Admission Assessment

Section GG: Functional Abilities and Goals (Select Items from the Admission Assessment)

GG0100. Prior Functioning: Everyday Activities

GG0100A. Self Care

- **Coding:** 3, Independent.
- **Rationale:** Mr. K was independent with self-care activities, such as bathing, dressing, using the toilet, and eating, prior to his hip fracture.

GG0100B. Indoor Mobility (Ambulation)

- **Coding:** 3, Independent.
- **Rationale:** Prior to his hip fracture, Mr. K walked by himself on indoor surfaces using a rollator walker.

GG0100C. Stairs

- **Coding:** 2, Needed Some Help.
- **Rationale:** Mr. K required standby assistance from his daughter to climb the stairs to the second level of his home prior to his hip fracture.

GG0100D. Functional Cognition

- **Coding:** 3, Independent.
- **Rationale:** Mr. K was independent with all functional cognition tasks prior to his hip fracture, including managing his medications, paying his bills and grocery shopping.

GG0110. Prior Device Use

- **Coding:** Checkmarks should be placed for **GG0110A. Manual wheelchair** and **GG0110D. Walker.**
- **Rationale:** Mr. K used both a rollator walker and a manual wheelchair prior to his hip fracture.

GG0130. Self-Care

GG0130A. Eating

- **Admission Performance Coding:** 05, Setup or clean-up assistance.
- **Rationale:** Mr. K feeds himself after setup assistance from a certified nursing assistant (CNA) to open containers and cut his food into small pieces.

- **Discharge Goal:** 06, Independent.
- **Rationale:** It is anticipated that Mr. K will be independent with eating at discharge, returning to his prior level of function.

GG0130B. Oral hygiene

- **Admission Performance Coding:** 04, Supervision or touching assistance.
- **Rationale:** Mr. K required a CNA to provide supervision as he brushed his teeth while standing for safety. He also required the CNA to provide setup and clean-up assistance. Do not consider the assistance provided to get to or from the bathroom when coding oral hygiene.

- **Discharge Goal:** 06, Independent.
- **Rationale:** It is anticipated that Mr. K will not need any type of assistance with oral hygiene by discharge.

GG0130C. Toileting hygiene

- **Admission Performance Coding:** 04, Supervision or touching assistance.
- **Rationale:** Mr. K required steadying assistance from one helper while he was standing and adjusting his underwear and slacks.

- **Discharge Goal**: 06, Independent.
- **Rationale:** The occupational therapist anticipated that Mr. K will manage his perineal hygiene and clothing without assistance when using the bathroom by discharge.

GG0170. Mobility

GG0170F. Toilet transfer

- **Admission Performance Coding:** 03, Partial/moderate assistance.
- **Rationale:** Mr. K required the assistance of one helper providing less than half of the effort to transfer on and off the toilet.

- **Discharge Goal:** 06, Independent.
- **Rationale:** The occupational therapist anticipated that Mr. K will not require any type of assistance to perform toilet transfers using a standard toilet with a raised toilet seat by discharge.

GG1070I. Walk 10 feet

- **Admission Performance Coding:** 03, Partial/moderate assistance.
- **Rationale:** Mr. K walked 10 feet with a rollator walker and the assistance of one helper providing less than half the effort. He required steadying as he began to walk, and then progressively required some of his weight to be supported for the last 3 feet of the 10-foot walk. The use of assistive devices to complete an activity should not affect the coding of an activity.

- **Discharge Goal:** 04, Supervision or touching assistance.
- **Rationale:** The physical therapist (PT) anticipated that the patient will walk 10 feet with a helper providing supervision assistance, using a rollator walker by discharge.

GG0170J. Walk 50 feet with two turns

- **Admission Performance Coding:** 88, Not attempted due to medical condition or safety concerns.
- **Rationale:** This activity was not performed at admission due to the patient's fatigue and decreased endurance.

- **Discharge Goal:** 04, Supervision or touching assistance.
- **Rationale:** Based on his prior mobility status, comorbidities, current functional performance, and motivation to improve, the PT anticipated that Mr. K will require contact guard assistance when walking 50 feet and making two turns using a rollator walker by discharge.

GG0170K. Walk 150 feet

- **Admission Performance Coding:** 09, Not applicable.
- **Rationale:** This activity was not attempted during the 3-day assessment period and Mr. K was not walking 150 feet prior to his current injury.

- **Discharge Goal:** 09, Not applicable.
- **Rationale:** The PT does not expect Mr. K to perform this activity by discharge. He could not perform the activity prior to his current injury. The maximum distance walked by the patient prior to his current illness was up to 60 feet. Therefore, this activity goal is not applicable.

GG0170Q1. Does the patient use a wheelchair and/or scooter?

- **Coding:** 1, Yes.
- **Rationale:** The patient used a manual wheelchair for self-mobilizing on the unit and during the therapy evaluation.

GG0170R. Wheel 50 feet with two turns

- **Admission Performance Coding:** 02, Substantial/maximal assistance.
- **Rationale:** Once seated in his manual wheelchair, Mr. K could only propel himself 20 feet and required some assistance from a helper to straighten himself after a turn. He then required the helper to propel his wheelchair the remaining 30 feet to complete the activity.

