessment. Patient assessments are to be done in compliance with facility, Federal, and State requirements.

Assessment Period: The 3-day assessment period for the admission assessment includes the day of admission and the two days following the day of admission, ending as 11:59 pm. Clinicians should code the patient's admission functional status based on a functional assessment that occurs soon after the patient's admission. The admission function scores are to reflect the patient's admission baseline status and are to be based on an assessment. The assessment should occur prior to the start of therapy services in order to capture the patient's true admission baseline status. This is because therapy interventions can affect the patient's functional status; the score should reflect the patient's status prior to any benefit from therapy. The discharge assessment period includes the day of discharge and the two calendar days prior to the day of discharge. Code the patient's discharge functional status based on a functional assessment that occurs close to the time of discharge.

Usual status: A patient's functional status can be impacted by the environment or situations encountered at the facility. Observing the patient in different locations and circumstances is important for a comprehensive understanding of the patient's functional status. If the patient's admission or discharge functional status varies, record the patient's usual ability to perform each activity. Do not record the patient's best performance and do not record the patient's worst performance, but rather record the patient's usual performance.

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Coding Instructions

Complete at the time of admission and discharge.

- Code 06, Independent, if the patient completes the activity by him/herself with no assistance from a helper.
- Code 05, Setup or clean-up assistance, if the helper SETS UP or CLEANS UP; patient completes activity. Helper assists only prior to or following the activity, but not during the activity. For example, the patient requires assistance cutting up food or opening container, or requires set-up of hygiene item(s) or assistive device(s).
- Code 04, Supervision or touching assistance, if the helper provides VERBAL CUES or TOUCHING/ STEADYING assistance as patient completes activity. Assistance may be provided throughout the activity or intermittently. For example, the patient requires verbal cueing, coaxing, or general supervision for safety to complete activity; or patient may require only incidental help such as contact guard or steadying assist during the activity.
- Code 03, Partial/moderate assistance, if the helper does LESS THAN HALF the effort. Helper lifts, holds, or supports trunk or limbs, but provides less than half the effort.
- Code 02, Substantial/maximal assistance, if the helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs and provides more than half the effort.
- Code 01, Dependent, if the helper does ALL of the effort. Patient does none of the effort to complete the activity; or the assistance of two or more helpers is required for the patient to complete the activity.
- Code 07, Patient refused, if the patient refused to complete the activity.
- Code 09, Not applicable, if the patient did not perform this activity prior to the current illness, exacerbation, or injury.
- Code 88, Not attempted due to medical condition or safety concerns, if the activity was not attempted due to medical condition or safety concerns.

Coding Tips

General coding tips:

- When reviewing the medical record, interviewing staff, and observing the patient, be familiar with the definition for each activity. For example, when assessing Eating (item GG0130A), determine the type and amount of assistance required to bring food and liquid to the mouth and swallow food once the meal is presented on a table/tray.

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- If two or more helpers are required to assist the patient to complete the activity, code as 01, Dependent.
- If the patient does not attempt the activity and a helper does not complete the activity for the patient, code the reason the activity was not attempted. For example, code 07 if the patient refused to attempt the activity, code 09 if the activity is not applicable for the patient, or code 88 if the patient was not able to attempt the activity due to medical condition or safety concerns.
- To clarify your own understanding of the patient's performance of an activity, ask probing questions to staff about the patient, beginning with the general and proceeding to the more specific. See examples of using probes when talking to staff, at the end of this section.
- A *dash* (“-”) sign indicates “*No information.*” CMS expects dash use for quality indicator items to be a rare occurrence. Use of dashes for quality items may result in a payment reduction. Do not use a dash (“-”) if the reason that the item was not assessed because the patient refused (code 07), the item is not applicable (code 09), or the activity was not attempted due to medical condition or safety concerns (code 88). A dash may be used for GG0130 discharge goal items provided that at least one self-care or one mobility item has a discharge goal.
- Documentation in the medical record is used to support assessment coding of Section GG. Data entered should be consistent with the clinical assessment documentation in the resident's medical record. This assessment can be conducted by appropriate healthcare personnel as defined by facility policy and in accordance with state and federal regulations.

Coding tips for coding the patient's usual status:

- On the admission assessment, code the patient's usual performance using the 6-point scale, or one of the three “activity was not attempted” codes to specify the reason why an activity was not attempted, as well as the patient's discharge goal(s) using the same 6-point scale. Instructions about coding discharge goals are provided under Discharge Goal: Coding Tips.
- On discharge, use the same 6-point scale or “activity was not attempted” codes that were used on the admission assessment to identify the patient's usual performance on the discharge assessment.
- Record the patient's usual ability to perform each activity. Do not record the patient's best performance and do not record the patient's worst performance, but rather record the patient's usual performance during the assessment period.
- Direct observation of the patient's performance, reviews of medical records and interviews of clinical staff are methods of gathering information to determine the patient's usual performance.

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- Do not record the staff's assessment of the patient's potential capability to perform the activity.

Coding tips for patients with incomplete stays:

- For patients with incomplete stays, such as a patient with an emergency discharge, the self-care and mobility items may be coded as 88, Not attempted due to medical condition or safety concerns. Patients with incomplete stays include patients who are unexpectedly discharged to an acute care setting (short-stay acute care hospital, critical access hospital, inpatient psychiatric facility, or long-term care hospital, because of a medical emergency); patients discharged to a hospice; patients discharged to another IRF; patients who die or leave the IRF against medical advice; and patients with a length of stay of less than 3 days.

Examples for Coding Admission Performance or Discharge Performance

1. **Eating:** Ms. S has Multiple Sclerosis, affecting her endurance and strength. Ms. S prefers to feed herself as much as she is capable. After eating three-fourths of her meal by herself, Ms. S usually becomes extremely fatigued and requests assistance from the certified nursing assistant to feed her the remainder of the meal.

Coding: GG0130A. Eating would be coded 03, Partial/moderate assistance.

Rationale: The certified nursing assistant provides less than half the effort for the patient to complete the activity of eating.

2. **Eating:** Mr. M has upper extremity weakness and fine motor impairments. The occupational therapist places an adaptive device onto Mr. M's hand that supports the eating utensil within his hand. At the start of each meal Mr. M can bring food to his mouth. Mr. M then tires and the certified nursing assistant feeds him more than half of each meal.

Coding: GG0130A. Eating would be coded 02, Substantial/maximal assistance.

Rationale: The helper provides more than half the effort for the patient to complete the activity of eating.

3. **Eating:** Mr. A. eats meals without any physical assistance or supervision from a helper. He has a gastrostomy tube (G-tube), but it is no longer used, and it will be removed later today.

Coding: GG0130A. Eating would be coded 06, Independent.

Rationale: The patient can independently complete the activity without any assistance from a helper for this activity. The presence of a G-tube does not affect the eating score.

4. **Eating:** The nurse opens all of Mr. S's cartons and containers on his food tray before leaving the room. There are no safety concerns regarding Mr. S's ability to eat. Mr. S eats

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the food himself, bringing the food to his mouth using appropriate utensils and swallowing the food safely.

Coding: GG0130A. Eating would be coded 05, Setup or clean-up assistance.

Rationale: The helper provided setup assistance only prior to the activity

5. **Eating:** Mrs. H does not have any food consistency restrictions, but often needs to swallow 2 or 3 times so that the food clears her throat due to difficulty with pharyngeal peristalsis. She requires verbal cues to use the compensatory strategy of extra swallows to clear the food.

Coding: GG0130A. Eating would be coded 04, Supervision or touching assistance.

Rationale: Mrs. H swallows all types of food consistencies, and requires verbal cueing (supervision) from the helper. Code based on assistance from the helper. The coding is not based on whether or not the patient had restrictions related to food consistency.

6. **Eating:** Mrs. V has had difficulty seeing on her left side since her stroke. During meals, a helper has to remind her to scan her entire meal tray to ensure she has seen all the food.

Coding: GG0130A. Eating would be coded 04, Supervision or touching assistance.

Rationale: The helper provides verbal cuing assistance as Mrs. V completes the activity of eating. Supervision, such as reminders, may be provided throughout the activity or intermittently.

7. **Eating:** Mrs. N is impulsive. While she eats, a helper provides verbal and tactile cuing so that Mrs. N does not lift her fork to her mouth until she has swallowed the food in her mouth.

Coding: GG0130A. Eating would be coded 04, Supervision or touching assistance.

Rationale: The patient requires supervision and touching assistance to eat safely.

8. **Eating:** Mr. R is unable to eat or drink by mouth since he had a stroke one week ago. He receives nutrition and fluids through a gastrostomy tube (G-tube), which is administered by nurses.

Coding: GG0130A. Eating would be coded 88, Not attempted due to medical condition or safety concerns.

Rationale: The patient does not eat or drink by mouth at this time due to his recent-onset stroke. This item includes eating and drinking by mouth only. If eating and drinking by mouth do not occur due to a recent-onset medical condition, then the activity is coded as 88, Not attempted due to medical condition. Assistance with G-tube feedings is not considered when coding this item.

9. **Eating:** Mr. F is fed by the certified nursing assistant, because Mr. F has severe arm weakness, and he is unable to assist in the eating activity.

Coding: GG0130A. Eating would be coded 01, Dependent

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Rationale: The helper does all of the effort. The patient does not contribute any effort to complete the activity.

10. **Oral Hygiene:** Mrs. F brushes her teeth while sitting on the side of the bed. The certified nursing assistant gathers her toothbrush, toothpaste, water, and an empty cup and puts them on the bedside table for her before leaving the room. Once Mrs. F is finished brushing her teeth, which she does without any help, the certified nursing assistant returns to gather her items and dispose of the waste.

Coding: GG0130B. Oral hygiene would be coded 05. Setup or clean-up assistance.

Rationale: The helper provides setup and clean-up assistance. The patient brushes her teeth without any help.

11. **Oral Hygiene:** The nurse provides steady assistance to Mr. S as he walks to the bathroom. The nurse applies toothpaste onto Mr. S's toothbrush. Mr. S then brushes his teeth at the sink in the bathroom without physical assistance or supervision. Once Mr. S is done brushing his teeth and washing his hands and face, the nurse returns provides steady assistance as the patient walks back to his bed.

Coding: GG0130B. Oral hygiene would be coded 05, Setup or clean-up assistance.

