SECTION GG:
FUNCTIONAL ABILITIES AND GOALS

Coding tips for coding the patient's usual performance:

- When coding the patient's usual performance and patient's discharge goal(s) use the six-point scale, or one of the 4 "activity was not attempted" codes (07, 09, 10, and 88) to specify the reason why an activity was not attempted.
- 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.
- An activity can be completed independently with or without devices. If the patient uses adaptive equipment and uses the device independently when performing an activity, enter code 06, Independent.
- Code based on patient's performance. Do not record the staff's assessment of the patient's potential capability to perform the activity.
- If the patient performs the activity more than once during the assessment period and the patient's performance varies, coding in Section GG should be based on the patient's "usual performance," which is identified as the patient's usual activity/performance for any of the Self-Care or Mobility activities - not the most independent or dependent performance over the assessment period. Therefore, if the patient's Self-Care performance varies during the assessment period, report the patient's usual performance, **not** the patient's most independent performance and **not** the patient's most dependent performance. A provider may need to use the entire 3-day assessment period to obtain the patient's usual performance.

Coding tip for patients with incomplete stays:

- For patients with incomplete stays, such as a patient with an emergency discharge, the self-care and mobility items are skipped. 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 and Specific Coding Tips for Admission Performance or Discharge Performance

Note: The following are coding examples for each Self-Care item. Some examples describe a single observation of the patient completing the activity; other examples describe a summary of several observations of the patient completing an activity across different times of the day and different days.

Coding tips for coding the patient's usual performance:

- When coding the patient's usual performance and discharge goal(s), use the 6-point scale, or one of the 4 "activity was not attempted" codes (07, 09, 10, and 88) to specify the reason why an activity was not attempted. 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.
- An activity can be completed independently with or without devices. If the patient uses adaptive equipment and uses the device independently when performing an activity, enter code 06, Independent.
- Code based upon the patient's performance. Do not record the staff's assessment of the patient's potential capability to perform the activity.
- If the patient performs the activity more than once during the assessment period and the patient's performance varies, coding in Section GG should be based on the patient's "usual performance," which is identified as the patient's usual activity/performance for any of the Self-Care or Mobility activities, not the most independent or dependent performance over the assessment period. Therefore, if the patient's Mobility performance varies during the assessment period, report the patient's usual performance, **not** the patient's most independent performance and **not** the patient's most dependent performance. A provider may need to use the entire 3-day assessment period to obtain the patient's usual performance.

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 are skipped. 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 and Specific Coding Tips for Admission or Discharge Performance

Note: The following are coding examples and coding tips for mobility items. Some examples describe a single observation of the person completing the activity; other examples describe a summary of several observations of the patient completing an activity across different times of the day and different days.

Coding Tip for GG0170A, Roll left and right

- If the clinician determines the patient's medical condition does not allow for the patient to complete all tasks of the activity (roll left, roll right, roll to back) for the entire 3-day assessment period then code Roll left to right as 88, Not attempted due to medical