Rationale: The helper provides setup assistance (putting toothpaste on the toothbrush) before Mr. S brushes his teeth. *Do not consider assistance provided to get to or from the bathroom to score Oral Hygiene.*

12. **Oral Hygiene:** The certified nursing assistant provides Mrs. K water and toothpaste to clean her dentures. Mrs. K cleans her upper denture plate. Mrs. K then cleans half of her lower denture plate, but states she is tired and unable to finish cleaning her lower denture plate. The certified nursing assistant finishes cleaning the lower denture plate and Mrs. K replaces the dentures in her mouth.

Coding: GG0130B. Oral hygiene would be coded 03, Partial/moderate assistance.

Rationale: The helper provided less than half the effort to complete oral hygiene.

13. **Oral Hygiene:** Mr. W is edentulous (without teeth) and his dentures no longer fit his gums. Mr. W begins to brush his upper gums after the helper applies toothpaste onto his toothbrush. He brushes his upper gums, but cannot finish due to fatigue. The helper completes the activity of oral hygiene by brushing his back upper gums and his lower gums.

Coding: GG0130B. Oral hygiene would be coded 02, Substantial/maximal assistance.

Rationale: The patient begins the activity. The helper completes the activity by performing more than half the effort.

14. **Oral Hygiene:** Mr. G has Parkinson's disease, resulting in tremors and incoordination. The certified nursing assistant retrieves all oral hygiene items for Mr. G and applies toothpaste to his toothbrush. Mr. G requires assistance to guide the toothbrush into his mouth and to steady his elbow while he brushes his teeth. Mr. G usually starts tooth

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brushing and the certified nursing assistant usually completes the activity by performing more than half of this activity.

Coding: GG0130B. Oral Hygiene would be coded 02, Substantial/maximal assistance.

Rationale: The helper provided more than half the effort for the patient to complete the activity of oral hygiene.

15. **Oral Hygiene:** Ms. T is recovering from a severe traumatic brain injury and multiple bone fractures. She does not understand how to use oral hygiene items nor does she understand the process of completing oral hygiene. The certified nursing assistant brushes her teeth and explains each step of the activity to engage cooperation from Ms. T; however, she requires full assistance for the activity of oral hygiene.

Coding: GG0130B. Oral Hygiene would be coded 01, Dependent.

Rationale: The helper provides all the effort for the activity to be completed.

16. **Toileting Hygiene:** Mrs. J uses a bedside commode. The certified nursing assistant provides steadying (touching) assistance as Mrs. J pulls down her underwear before sitting down on the toilet. When Mrs. J is finished voiding or having a bowel movement, the certified nursing assistant provides steadying assistance as Mrs. J wipes her perineal area and pulls up her underwear without assistance.

Coding: GG0130C. Toileting hygiene would be coded 04, Supervision or touching assistance.

Rationale: The helper provides steadying (touching) assistance to the patient to complete toileting hygiene.

17. **Toileting Hygiene:** Mrs. L uses the toilet to void and have bowel movements. Mrs. L is unsteady, so the certified nursing assistant walks into the bathroom with her in case she needs help. During the assessment period, a staff member has been present in the bathroom, but has not needed to provide any physical assistance with managing clothes or cleansing.

Coding: GG0130C. Toileting hygiene would be coded 04, Supervision or touching assistance.

Rationale: The helper provides supervision as the patient performs the toileting hygiene activity. The patient is unsteady and the staff provide supervision for safety reasons.

18. **Toileting Hygiene:** Mrs. P has urinary urgency. As soon as she gets in the bathroom, she asks the certified nursing assistant to lift her gown and pull down her underwear due to her balance problems. After voiding, Mrs. P wipes herself and pulls her underwear back up.

Coding: GG0130C. Toileting hygiene would be coded 03, Partial/moderate assistance.

Rationale: The helper provides more than touching assistance. The patient performs more than half the effort; the helper does less than half the effort. The patient does 2 of the 3 toileting hygiene tasks.

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19. **Toileting Hygiene:** Ms. Q has a progressive neurological disease that affects her fine and gross motor coordination, balance, and activity tolerance. She wears a hospital gown and underwear during the day. Ms. Q uses the bedside commode as she steadies herself in standing with one hand and initiates pulling down her underwear with the other hand but needs assistance to complete this activity due to her coordination impairment. After voiding, Ms. Q wipes her perineal area without assistance while sitting on the commode. When Ms. Q has a bowel movement, the certified nursing assistant performs perianal hygiene as she needs to steady herself with both hands to stand for this activity. Ms. Q is usually too fatigued at this point and requires full assistance to pull up her underwear.

Coding: GG0130C. Toileting hygiene would be coded 02, Substantial/maximal assistance.

Rationale: The helper provided more than half the effort for the patient to complete the activity of toileting hygiene.

20. **Toileting Hygiene:** Mr. J is morbidly obese and has a diagnosis of debility. He requests the use of a bed pan when voiding or having bowel movements and requires two certified nursing assistants to mobilize him onto and off the bedpan. Mr. J is unable to complete any of his perineal/perianal hygiene.

Coding: GG0130C. Toileting hygiene would be coded 01, Dependent.

Rationale: The assistance of two helpers was needed to complete the activity of toileting hygiene.

21. **Shower/Bathe Self:** Mr. J. sits on a tub bench as he washes, rinses and dries himself. The certified nursing assistant stays with him to ensure his safety as Mr. J has had instances of losing his sitting balance. The certified nursing assistant provides lifting assistance as Mr. J gets onto and off the tub bench.

Coding: GG0130E Shower/Bathe Self would be coded 04 Supervision or touching assistance.

Rationale: The helper provides supervision as Mr. J. washes, rinses, and dries himself. The transfer onto or off the tub bench is *not* considered when coding the Shower/bathe self activity.

22. **Shower/Bathe Self:** Mrs. E had a severe and progressive neurological condition that has affected her endurance as well as her fine and gross motor skills. She is transferred to the shower bench at partial/moderate assistance. When showering she uses a wash mitt that was provided by the acute care facility prior to her admission to the inpatient rehabilitation facility. Mrs. E showers while sitting on a tub bench and washes her arms and chest. The certified nursing assistant then must help wash her with the remaining parts of her body due to fatigue. Mrs. E uses a long-handled shower to rinse herself but tires half way through the task. The certified nursing assistant dries Mrs. E.'s entire body.

Coding: GG0130E Shower/Bathe Self would be coded 02, Substantial/maximal assistance.

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Rationale: The helper assists Mrs. E with more than half of the task of showering that includes bathing, rinsing and drying her body. The transfer onto the shower bench is not considered in coding this activity.

23. **Shower/Bathe Self:** Mr. Y has limited mobility due to his multiple and complex medical conditions. Mr. Y prefers to sponge bathe at his bedside. Mr. Y washes, rinses and dries his face, chest and abdomen. The helper assists with washing, rinsing and drying Mr. Y's arms/hands, upper legs, lower legs, buttocks and back.

Coding: GG0130E Shower/Bathe Self would be coded 2, Substantial, maximal assistance.

Rationale: The helper completed more than half the activity. Bathing may occur at the bedside. When coding this activity do not include assistance provided with washing, rinsing or drying the person's back.

24. **Upper Body Dressing:** Mrs. Y has right side upper extremity weakness as a result of a stroke and has worked in therapy to re-learn how to dress her upper body. During the day, she only requires the certified nursing assistant to place her clothing next to her bedside. Mrs. Y can now use compensatory strategies to put on her bra and top without any assistance. At night she removes her top and bra independently and puts the clothes on the nightstand and the certified nursing assistant puts them away in her dresser.

Coding: GG0130F Upper Body Dressing would be coded 05, Set-up or clean-up assistance.

Rationale: Mrs. Y dresses and undresses her upper body clothing and only requires the helper to retrieve her clothing; that is, setting-up the clothing for her use. The description refers to Mrs. Y as "independent" (when removing clothes), but she needs set-up assistance, so she is not "independent" with the entire activity of upper body dressing.

25. **Upper Body Dressing:** Mr. D has Parkinson's disease resulting mild tremors in his upper extremities upon intentional movement. Mr. D has worked hard with the occupational therapist to increase his independence in self-dressing. Mr. D prefers to wear loose undershirts and sweaters with buttons or zippers. He puts on and takes off his undershirt and sweaters without assistance; however, he requires only incidental help for assistance with buttons and zippers by the certified nursing assistant during upper body dressing.

Coding: GG0130F Upper Body Dressing would be coded 04, Supervision or touching assistance.

Rationale: Mr. D needs a helper to provide touching assistance (button or zipper his upper body clothing) to complete the activity.

26. **Upper Body Dressing:** Mrs. Z wears a bra and a sweatshirt most days while in the rehabilitation program. Mrs. Z requires assistance from the certified nursing assistant to thread her arms into her bra and into her sweatshirt when putting on and removing these garments. Mrs. Z initiates the placement of the bra and sweatshirt over her arms, and once her arms are threaded into the arm openings, Mrs. Z pulls the bra straps over her

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arms and pulls her sweatshirt over her arms, head and trunk. The helper hooking the bra clasps.

Coding: GG0130F Upper Body Dressing would be coded 03, partial/moderate assistance.

Rationale: The helper provides assistance with threading the Mrs. Z's arms into and out of upper body garments and hooking the bra clasps, but Mrs. Z performs more than half of the effort.

27. **Upper Body Dressing:** Mr. K had a spinal cord injury that has affected both movement and strength in both upper extremities. He places his left hand into one third of his left sleeve of his shirt with much time and effort and is unable to continue with the activity. The certified nursing assistant then completes the remaining upper body dressing for Mr. K.

Coding: GG0130F Upper Body Dressing would be coded 02 – Substantial/maximal Assistance

Rationale: Mr. K can perform a small portion of the activity of upper body dressing and requires assistance by the helper for more than half of the effort of upper body dressing.

28. **Lower Body Dressing:** Mr. D is required to follow hip precautions due to recent hip surgery. The occupational therapist in the acute care hospital instructed him in the use of adaptive equipment to facilitate lower extremity dressing. Mr. D requires the helper to retrieve his clothing from the closet. Mr. D uses his adaptive equipment to assist in threading his legs into his pants. Due to balance issues, Mr. D needs the helper to steady him when standing to manage pulling on or pulling down his pants/undergarments. Mr. D needs some assistance to put on and take off his socks and shoes.

Coding: GG0130G lower body dressing would be coded 04, Supervision or touching assistance.

Rationale: The helper steadies Mr. D when he is standing and performing the activity of lower body dressing. Putting on and taking off socks and shoes is not considered when coding lower body dressing nor is putting on and taking off adaptive equipment associated with the foot, for example Ankle Foot Orthosis these are considered when coding Putting on and Taking Off Shoes and Socks.

29. **Lower Body Dressing:** Mrs. M has severe rheumatoid arthritis and multiple fractures and sprains due to a fall. Mrs. M has been issued a knee brace, to be worn during the day. Mrs. M threads her legs into her garments, and pulls up and down the clothing just below her hips. Only a little assistance from a helper is needed to pull up her garments over her hips. Mrs. M requires a helper to fasten her knee brace due to grasp and fine motor weakness.

Coding: GG0130G lower body dressing would be coded 03, Partial/moderate assistance.

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Rationale: The helper provides only a little assistance when putting on the lower extremity garments and fastening the knee brace. The helper provides less than half of the effort. Assistance putting on and removing the knee brace she wears is considered when determining the help needed when coding lower body dressing.

30. **Putting On/Taking Off Footwear** Mr. M is undergoing rehabilitation for right side upper and lower body weakness following a stroke. Mr. M has made significant progress toward his independence and will be discharged to home tomorrow. Mr. M wears an Ankle Foot Orthosis (AFO) that he puts on his foot and ankle after he puts on his socks but before he puts on his shoes. He always places his AFO, socks and shoes within easy reach of his bed. While sitting on the bed he needs to bend over to take on and off his AFO, socks and shoes and occasionally loses his sitting balance requiring touching or steadying assistance for performing any of these tasks within the activity.

Coding: GG0130H Putting on/taking off footwear would be coded 04 – Supervision or touching assistance

Rationale: Mr. M puts on and takes off his socks, AFO and shoes by himself; however because of occasional loss of balance needs a helper to provide touching assistance when he is bending over.

31. **Putting On/Taking Off Footwear** Mrs. F was admitted to rehabilitation for a neurologic condition and experiences visual impairments, fine motor coordination and endurance issues. She requires set-up for retrieving her socks and shoes which she prefers to keep in the closet. Mrs. F often drops her shoes and socks as she attempts to put them onto her feet or as she takes them off. Often the certified nursing assistant must first thread her socks or shoes over her toes and then Mrs. F can complete the task. Mrs. F needs the certified nursing assistant to initiate taking off her socks and unstrapping the Velcro used on her shoes.

Coding: GG0130H Putting on/taking off footwear would be coded 03 – Partial/moderate assistance

Rationale: The helper provides assistance with initiating putting on and taking off Mrs. F's footwear due to her limitations of fine motor coordination when completing putting on/taking off footwear.

Examples of Conversations with Staff

1. **Eating:** Example of a probing conversation between a nurse and a certified nursing assistant regarding the patient's eating abilities:

Nurse: "Please describe to me how Mr. S eats his meals. Once the food and liquid is presented to him, does he use utensils to bring food to his mouth and swallow?"

Certified nursing assistant: "No I have to feed him."

Nurse: "Do you always have to physically feed him or can he sometimes do some aspect of the eating activity with encouragement or cues to feed himself?"

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Certified nursing assistant: “No, he can’t do anything by himself. I scoop up each portion of the food and bring the fork or spoon to his mouth. I try to encourage him to feed himself or to help guide the spoon to his mouth but can’t hold the fork. I even tried encouraging him to eat food he could pick up with his fingers, but he will not eat unless he is completely assisted for food and liquid.”

In this example, the nurse inquired specifically how Mr. S requires assistance to eat his meals. The nurse asked about instructions and physical assistance. If this nurse did not ask probing questions, he/she may not have received enough information to make an accurate assessment of the assistance Mr. S received. Accurate coding is important for reporting on the type and amount of care provided. Be sure to consider each activity definition fully.

Coding: GG0130A. Eating would be coded 01, Dependent.

Rationale: The patient requires complete assistance to eat his meals.

2. **Oral hygiene:** Example of a probing conversation between a nurse determining a patient’s oral hygiene score and a certified nursing assistant regarding the patient’s oral hygiene routine:

Nurse: “Does Mrs. K help with brushing her teeth?”

Certified nursing assistant: “She can help clean her teeth.”

Nurse: “How much help does she need to brush her teeth?”

Certified nursing assistant: “She usually gets tired after starting to brush her upper teeth. I have to brush most of her teeth.”

In this example, the nurse inquired specifically how Mrs. K manages her oral hygiene. The nurse asked about physical assistance and how the patient performed the activity. If this nurse did not ask probing questions, he/she would not have received enough information to make an accurate assessment of the actual assistance Mrs. K received.

Coding: GG0130B. Oral hygiene would be coded 02, Substantial/maximal assistance.

Rationale: The certified nursing assistant provides more than half the effort to complete Mrs. K’s oral hygiene.

3. **Toileting hygiene:** Example of a probing conversation between a nurse and a certified nursing assistant regarding the patient’s toileting hygiene routine:

Nurse: “I understand Mrs. J wears a hospital gown and underwear. Describe to me how Mrs. J usually does her toileting hygiene. Is she able to manage her clothing before and after going to the bathroom and is she able to wipe herself?”

Certified nursing assistant: “She needs help getting to the bathroom and some help to wipe herself.”

Nurse: “She needs assistance to complete her perineal hygiene. Does she manage her underwear before and after using the toilet without you giving her physical assistance, cues or setting her up with the toilet paper?”

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Certified nursing assistant: “No, I have to physically hold onto her gait belt and support her as I pull her underwear down. She wipes her perineal area and then I pull up her underwear afterwards. ”

In this example, the nurse inquired specifically about the three tasks of this activity Mrs. J was able to participate in to manage her toileting hygiene. The nurse asked about instructions and physical assistance.

Coding: GG0130C. Toileting hygiene would be coded 02, Substantial/maximal assistance.

Rationale: The helper provided more than half the effort for the patient to complete the activity of toileting hygiene.

Discharge Goal: Coding Tips

- Use the 6-point scale to code the patient’s discharge goal(s). Do not use the “activity was not attempted” codes (07, 09, or 88) to code discharge goal(s)? Use a dash (-) to indicate that a specific activity is not a goal. Of note, one goal must be indicated for either self-care or mobility. Using the dash in this allowed instance does not affect APU determination.
- For the cross-setting quality measure, the Application of Percent of Long-Term Care Hospital Patients with an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function, a minimum of one self-care or mobility goal must be coded per patient stay on the admission assessment. Even though only one discharge goal is required, the facility may choose to code more than one discharge goal for a patient.
- Licensed clinicians can establish a patient’s discharge goal(s) at the time of admission based on the admission assessment, discussions with the patient and family, professional judgment, and the professional’s standard of practice. Goals should be established as part of the patient’s care plan.
- Goals may be determined by the clinician based on the patient’s medical condition(s), prior and admission self-care and mobility status, discussions with patient and family concerning discharge goals, expected treatments, patient motivation to improve, anticipated length of stay and the discharge plan.
- If the admission performance of an activity was coded 88, Not attempted due to medical condition or safety concern during the admission assessment, a discharge goal may be submitted using the 6-point scale if the patient is expected to be able to perform the activity by discharge.

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Discharge Goal Coding Examples

Example 1: Discharge Goal Code Is *Higher* than Admission Performance Code

In the IRF, patients are expected to make gains in function by discharge. Therefore, the code reported for the patient's discharge goal may be higher than the patient's admission performance code.

Shower/Bathe Self Admission Performance: Mr. M has stated that he prefers to bathe himself rather than depending on helpers or his wife to perform this activity. The clinician assesses Mr. M's admission performance for Shower/Bathe Self. The clinician codes Mr. M's Admission Performance as 02, Substantial/maximal assistance, because the helper performs more than half the effort.

Shower/Bathe Self Discharge Goal: The clinician reflects upon the patient's prior self-care functioning, current multiple diagnoses, expected treatments, motivation to improve, anticipated length of stay, and medical prognosis. The clinician discusses discharge goals with the patient and family and they anticipate that by discharge Mr. M will require a helper to do less than half the effort in assisting him to complete the activity of bathing. The clinician codes the Discharge Goal as 03, Partial/moderate assistance.

Example 2: Discharge Goal Code Is the *Same* as Admission Performance Code

The clinician determines that a medically complex patient is not expected to progress to a higher level of functioning during the IRF stay for a specific activity. The clinician determines that the patient would be able to maintain his/her admission functional performance level. The clinician discusses functional status goals with the patient and his family and they agree that maintaining functioning for a specific activity is a reasonable goal. In this example, the discharge goal is coded at the *same* level as the patient's admission performance code.

Oral Hygiene Admission Performance and Discharge Goal: In this example, the clinician anticipates that the patient will have the same level of function for oral hygiene at admission and discharge. The patient's admission performance code is coded and the discharge goal is coded at the same level. Mrs. E has stated her preference for participation twice daily in her oral hygiene activity. Mrs. E has severe arthritis, Parkinson's disease, diabetic neuropathy, and renal failure. These conditions result in multiple impairments (e.g., limited endurance, weak grasp, slow movements, tremors). The clinician observes Mrs. E's admission performance and discusses her usual performance with clinicians, caregivers, and family to determine the necessary interventions for skilled therapy (e.g., positioning of an adaptive toothbrush cuff, verbal cues, lifting, and supporting Mrs. E's limb). The clinician codes Mrs. E's admission performance as 02, Substantial/maximal assistance. The helper does more than half the effort of the activity and performs more than half the effort when lifting or holding her limb also.

Oral Hygiene Admission Performance and Discharge Goal: The clinician anticipates her discharge performance will remain 02, Substantial/maximal assistance. Due to Mrs. E's

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progressive and degenerative condition, the clinician and patient feel that, while Mrs. E is not expected to make gains in oral hygiene performance, maintaining her function at this same level is desirable and achievable as a discharge goal. GG0170: Mobility (3-day assessment period)

GG0170. Mobility (3-day assessment period)		
Code the patient's usual performance at admission for each activity using the 6-point scale. If activity was not attempted at admission, code the reason. Code the patient's discharge goal(s) using the 6-point scale. Do not use codes 07, 09, or 88 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. <i>Activities may be completed with or without assistive devices.</i> 06. Independent - Patient completes the activity by him/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 or TOUCHING/STEADYING 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 88. Not attempted due to medical condition or safety concerns		
1. Admission Performance	2. Discharge Goal	
↓ Enter Codes In Boxes ↓		
<input type="text"/>	<input type="text"/>	A. Roll left and right: The ability to roll from lying on back to left and right side, and return to lying on back.
<input type="text"/>	<input type="text"/>	B. Sit to lying: The ability to move from sitting on side of bed to lying flat on the bed.
<input type="text"/>	<input type="text"/>	C. 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.
<input type="text"/>	<input type="text"/>	D. Sit to stand: The ability to safely come to a standing position from sitting in a chair or on the side of the bed.
<input type="text"/>	<input type="text"/>	E. Chair/bed-to-chair transfer: The ability to safely transfer to and from a bed to a chair (or wheelchair).
<input type="text"/>	<input type="text"/>	F. Toilet transfer: The ability to safely get on and off a toilet or commode.
<input type="text"/>	<input type="text"/>	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.
		<input type="checkbox"/> H1. Does the patient walk? 0. No, and walking goal is not clinically indicated → Skip to GG0170Q1. Does the patient use a wheelchair/scooter? 1. No, and walking goal is clinically indicated → Code the patient's discharge goal(s) for items GG0170I, J, K, L, M, N, O, and P. For admission performance, skip to GG0170Q1. Does the patient use a wheelchair/scooter? 2. Yes → Continue to GG0170L. Walk 10 feet
<input type="text"/>	<input type="text"/>	I. Walk 10 feet: Once standing, the ability to walk at least 10 feet in a room, corridor or similar space.
<input type="text"/>	<input type="text"/>	J. Walk 50 feet with two turns: Once standing, the ability to walk at least 50 feet and make two turns.
<input type="text"/>	<input type="text"/>	K. Walk 150 feet: Once standing, the ability to walk at least 150 feet in a corridor or similar space.

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<input type="checkbox"/>	<input type="checkbox"/>	L. Walking 10 feet on uneven surfaces: The ability to walk 10 feet on uneven or sloping surfaces, such as grass or gravel.
<input type="checkbox"/>	<input type="checkbox"/>	M. 1 step (curb): The ability to step over a curb or up and down one step.
<input type="checkbox"/>	<input type="checkbox"/>	N. 4 steps: The ability to go up and down four steps with or without a rail.
<input type="checkbox"/>	<input type="checkbox"/>	O. 12 steps: The ability to go up and down 12 steps with or without a rail.
<input type="checkbox"/>	<input type="checkbox"/>	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.
		<input type="checkbox"/> Q1. Does the patient use a wheelchair/scooter? 0. No → Skip to H0350. Bladder Continence 1. Yes → Continue to GG0170R. Wheel 50 feet with two turns
<input type="checkbox"/>	<input type="checkbox"/>	R. Wheel 50 feet with two turns: Once seated in wheelchair/scooter, the ability to wheel at least 50 feet and make two turns.
		<input type="checkbox"/> RR1. Indicate the type of wheelchair/scooter used. 1. Manual 2. Motorized
<input type="checkbox"/>	<input type="checkbox"/>	S. Wheel 150 feet: Once seated in wheelchair/scooter, the ability to wheel at least 150 feet in a corridor or similar space.
		<input type="checkbox"/> SS1. Indicate the type of wheelchair/scooter used. 1. Manual 2. Motorized

Item Rationale

- Patients in IRFs may have mobility limitations on admission. In addition, patients may be at risk of further functional decline during their stay in the IRF.

Steps for Assessment

- Assess the patient's mobility abilities based on direct observation, the patient's self-report, and reports from the clinician, care staff, or family as documented in the medical record during the 3-day assessment period.
- 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.
- Activities may be completed with or without assistive device(s). Use of assistive device(s) to complete an activity should not affect coding of the activity.
- If the patient's mobility performance varies during the assessment period, report the patient's usual status, **not** the patient's most independent performance and **not** the patient's most dependent episode.
- Refer to facility, Federal, and State policies and procedures to determine which IRF staff members may complete an assessment. Patient assessments are to be done in compliance with facility, Federal, and State requirements.

Assessment Period: The 3-day assessment period for the admission assessment includes the day of admission and the two days following the day of admission, ending as 11:59 pm. Clinicians should code the patient's admission functional status, based on a functional assessment that occurs soon after the patient's admission. The admission function scores are to reflect the

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patient's admission baseline status and are to be based on an assessment. The assessment should occur prior to the start of therapy services in order to capture the patient's true admission baseline status. This is because therapy interventions can affect the patient's functional status; the score should reflect the patient's status prior to any benefit from therapy. The discharge assessment period includes the day of discharge and the two calendar days prior to the day of discharge. Code the patient's discharge functional status based on a functional assessment that occurs close to the time of discharge.

Usual status: A patient's functional status can be impacted by the environment or situations encountered at the facility. Observing the patient in different locations and circumstances is important for a comprehensive understanding of the patient's functional status. If the patient's admission or discharge functional status varies, record the patient's usual ability to perform each activity. Do not record the patient's best performance and do not record the patient's worst performance, but rather record the patient's usual performance.

Turns: The turns included in the items GG0170J and GG0170R (walking or wheeling 50 feet with 2 turns) are 90 degree turns. The turns may be in the same direction (two 90 degree turns to the right or two 90 degree turns to the left) or may be in different directions (one 90 degree turn to the left and one 90 degree turn to the right). The 90 degree turn should occur at the person's ability level and can include use of an assistive device (for example cane, wheelchair).

Coding Instructions

Complete at the time of admission and discharge.

- Code 06, Independent, if the patient completes the activity by him/herself with no assistance from a helper.
- Code 05, Setup or clean-up assistance, if the helper SETS UP or CLEANS UP; patient completes activity. Helper assists only prior to or following the activity, but not during the activity. For example, the patient requires placement of a bed rail to facilitate rolling, or requires set-up of a leg lifter or other assistive devices.
- Code 04, Supervision or touching assistance, if the helper provides VERBAL CUES or TOUCHING/STEADYING assistance as patient completes activity. Assistance may be provided throughout the activity or intermittently. For example, the patient requires verbal cueing, coaxing, or general supervision for safety to complete the activity; or patient may require only incidental help such as contact guard or steadying assistance during the activity.
- Code 03, Partial/moderate assistance, if the helper does LESS THAN HALF the effort. Helper lifts, holds, or supports trunk or limbs, but provides less than half the effort. For example, the patient requires assistance such as partial weight-bearing assistance, but HELPER does LESS THAN HALF the effort.

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- Code 02, Substantial/maximal assistance, if the helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs and provides more than half the effort.
- Code 01, Dependent, if the 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.
- Code 07, Patient refused, if the patient refused to complete the activity.
- Code 09, Not applicable, if the patient did not perform this activity prior to the current illness, exacerbation, or injury.
- Code 88, Not attempted due to medical condition or safety concerns, if the activity was not attempted due to medical condition or safety concerns.

Coding Tips

General coding tips:

- When reviewing health records, interviewing staff, and observing the patient, be familiar with the definition of each the activity. For example, when assessing Roll left and right (item GG0170A), determine the level of assistance required to roll from lying on the back to the left side and right side and then return to lying on the back.
- If the patient does not attempt the activity and a helper does not complete the activity for the patient, code the reason the activity was not attempted. For example, code 07 if the patient refused to attempt the activity, code 09 if the activity is not applicable for the patient, or code 88 if the patient was not able to attempt the activity due to medical condition or safety concerns.
- If two or more helpers are required to assist the patient to complete the activity, code as 01, Dependent.
- To clarify your own understanding and observations about a patient's performance of an activity, ask probing questions, beginning with the general and proceed to the more specific. See examples of using probes when talking with staff at the end of this section.
- A *dash* (“-”) sign indicates “*No information.*” CMS expects dash use for quality indicator items to be a rare occurrence. Use of dashes for quality items may result in a payment reduction. Do not use a dash (“-”) if the reason that the activity was not attempted is that the patient refused (code 07), the item is not applicable (code 09), or the activity was not attempted due to medical condition or safety concerns (code 88). A dash may be used to for GG0170 discharge goal items provided that at least one self-care or one mobility item has a discharge goal.
- Use the 6-point scale to code the patient's discharge goal(s). Do not use the “activity was not attempted” codes (07, 09, or 88) to code discharge goal(s)? Use a dash (-) to indicate that a specific activity is not a goal. Of note, one goal must be indicated for either self-

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care or mobility. **Using the dash in this allowed instance does not affect APU determination.**

Coding tips for coding the patient's usual performance:

- On the admission assessment, code the patient's usual performance using the 6-point scale, or one of the 3 "activity was not attempted" codes to specify the reason why an activity was not attempted, as well as the patient's discharge goal(s) using the same 6-point scale..
- On discharge, use the same 6-point scale or "activity was not attempted" codes that were used on the admission assessment to identify the patient's usual performance on the discharge assessment.

Record the patient's usual ability to perform each activity. Do not record the patient's best performance and do not record the patient's worst performance, but rather record the patient's usual performance.

- Direct observation of the patient's performance, reviews of medical records and interviews of clinical staff are methods of gathering information to determine the patient's usual performance.
- Do not record the staff's assessment of the patient's potential capability to perform the activity.

Coding tips for patients with incomplete stays:

- For patients with incomplete stays, such as a patient with an emergency discharge, the self-care and mobility items may be coded as 88, Not attempted due to medical condition or safety concerns. Patients with incomplete stays include patients who are unexpectedly discharged to an acute care setting (short-stay acute care hospital, critical access hospital, inpatient psychiatric facility, or long-term care hospital, because of a medical emergency); patients discharged to a hospice; patients discharged to another IRF; patients who die or leave the IRF against medical advice; and patients with a length of stay of less than 3 days.

Examples

1. **Roll Left and Right:** Mr. R has a history of skin breakdown. The nurse instructs him to turn onto his right side providing step-by-step instructions to use the bedrail, bend his left leg, and then roll onto his right side. The patient attempts to roll with the use of the bedrail, but indicates he cannot do the task. The nurse then rolls him onto his right side. Next, the patient is instructed to return to lying on his back, which he successfully completes. Mr. R then requires physical assistance from the nurse to roll onto his left side and to return to lying on his back to complete the activity.

Coding: GG0170A. Roll left and right would be coded 02, Substantial/maximal assistance.

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Rationale: The nurse provided more than half of the effort for the patient to complete the activity of roll left and right.

2. **Roll Left and Right:** The physical therapist helps Mr. R turn onto his right side by instructing him to bend his left leg and roll to his right side. He is then instructs him how to position his limbs to return to lying on his back and then to repeat a similar process for rolling onto his left side and then return to lying on his back. Mr. R completes the activity without physical assistance from a helper.

Coding: GG0170A. Roll left and right would be coded 04, Supervision or touching assistance.

Rationale: The physical therapist provides verbal cues (for example, instructions) to Mr. R as he rolls from his back to his right side and returns to lying on his back. The physical therapist does not provide any physical assistance.

3. **Roll Left and Right:** Mr. Z had a stroke that resulted in paralysis on his right side and is recovering from cardiac surgery. Mr. Z requires the assistance of two certified nursing assistants when rolling onto his right side and returning to lying on his back and then rolling onto his left side and returning to lying on his back.

Coding: GG0170A. Roll left and right would be coded 01, Dependent.

Rationale: Two certified nursing assistants were needed to help Mr. Z roll to his left and right side while in bed.

4. **Roll Left and Right:** Mr. R fell and sustained left shoulder contusions and a fractured left hip, and underwent an open reduction internal fixation of the left hip. The physician's order allows him to roll onto the left hip as tolerated. The certified nursing assistant facilitates Mr. R rolling onto his right side by instructing him to bend his left leg while rolling to his right side. Mr. R needs physical assistance from the helper to initiate his rolling right due to his left arm weakness when grasping the right bedrail to assist in rolling. Mr. R returns to lying on his back without assistance and uses his right arm to grasp the left bedrail to slowly roll onto his left hip and then return to lying on his back.

Coding: GG0170A. Roll left and right would be coded 03. Partial/moderate assistance.

Rationale: The helper provided less than half the effort for the patient to complete the activity of rolling left and right.

5. **Sit to lying:** Mrs. H requires assistance from a nurse to transfer from sitting at the edge of the bed to lying flat on the bed because of paralysis on her right side. The helper lifts and positions Mrs. H's right leg. Mrs. H uses her arms to position her upper body. Overall, Mrs. H performs more than half of the effort.

Coding: GG0170B. Sit to lying would be coded 03, Partial/moderate assistance.

Rationale: A helper lifts Mrs. H's right leg and helps her position it as she moves from a seated to a lying position; Mrs. H does more than half of the effort.

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6. **Sit to Lying:** Mrs. F requires assistance from a certified nursing assistant to get from a sitting position to lying flat on the bed because of postsurgical open reduction internal fixation healing fractures of her right hip and left and right wrists. The certified nursing assistant cradles and supports her trunk and right leg to transition Mrs. F from sitting at the side of the bed to lying flat on the bed. Mrs. F assists herself a small amount by bending her elbows and left leg while pushing her elbows and left foot into the mattress only to straighten her trunk while transitioning into a lying position.

Coding: GG0170B. Sit to lying would be coded 02, Substantial/maximal assistance.

Rationale: The helper provided more than half the effort for the patient to complete the activity of sit to lying.

7. **Sit to Lying:** Mrs. H requires assistance from two certified nursing assistants to transfer from sitting at the edge of the bed to lying flat on the bed due to paralysis on her right side, obesity, and cognitive limitations. One of the certified nursing assistants explains to Mrs. H each step of the sitting to lying activity. Mrs. H is then fully assisted to get from sitting to a lying position on the bed. Mrs. H makes no attempt to assist while asked to perform the incremental steps of the activity.

Coding: GG0170B. Sit to lying would be coded 01, Dependent.

Rationale: The assistance of two certified nursing assistants was needed to complete the activity of sit to lying. If two or more helpers are required to assist the patient to complete an activity, code as 01, Dependent.

8. **Lying to Sitting on Side of Bed:** Mr. B pushes up from the bed to get himself from a lying to a seated position. The certified nursing assistant provides steadying (touching) assistance as Mr. B scoots himself to the edge of the bed and lowers his feet onto the floor.

Coding: GG0170C. Lying to sitting on side of bed would be coded 04, Supervision or touching assistance.

Rationale: The helper provides touching assistance as the patient moves from a lying to sitting position.

9. **Lying to Sitting on Side of Bed:** Mr. B pushes up on the bed to attempt to get himself from a lying to a seated position as the occupational therapist provides much of the lifting assistance necessary for him to sit upright. The occupational therapist provides assistance as Mr. B scoots himself to the edge of the bed and lowers his feet to the floor. Overall, the occupational therapist performs more than half of the effort.

Coding: GG0170C. Lying to sitting on side of bed would be coded 02, Substantial/maximal assistance.

Rationale: The helper provides lifting assistance (more than half the effort) as the patient moves from a lying to sitting position.

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10. **Lying to Sitting on Side of Bed:** Mr. U is obese and recovering from surgery for spinal stenosis with lower extremity weakness. The certified nursing assistant partially lifts Mr. U's trunk to a fully upright sitting position on the bed and minimally lifts each leg toward the edge of the bed. Mr. U then scoots toward the edge of the bed, placing both feet flat onto the floor. Mr. U completes most of the activity himself.

Coding: GG0170C. Lying to sitting on side of bed would be coded 03, Partial/moderate assistance.

Rationale: The helper provided less than half the effort for the patient to complete the activity of lying to sitting on side of bed.

11. **Lying to Sitting on Side of Bed:** Ms. P is being treated for sepsis and has multiple infected wounds on her lower extremities. Full assistance from the certified nursing assistant is needed to move Ms. P from a lying position to sitting on the side of her bed because she usually has pain in her lower extremities upon movement.

Coding: GG0170C. Lying to sitting on side of bed would be coded 01, Dependent.

Rationale: The helper fully completed the activity of lying to sitting on the side of bed for the patient.

12. **Sit to Stand:** Mr. M has osteoarthritis and is recovering from sepsis. Mr. M transitions from a sitting to a standing position with the steadying (touching) assistance of the nurse's hand on Mr. M's trunk.

Coding: GG0170D. Sit to stand would be coded 04, Supervision or touching assistance.

Rationale: The helper provides touching assistance only.

13. **Sit to Stand:** Mrs. L has multiple healing fractures and multiple sclerosis, requiring two certified nursing assistants to assist her to stand up from sitting in a chair.

Coding: GG0170D. Sit to stand would be coded 01, Dependent.

Rationale: Mrs. L requires the assistance of two helpers to complete the activity.

14. **Sit to Stand:** Mr. B has complete tetraplegia and is currently unable to stand when getting out of bed. He transfers from his bed into a wheelchair with assistance. The activity of sit to stand is not attempted due to his medical condition.

Coding: GG0170D. Sit to stand would be coded 88, Not attempted due to medical condition or safety concerns.

Rationale: The activity is not attempted due to the patient's diagnosis of complete tetraplegia.

15. **Sit to Stand:** Ms. Z has amyotrophic lateral sclerosis with moderate weakness in her lower and upper extremities. Ms. Z has prominent foot-drop in her left foot requiring the use of an ankle foot orthosis (AFO) for standing and walking. The certified nursing assistant dons Ms. Z's AFO and places the platform walker in front of Ms. Z, which she uses to steady herself once standing. The certified nursing assistant provides lifting

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assistance to get Ms. Z to a standing position and must also provide assistance to steady Ms. Z's balance to complete the activity.

Coding: GG0170D. Sit to stand would be coded 02, Substantial/maximal assistance.

Rationale: The helper provided lifting assistance and more than half of the effort for the patient to complete the activity of sit to stand. When coding Putting On/Taking Off Footwear, consider help needed to putt on and take off an AFO.

16. **Chair/Bed-to-Chair Transfer:** Mr. L had a stroke and is not currently able to walk. He uses a wheelchair for mobility. When Mr. L gets out of bed, the certified nursing assistant moves the wheelchair into the correct position, and locks the brakes so that Mr. L can transfer into the wheelchair safely. Mr. L had been observed several other times to determine any safety concerns, and it was documented that he transfers safely without the need for supervision. Mr. L transfers into the wheelchair by himself (no helper) after the certified nursing assistant leaves the room.

Coding: GG0170E. Chair/bed-to-chair transfer would be coded 05, Setup or clean-up Assistance

Rationale: Mr. L is not able to walk, so he transfers from his bed to a wheelchair when getting out of bed. The helper provides setup assistance only. Mr. L transfers safely and does not need supervision or physical assistance during the transfer.

17. **Chair/Bed-to-Chair Transfer:** Mr. C is sitting on the side of the bed. He stands and pivots into the chair as the nurse provides contact guard (touching) assistance. The nurse reports that one time Mr. C only required verbal cues for safety, but usually Mr. C requires touching assistance.

Coding: GG0170E. Chair/bed-to-chair transfer would be coded 04, Supervision or touching assistance.

Rationale: The helper provides touching assistance during the transfers.

18. **Chair/Bed-to-Chair Transfer:** Mr. F's medical conditions include morbid obesity, diabetes mellitus, and sepsis, and he recently underwent bilateral above-the-knee amputations. Mr. F requires full assistance with transfers from the bed to the wheelchair using a lift device. Two certified nursing assistants are required for safety when using the device to transfer Mr. F from the bed to a wheelchair. Mr. F is unable to assist in the transfer from his bed to the wheelchair.

Coding: GG0170E. Chair/bed-to-chair transfer would be coded 01, Dependent.

Rationale: The two helpers completed all the effort for the activity of chair/bed-to-chair transfer. If two or more helpers are required to assist the patient to complete an activity, code as 01, Dependent.

19. **Chair/Bed-to-Chair Transfer:** Ms. P has metastatic bone cancer, severely affecting her ability to use her lower and upper extremities during daily activities. Ms. P is motivated to assist with her transfers from the side of her bed to the wheelchair. Ms. P pushes herself up from the bed to begin the transfer while the therapist provides trunk support

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with weight-bearing assistance. Once standing, Ms. P shuffles her feet, turns, and slowly sits down into the wheelchair with the therapist providing steadying support. Overall, the therapist provides less than half of the effort.

Coding: GG0170E. Chair/bed-to-chair transfer would be coded 03, Partial/moderate assistance.

Rationale: The helper provided less than half of the effort for the patient to complete the activity of chair/bed-to-chair transfer.

20. **Toilet Transfer:** The certified nursing assistant moves the wheelchair foot rests up so that Ms. T can transfer onto the toilet by herself safely. The certified nursing assistant is not present during the transfer, because supervision is not required. Once Mrs. T completes the transfer, she flips the foot rests back down herself.

Coding: GG0170F. Toilet transfer would be coded 05, Setup or clean-up assistance

Rationale: The helper provides setup assistance (moving the foot rest out of the way) before Mrs. T can transfer safely onto the toilet.

21. **Toilet Transfer:** Mrs. Q transfers onto and off the elevated toilet seat with the certified nursing assistant supervising due to her unsteadiness.

Coding: GG0170F. Toilet transfer would be coded 04, Supervision or touching assistance.

Rationale: The helper provides supervision as the patient transfers onto and off the toilet. The patient may use an assistive device.

22. **Toilet Transfer:** Mrs. Y is anxious about getting up to use the bathroom. She asks the certified nursing assistant to stay with her in the bathroom as she gets on and off the toilet. The certified nursing assistant stays with her, as requested, and provides verbal encouragement and instructions (cues) to Mrs. Y.

Coding: GG0170F. Toilet transfer would be coded 04, Supervision or touching assistance

Rationale: The helper provides supervision/verbal cues as Mrs. Y transfers onto and off the toilet.

23. **Toilet Transfer:** The certified nursing assistant provides steady (touching) assistance as Mrs. Z transfers onto the toilet and lowers her underwear. After voiding, Mrs. Z cleanses herself. She then stands up as the helper steadies her. Mrs. Z pulls up her underwear as the helper steadies her to ensure Mrs. Z does not lose her balance.

Coding: GG0170F. Toilet transfer would be coded 04, Supervision or touching assistance.

Rationale: The helper provides steady assistance as the patient transfers onto and off the toilet. Assistance with managing clothing and cleansing is coded under item GG0130C. Toileting hygiene, and is not considered when rating the Toilet transfer item.

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24. **Toilet Transfer:** The therapist supports Mrs. M's trunk with a gait belt as Mrs. M pivots and lowers herself onto the toilet. The therapist provides less than half the effort during the toilet transfer.

Coding: GG0170F. Toilet transfer would be coded 03, Partial/moderate assistance.

Rationale: The helper provides less than half the effort to complete the activity. The assistance provided to the patient was physical support or weight bearing assistance.

25. **Toilet Transfer:** Ms. W has peripheral vascular disease and sepsis, resulting in lower extremity pain and severe weakness. Ms. W uses a bedside commode when having a bowel movement. The certified nursing assistant raises the bed to a height that facilitates the transfer activity. Ms. W initiates lifting her buttocks from the bed and in addition requires some of her weight to be lifted by the certified nursing assistant to stand upright. Ms. W then reaches and grabs onto the armrest of the bedside commode to further steady herself. The certified nursing assistant slowly lowers Ms. W onto the bedside commode.

Coding: GG0170F. Toilet transfer would be coded 02, Substantial/maximal assistance.

Rationale: The helper provided more than half of the effort for the patient to complete the activity of toilet transfer.

26. **Toilet Transfer:** Mr. H has paraplegia incomplete, pneumonia, and COPD. Mr. B prefers to use the bedside commode when moving his bowels. Due to his severe weakness, history of falls, and dependent transfer status, two certified nursing assistants assist during the toilet transfer.

Coding: GG0170F. Toilet transfer would be coded 01, Dependent.

Rationale: The activity required the assistance of two or more helpers for the patient to complete the activity.

27. **Toilet Transfer:** Mrs. S is on bedrest due to a medical complication. She uses a bedpan for bladder and bowel management.

Coding: GG0170F. Toilet transfer would be coded 88, Not attempted due to medical condition or safety concerns.

Rationale: The patient does not transfer onto or off a toilet due to being on bedrest because of a medical condition.

28. **Car transfer:** Mrs. W uses a wheelchair and ambulates for only short distances. Mrs. W requires lifting assistance from the physical therapist to get from a seated position in the wheelchair to a standing position. The therapist provides trunk support when Mrs. W takes several steps during the transfer turn. Mrs. W lowers herself into the car seat with steadying assistance from the therapist. Mrs. W. lifts her legs into the car with support from the therapist.

Coding: GG0170G car transfer would be coded 02, Substantial/maximal assistance.

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Rationale: The helper completed more than half the effort to transfer Mrs. W into the car by providing lifting assistance and trunk support. Mrs. W contributes effort to complete the activity.

29. **Car Transfer:** During her rehabilitation stay Mrs. N works with an occupational therapist on transfers in and out of the passenger side of a car. On the day before discharge, when performing car transfers, Mrs. N requires verbal reminders for safety and light touching assistance. The therapist instructs her on strategic hand placement while Mrs. N transitions to sitting into the car seat. The therapist opens and closes the door.

Coding: GG0170G. Car transfer would be coded 04, Supervision or touching assistance.

Rationale: The helper provides touching assistance as the patient transfers in the passenger seat of the car. Assistance with opening and closing the car door is not included in the definition of this item, and is not considered when coding this item.

30. **Does the Patient Walk?** Mr. Z currently does not walk, but a walking goal is clinically indicated.

Coding: GG0170H1. Does the patient walk? would be coded 1, No, and walking goal is clinically indicated. Discharge goal(s) for walking, stairs and pick up object items.

Rationale: Patient does not currently walk, so no admission performance code is entered for the walking items. However, a walking goal is clinically indicated and walking goals may be coded.

31. **Does the Patient Walk?** Ms. Y currently walks with great difficulty due to her progressive neurological disease. It is not expected that Ms. Y will continue to walk. Ms. Y also uses a wheelchair so both GG0170H1. Does the patient walk? and GG0170Q1. Does the patient use a wheelchair/scooter? would be coded Yes.

Coding: GG0170H1. Does the patient walk? would be coded 2, Yes, and each walking admission performance activity for walk, stairs and pick up object items would then be coded.

Rationale: The patient currently walks and admission performance codes are entered for each walking item.

32. **Walk 10 Feet:** Mrs. C has Parkinson's disease and walks with a walker. The physical therapist must advance the walker for Mrs. C with each step. The physical therapist assists Mrs. C by physically initiating the stepping movement forward, advancing Mrs. C's foot during the activity of walking 10 feet. The assistance provided to Mrs. C is more than half of the effort for her to walk the 10 foot distance.

Coding: GG0170I. Walk 10 feet would be coded 02, Substantial/maximal assistance.

Rationale: The helper provides more than half the effort as the patient completes the activity.

33. **Walk 10 Feet:** Mr. O has bilateral upper extremity tremors, lower extremity weakness, and Parkinson's disease. The therapy assistant secures Mr. O's arms onto the platform walker's arm supports to reduce the tremors. The therapy assistant guides and steadies the

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shaking, rolling walker forward while cueing Mr. O to take larger steps. Mr. O requires steadying at the beginning of the walk and progressively requires some of his weight to be supported for the last 5 feet of the 10-foot walk. Overall, the assistant provides less than half of the effort.

Coding: GG0170I. Walk 10 feet would be coded 03, Partial/moderate assistance.

Rationale: The helper provided less than half the effort for the patient to complete the activity walk 10 feet.

34. **Walk 10 Feet:** Mrs. U has an above-the-knee amputation and severe rheumatoid arthritis. Once the nurse has donned her stump sock and prosthesis, Mrs. U is assisted to stand and uses her rolling walker with only touching assistance provided toward the last half of her 10-foot walk.

Coding: GG0170I. Walk 10 feet would be coded 04, Supervision or touching assistance.

Rationale: The helper provided touching assistance for the patient to complete the activity of walk 10 feet. Assistance getting from a sitting to standing position is not coded as part of the Walk 10 Feet item.

35. **Walk 50 Feet with Two Turns:** A therapist provides contact guard (steady) assistance as Mrs. W gets up from a sitting position to a standing position. After the therapist places Mrs. W's walker within reach, Mrs. W walks 60 feet down the hall with two turns without any assistance from the therapist. No supervision is required while she walks.

Coding: GG0170J. Walk 50 feet with two turns would be coded 05, Setup or clean-up assistance

Rationale: Mrs. W walks more than 50 feet and makes two turns once the helper places the walker within reach. Assistance with getting from a sitting to a standing position is coded separately under the item GG0170D. Sit to Stand (04, Supervision or touching assistance).

36. **Walk 50 Feet with Two Turns:** Mrs. P walks 70 feet with a quad cane, completing two turns during the walk. The therapist provides steadying assistance only when Mrs. P turns.

Coding: GG0170J. Walk 50 feet with two turns would be coded 04, Supervision or Touching Assistance.

Rationale: The helper provides touching assistance as the patient walks more than 50 feet and make two turns. The patient may use an assistive device.

37. **Walk 50 Feet with Two Turns:** Mrs. L is unable to bear her full weight on her left leg. As she walks 60 feet down the hall with her crutches and making two turns, her husband supports her trunk. He provides less than half the effort.

Coding: GG0170J. Walk 50 feet with two turns would be coded 03, Partial/moderate assistance.

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Rationale: The helper (her husband) provides trunk support as the patient walks more than 50 feet and two turns (but not 100 feet).

38. **Walk 50 Feet with Two Turns:** Mr. T walks 50 feet with one helper providing trunk support and a second helper providing supervision. Mr. T walks the 50 feet with two turns.

Coding: GG0170J. Walk 50 feet with two turns would be coded 01, Dependent.

Rationale: Mr. T requires two helpers to complete the activity.

39. **Walk 50 Feet with Two Turns:** Mrs. U has an above-the-knee amputation, severe rheumatoid arthritis, and uses a prosthesis. Mrs. U is assisted to stand and, after walking 10 feet, requires progressively more help as she nears the 50-foot mark. Mrs. U is unsteady and typically loses her balance when turning, requiring significant support to remain upright. The therapist provides more than half of the effort.

Coding: GG0170J. Walk 50 feet with two turns would be coded 02, Substantial/maximal assistance.

Rationale: The helper provided more than half of the effort for the patient to complete the activity of walk 50 feet with two turns.

40. **Walk 50 Feet with Two Turns:** Mr. B is recovering from a stroke and has difficulty walking. He is only able to walk a distance of 30 feet.

Coding: GG0170J. Walk 50 feet with two turns would be coded 88, Not attempted due to medical condition or safety concerns.

Rationale: The patient was not able to walk the entire distance, and the patient's ability to walk a shorter distance would be captured in the item "GG0170I Walk 10 feet."

41. **Walk 150 Feet:** Mrs. D walks down the hall using her walker and the certified nursing assistant usually needs to provide touching assistance to Mrs. D who intermittently loses her balance while she uses the walker.

Coding: GG0170K. Walk 150 feet would be coded 04, Supervision or touching assistance.

Rationale: The helper provides touching assistance intermittently throughout the activity.

42. **Walk 150 Feet:** Mr. R has endurance limitations due to heart failure, and has only walked about 30 feet during the 3-day assessment period. He has not walked 150 feet or more during the assessment period, including with the physical therapist who has been working with Mr. R. The therapist speculates that Mr. R could walk this distance in the future with additional assistance.

Coding: GG0170K. Walk 150 feet would be coded 88, Activity not attempted due to medical or safety concerns.

Rationale: The activity was not attempted.

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43. **Walking 10 Feet on Uneven Surfaces:** Mrs. N has severe joint degenerative disease and is recovering from sepsis. Upon discharge Mrs. N will need to be able to walk on the uneven and sloping surfaces of her driveway. Near the end of her IRF stay, the physical therapist takes Mrs. N outside to walk on uneven surfaces. Mrs. N requires the therapist's weight-bearing assistance several times during walking in order to prevent Mrs. N from falling as she navigates walking 10 feet over uneven surfaces.

Coding: GG0170L walking 10 feet on uneven surfaces would be coded 03, Partial/moderate assistance

Rationale: Mrs. N requires the helper to provide weight-bearing assistance several times to prevent her from falling as Mrs. N walks 10 feet on uneven surfaces. The helper does less than half the effort for walking 10 feet on uneven surfaces

44. **1 Step (curb):** Mrs. Z had a stroke and needs to learn how to step up and down one step to enter and exit her home. The physical therapist provides standby assistance as she uses her quad cane to aid her balance in stepping up one step. The physical therapist provides touching assistance as Mrs. Z uses her cane for balance and steps down one step.

Coding: GG0170M 1 step would be coded 04, Supervision or touching assistance

Rationale: The helper provides touching assistance as Mrs. Z completes the activity of stepping down one step.

45. **4 Steps:** Mr. J has lower body weakness and the physical therapist provides touching assistance when he ascends 4 steps. While descending 4 steps, the physical therapist provides trunk support (more than touching assistance) as Mr. J holds the stair railing.

Coding: GG0170N 4 steps would be coded 03, Partial/moderate assistance

Rationale: The helper provides touching assistance as Mr. J ascends 4 steps. The therapist provides trunk support (more than touching assistance) when he descends the 4 steps.

46. **12 Steps:** Ms. Y is recovering from a stroke resulting in motor issues and poor endurance. Ms. Y's home has 12 stairs with a railing and she needs to use these stairs to enter and exit her home. The physical therapist uses a gait belt around her trunk and supports less than half of the effort as Ms. Y ascends and then descends 12 stairs.

Coding: GG0170O 12 steps would be coded 03, Partial/moderate assistance

Rationale: The helper provides less than half the effort in providing the necessary support for Ms. Y as she ascends and descends 12 stairs.

47. **Picking Up Object:** Mr. P has a neurologic condition that has resulted in coordination problems. He wants to be as independent as possible. Mr. P lives with his wife and will soon be discharged. He tends to drop objects and has been practicing bending or stooping from a standing position to pick up small objects, such as a spoon, from the floor. The occupational therapist needs to remind Mr. P of safety strategies when he bends to pick up objects from the floor and she needs to steady him (touching assistance) to prevent him from falling.

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Coding: GG0170P Picking up object would be coded 04, Supervision or touching assistance

Rationale: A helper is needed to provide verbal cues and touching or steadying (touching) assistance when Mr. P picks up an object due to his coordination issues.

48. **Picking Up Object:** Ms. C has recently undergone a hip replacement. When she drops items she uses a long-handled reacher that she has been using at home prior to admission. She is ready for discharge and can now ambulate with a walker without assistance. When she drops objects from her walker basket she requires the certified nursing assistant to locate her long-handled reacher and bring it to her in order for her to use it. She does not need assistance to pick up the object after the helper brings her the reacher.

Coding: GG0170P Picking up object would be coded 05, Set-up or clean-up assistance

Rationale: The helper provides set-up assistance so that Ms. C can use her long-handled reacher.

49. **Wheel 50 Feet with Two Turns:** Mrs. M is unable to bear any weight on her right leg due to a recent fracture. The certified nursing assistant provides steadying assistance when transferring Mrs. M from the bed into the wheelchair. Once in her wheelchair, Mrs. M propels herself about 60 feet down the hall using her left leg and makes two turns without any physical assistance or supervision.

Coding: GG0170R. Wheel 50 feet with two turns would be coded 06, Independent.

Rationale: The patient wheels herself more than 50 feet. Assistance provided with the transfer is not considered when scoring wheel 50 feet with two turns. There is a separate item for scoring bed-to-chair transfers.

50. **Wheel 50 Feet with Two Turns:** Mr. R is very motivated to use his motorized wheelchair with an adaptive throttle for speed and steering. Mr. R has amyotrophic lateral sclerosis, and moving his upper and lower extremities is very difficult. The therapy assistant is required to walk next to Mr. R. for frequent readjustments of his hand position to better control the steering and speed throttle. Mr. R often drives too close to corners, becoming stuck near doorways upon turning, preventing him from continuing to mobilize/wheel himself. The therapy assistant backs up Mr. M's wheelchair for him so that he may continue mobilizing/wheeling himself. Overall, Mr. R provides more than half of the effort.

Coding: GG0170R. Wheel 50 feet with two turns would be coded 03, Partial/moderate assistance.

Rationale: The helper provided less than half of the effort for the patient to complete the activity, wheel 50 feet with two turns. The patient provided more than half the effort.

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51. **Wheel 50 Feet with Two Turns:** Once seated in the manual wheelchair, Ms. R wheels about 10 feet then asks the therapist to push the wheelchair an additional 40 feet into her room and her bathroom.

Coding: GG0170R. Wheel 50 feet with two turns would be coded 02, Substantial/maximal assistance.

Rationale: The helper provides more than half the effort.

52. **Indicate the Type of Wheelchair/Scooter Used.** Patients may use a manual wheelchair or motorized wheelchair/scooter to accomplish mobilizing different distances. In this example Mrs. R used a manual wheelchair during the 3-day assessment period.

Coding: GG0170RR. Indicate the type of wheelchair/scooter used would be coded 1, Manual.

Rationale: Mrs. R used a manual wheelchair scooter during the 3-day assessment period.

53. **Wheel 150 Feet:** Mr. G always uses a motorized scooter to mobilize himself down the hallway and the therapist provides cues due to safety issues (to avoid running into the walls).

Coding: GG0170S. Wheel 150 feet would be coded 04, Supervision or touching assistance.

Rationale: The helper provides verbal cues to complete the activity.

54. **Wheel 150 feet:** Mr. L has peripheral neuropathy and limited vision due to complications of diabetes. Mr. L uses a below the knee prosthetic limb. Mr. L's prior preference was to ambulate within the home and use a wheelchair when mobilizing himself while in the community. Mr. L is assessed performing the activity of mobilizing 150 feet in her wheelchair. A helper is needed to provide verbal cues for safety due to vision deficits.

Coding: GG0170S wheel 150 feet would be coded 04, Supervision or touching assistance.

Rationale: Mr. L requires the helper to provide verbal cues for his safety when using a wheelchair to mobilize 150 feet.

55. **Type of Wheelchair/Scooter Used.** Mr. G always uses a motorized scooter to mobilize himself down the hallway and the therapist provides cues due to safety issues (to avoid running into the walls).

Coding: GG170SS1. Indicate the type of wheelchair/scooter used would be coded 2, Motorized.

Rationale: Mr. G used a motorized scooter during the 3-day assessment period.

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56. **Wheel 150 Feet:** Ms. D has renal failure, peripheral vascular disease, and diabetes mellitus, resulting in severe muscle weakness and poor vision. Ms. D struggles to wheel 20 feet using her manual wheelchair to propel herself using her feet on the floor and hands on the wheels to propel herself. She requires verbal and tactile cues from the certified nursing assistant. The therapist determines Ms. D is unable to safely wheel herself 150 feet and is not assessed for the activity.

Coding: GG0170S. Wheel 150 feet would be coded 88, Not attempted due to medical condition or safety concerns.

Rationale: The patient did not complete the activity due to medical condition or safety concerns.

57. **Wheel 150 Feet:** Mr. L has multiple sclerosis, resulting in extreme muscle weakness and minimal vision impairment. Mr. L uses a motorized wheelchair with an adaptive joystick to control both the speed and steering of the motorized scooter. He occasionally needs reminders to slow down around the turns and requires assistance from the nurse for backing up the scooter when barriers are present.

Coding: GG0170S. Wheel 150 feet would be coded 03, Partial/moderate assistance.

Rationale: The helper provides less than half of the effort to complete the activity of wheel 150 feet.

58. **Indicate the type of wheelchair/scooter used:** In the above example Mr. N used a manual wheelchair during the 3-day assessment period.

Coding: GG0170SS. Indicate the type of wheelchair/scooter used would be coded 1, Manual.

Rationale: Mr. N used a manual wheelchair during the 3-day assessment period.

Example of a Probing Conversation with Staff

1. **Roll Left and Right:** Example of a probing conversation between a nurse determining a patient's score for roll left and right and a certified nursing assistant regarding the patient's bed mobility:

Nurse: "Describe to me how Mr. R usually moves himself in bed. Once he is in bed, how does he turn from lying on his back to lying on his left and right sides and then return to lying on his back?"

Certified nursing assistant: "He can roll to his sides by himself."

Nurse: "He rolls from side to side and returns to lying on his back without any instructions or physical help?"

Certified nursing assistant: "No, I have to remind him to bend his left leg and roll to his right side, and then to roll to his back and then to do the same on his left side and back to his back, but once I remind him he can do it himself."

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In this example, the nurse inquired specifically about how Mr. R moves from lying on his back to lying on his sides and then returns to lying on his back. The nurse asked about instructions and physical assistance. If this nurse did not ask probing questions, he/she would not have received enough information to make an accurate assessment of the actual assistance Mr. R received.

Coding: GG0170A. Roll left and right would be coded 04, Supervision or touching assistance.

Rationale: The certified nursing assistant provides verbal instructions as the patient moves from lying on his back to lying on his sides and then returns to lying on his back.

2. **Sit to Lying:** Example of a probing conversation between a nurse determining a patient's score for sit to lying and a certified nursing assistant regarding the patient's bed mobility:

Nurse: "Please describe how Mrs. H moves herself from sitting on the side of the bed to lying flat on the bed. When she is sitting on the side of the bed, how does she move to lying on her back?"

Certified nursing assistant: "She can lay down with some help."

Nurse: "Please describe how much help she needs and how exactly you help her."

Certified nursing assistant: "I have to lift and position her right leg, but once I do that, she can use her arms to position her upper body."

In this example, the nurse inquired specifically about how Mrs. H moves from a sitting position to a lying position. The nurse asked about physical assistance.

Coding: GG0170B. Sit to lying would be coded 03, Partial/moderate assistance.

Rationale: The certified nursing assistant lifts Mrs. H's right leg and helps her position it as she moves from a sitting position to a lying position. The helper does less than half the effort.

3. **Lying to Sitting on Side of Bed:** Example of a probing conversation between a nurse determining a patient's score for lying to sitting on side of bed, and a certified nursing assistant regarding the patient's bed mobility:

Nurse: "Please describe how Mrs. L moves herself in bed. When she is in bed, how does she move from lying on her back to sitting up on the side of the bed?"

Certified nursing assistant: "She can sit up by herself."

Nurse: "She sits up without any instructions or physical help?"

Certified nursing assistant: "No, I have to remind her to check on the position of her arm that has limited movement and sensation as she moves in the bed, but once I remind her to check her arm, she can do it herself."

In this example, the nurse inquired specifically about how Mrs. L moves from a lying position to a sitting position. The nurse asked about instructions and physical assistance.

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Coding: GG0170C. Lying to sitting on side of bed would be coded 04, Supervision or touching assistance.

Rationale: The certified nursing assistant provides verbal instructions as the patient moves from a lying to sitting position.

4. **Sit to Stand:** Example of a probing conversation between a nurse determining a patient's sit to stand score and a certified nursing assistant regarding the patient's sit to stand ability:

Nurse: "Please describe how Mrs. L usually moves from sitting on the side of the bed or chair to a standing position. Once she is sitting, how does she get to a standing position?"

Certified nursing assistant: "She needs help to get to sitting up and then standing."

Nurse: "I'd like to know how much help she needs for safely rising up from sitting in a chair or sitting on the bed to get to standing position."

Certified nursing assistant: "She needs two people to assist her to stand up from sitting on the side of the bed or when she is sitting in a chair"

In this example, the nurse inquired specifically about how Mrs. L moves from a sitting position to a standing position, and clarified that this did not include any other positioning to be included in the answer. The nurse specifically asked about physical assistance.

Coding: GG0170D. Sit to stand would be coded 01, Dependent.

Rationale: Mrs. L requires the assistance of two helpers to complete the activity.

5. **Chair/Bed-to-Chair Transfer:** Example of a probing conversation between a nurse determining a patient's score for chair/bed-to-chair transfer and a certified nursing assistant regarding the patient's chair/bed-to-chair transfer ability:

Nurse: "Please describe how Mr. C moves into the chair from the bed. When he is sitting at the side of the bed, how much help does he need to move from the bed to the chair?"

Certified nursing assistant: "He needs me to help him move from the bed to the chair."

Nurse: "Does he help with these transfers when you give him any instructions, setup or physical help?"

Certified nursing assistant: "Yes, he will follow some of my instructions to get ready to transfer, such as moving his feet from being spread out to placing them under his knees. I have to place the chair close to the bed and then I lift him because he is very weak. I then tell him to reach for the armrest of the chair. Mr. C follows these directions and that helps a little in transferring him from the bed to the chair. He does help with the transfer."

In this example, the nurse inquired specifically about how Mr. C moves from sitting on the side of the bed to sitting in a chair. The nurse asked about instructions, physical assistance, and cuing instructions. If this nurse did not ask probing questions he/she would not have

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received enough information to make an accurate assessment of the actual assistance Mr. C received.

Coding: GG0170E. Chair/bed-to-chair transfer would be coded 02, Substantial/maximal assistance.

Rationale: The helper provides more than half of the effort to complete the activity of Chair/bed-to-chair transfer.

6. **Toilet Transfer:** Example of a probing conversation between a nurse determining the patient's score and a certified nursing assistant regarding a patient's toilet transfer assessment:

Nurse: "I understand that Mrs. M usually uses a wheelchair to get to her toilet. Please describe how Mrs. M moves from her wheelchair to the toilet. How does she move from sitting in a wheelchair to sitting on the toilet?"

Certified nursing assistant: "It is hard for her, but she does it with my help."

Nurse: "Can you describe the amount of help in more detail?"

Certified nursing assistant: "I have to give her a bit of a lift using a gait belt to get her to stand and then remind her to reach for the toilet grab bar while she pivots to the toilet. Sometimes, I have to remind her to take a step while she pivots to or from the toilet, but she does most of the effort herself."

In this example, the nurse inquired specifically about how Mrs. M moves from sitting in a wheelchair to sitting on the toilet. The nurse specifically asked about instructions and physical assistance. If this nurse did not ask probing questions, he/she would not have received enough information to make an accurate assessment of the actual assistance Mrs. M received.

Coding: GG0170F. Toilet transfer would be coded 03, Partial/moderate assistance.

Rationale: The certified nursing assistant provides less than half the effort to complete this activity.

7. **Walk 10 Feet:** Example of a probing conversation between a nurse determining a patient's score for walk 10 feet and a certified nursing assistant regarding the patient's walking ability:

Nurse: "Please describe how Mrs. C usually walks in her room. Once standing, how does she walk 10 feet in her room or the corridor?"

Certified nursing assistant: "She walks with a walker."

Nurse: "She walks with a walker without any instructions or physical help?"

Certified nursing assistant: "No, I have to help her position her walker correctly, remind her to stand up straight so that she is positioned correctly over the walker, and help her intermittently by providing touching assistance and reminding her to advance the walker forward so she doesn't bump into the front of the walker."

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In this example, the nurse inquired specifically about what assistance is needed when Mrs. C walks 10 feet. The nurse asked about instructions and physical assistance. If this nurse did not ask probing questions, he/she would not have received enough information to make an accurate assessment of the actual assistance Mrs. C received.

Coding: GG0170I. Walk 10 feet would be coded 04, Supervision or touching assistance.

Rationale: The certified nursing assistant provides cueing, supervision, and touching assistance during the activity.

8. **Walk 50 Feet with Two Turns:** Example of a probing conversation between a nurse determining a patient's score for walking 50 feet with two turns and a certified nursing assistant regarding the patient's walking ability:

Nurse: "How much help does Mr. T need to walk 50 feet and make two turns once he is standing?"

Certified nursing assistant: "He needs help to do that."

Nurse: "How much help does he need?"

Certified nursing assistant: "He walks about 50 feet with one of us holding onto the gait belt and another person following closely with a wheelchair in case he needs to sit down."

In this example, the nurse inquired specifically about how Mr. T walks 50 feet and makes two turns. The nurse asked about physical assistance. If this nurse did not ask probing questions, he/she would not have received enough information to make an accurate assessment of the actual assistance Mr. T received.

Coding: GG0170J. Walk 50 feet with two turns would be coded 01, Dependent.

Rationale: Mr. T requires two helpers to complete this activity.

9. **Walk 150 Feet:** Example of a probing conversation between a nurse determining a patient's score for walking 150 feet and a certified nursing assistant regarding the patient's walking ability:

Nurse: "Please describe how Mrs. D walks 150 feet in the corridor once she is standing."

Certified nursing assistant: "She uses a walker and some help."

Nurse: "She uses a walker and how much instructions or physical help does she need?"

Certified nursing assistant: "I have to support her by holding onto the gait belt that is around her waist so that she doesn't fall. She does push the walker forward most of the time."

Nurse: "Do you help with more than or less than half the effort?"

Certified nursing assistant: "I have to hold onto her belt firmly when she walks because she frequently loses her balance when taking steps. Her balance gets worse the

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further she walks, but she is very motivated to keep walking. I would say I help her with more than half the effort.”

In this example, the nurse inquired specifically about how Mrs. D walks 150 feet. The nurse asked about instructions and physical assistance. If this nurse did not ask probing questions, he/she would not have received enough information to make an accurate assessment of the actual assistance Mrs. D received.

Coding: GG0170K. Walk 150 feet would be coded 02, Substantial/maximal assistance.

Rationale: The certified nursing assistant provides trunk support as Mrs. D walks 150 feet that is more than half the effort.

10. **Wheel 50 Feet with Two Turns:** Example of a probing conversation between a nurse determining a patient’s score for wheel 50 feet with two turns and a certified nursing assistant regarding the patient’s mobility:

Nurse: “I understand that Ms. R uses a manual wheelchair. Describe to me how Ms. R wheels herself 50 feet and makes two turns once she is seated in the wheelchair.”

Certified nursing assistant: “She wheels herself.”

Nurse: “She wheels herself without any instructions or physical help?”

Certified nursing assistant: “Well yes, she needs help to get around turns, so I have to help her and set her on a straight path, but once I do, she wheels herself.”

In this example, the nurse inquired specifically about how Ms. R wheels 50 feet with two turns. The nurse asked about instructions and physical assistance. If this nurse did not ask probing questions, he/she would not have received enough information to make an accurate assessment of the actual assistance Ms. R received.

Coding: GG0170R. Wheel 50 feet with two turns would be coded 03, Partial/moderate assistance.

Rationale: The certified nursing assistant must physically push the wheelchair at some points of the activity; however, the helper does less than half of the activity for the patient.

11. **Wheel 150 Feet:** Example of a probing conversation between a nurse determining a patient’s score for wheel 150 feet and a certified nursing assistant regarding the patient’s mobility:

Nurse: “I understand that Mr. G usually uses an electric scooter for longer distances. Once he is seated in the scooter, does he need any help to mobilize himself at least 150 feet?”

Certified nursing assistant: “He drives the scooter himself.....he’s very slow.”

Nurse: “He uses the scooter himself without any instructions or physical help?”

Certified nursing assistant: “That is correct.”

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In this example, the nurse inquired specifically about how Mr. G uses an electric scooter to mobilize himself 150 feet. If this nurse did not ask probing questions, he/she would not have received enough information to make an accurate assessment of the actual assistance Mr. G received.

Coding: GG0170S. Wheel 150 feet would be coded 06, Independent.

Rationale: The patient navigates in the corridor for at least 150 feet without assistance.