- **Discharge Goal:** 06, Independent.
- **Rationale:** The PT anticipated that Mr. K will increase his level of endurance and complete self-mobilizing 50 feet in a manual wheelchair with two turns, without any type of assistance at discharge.

GG0170RR1: Indicate the type of wheelchair or scooter used

- **Coding:** 1, Manual.
- **Rationale:** Mr. K used a manual wheelchair.

GG0170S. Wheel 150 feet

- **Admission Performance Coding:** 02, Substantial/maximal assistance.
- **Rationale:** After propelling himself 20 feet, Mr. K becomes fatigued and a helper must propel him the remaining 130 feet distance to complete this activity.

- **Discharge Goal:** 02, Substantial/maximal assistance.
  Rationale: Based on Mr. K's prior level of function, the PT anticipated that beyond approximately 70 feet, a helper will propel Mr. K for the remaining distance to complete this activity.

GG0170SS1. Indicate the type of wheelchair or scooter used

- **Coding:** 1, Manual.
- **Rationale:** Mr. K used a manual wheelchair.

Section M: Skin Conditions (Admission Assessment)

M0210. Unhealed Pressure Ulcers/Injuries

- **Coding**: 1. Yes. *Continue to M0300, Current Number of Unhealed Pressure Ulcers/Injuries at Each Stage.*

M0300. Current Number of Unhealed Pressure Ulcers/Injuries at Each Stage

- **Coding:**
  - M0300A1. Stage 1: **Code as 0.**
  - M0300B1. Stage 2: **Code as 0.**
  - M0300C1. Stage 3: **Code as 0.**
  - M0300D1. Stage 4: **Code as 1.**
  - M0300E1. Unstageable: Non-removable dressing/device: **Code as 0.**
  - M0300F1. Unstageable: Slough and/or eschar: **Code as 0.**
  - M0300G1. Unstageable: Deep tissue injury: **Code as 1.**
- **Rationale:**
  - Upon admission to the inpatient rehabilitation facility (IRF) setting, Mr. K had a pressure ulcer on his coccyx and a deep tissue injury (DTI) on his right lateral malleolus. To accurately stage these wounds, the nurse reviewed the history of these pressure ulcers in the patient's medical record.
  - Although the coccyx pressure ulcer had evidence of improvement and a decrease in size upon IRF admission assessment, the acute care medical record classified it as a Stage 4. Clinical standards do not support reverse staging or backstaging as a way to document healing as it does not accurately characterize what is physiologically occurring as the ulcer heals. Therefore, this pressure ulcer should continue to be classified as a stage 4.
  - The pressure ulcer on the right lateral malleolus was assessed as a DTI. This was confirmed upon review of the patient's acute care medical record.
  - The surgical site would not be coded in M0300 as it is not a pressure ulcer or injury. It is a surgical wound.

Section N: Medications (Admission Assessment)

N2001. Drug Regimen Review: Did a complete drug regimen review identify potential clinically significant medication issues?

- **Coding:** 1. Yes – Issues found during review.
- **Rationale:** The pharmacist identified that two different doses of the same medication to address mild pain were ordered. The combined dosage could exceed the maximum daily dosage for ibuprofen. The pharmacist considered this duplicate therapy a clinically significant medication issue.

N2003. Medication Follow-Up: Did the facility contact a physician (or physician-designee) by midnight of the next calendar day and complete prescribed/recommended actions in response to the identified potential clinically significant medication issues?

- **Coding:** 1. Yes.
- **Rationale:** On the day of admission, the pharmacist identified a significant medication issue. He contacted the admitting physician and left a message to discuss the medication orders. One hour later, the admitting physician returned the pharmacist's phone call to clarify and change the order. That evening, the charge nurse noted and implemented the order.

Discharge Assessment

Section GG: Functional Abilities and Goals (Select Items from the Discharge Assessment)

GG0130. Self-Care

GG0130A. Eating

- **Discharge Performance Coding:** 06, Independent.
- **Rationale:** Mr. K opened containers and used utensils and a cup/glass to feed himself and drink liquids without any assistance.

GG0130B. Oral hygiene

- **Discharge Performance Coding:** 06, Independent.
- **Rationale:** Mr. K brushed his teeth and completed all oral hygiene tasks without any type of assistance.

GG0130C. Toileting hygiene

- **Discharge Performance Coding:** 06, Independent.
- **Rationale:** Mr. K managed his perineal hygiene and clothing without any assistance.

GG0170. Mobility

GG0170F. Toilet transfer

- **Discharge Performance Coding:** 06, Independent.
- **Rationale:** Mr. K completed this activity without any type of assistance.

GG0170I. Walk 10 feet

- **Discharge Performance Coding:** 04, Supervision or touching assistance.
- **Rationale**: Mr. K walked 10 feet using a rollator walker with supervision from one helper. The use of assistive devices to complete an activity should not affect the coding of an activity.

GG0170J. Walk 50 feet with two turns

- **Discharge Performance Coding:** 04, Supervision or touching assistance.
- **Rationale:** Mr. K walked 50 feet with two turns using a rollator walker and contact guard assistance. The use of assistive devices to complete an activity should not affect the coding of an activity.

GG0170K. Walk 150 feet

- **Discharge Performance Coding:** 09, Not applicable.
- **Rationale:** This activity was not attempted, and Mr. K was not walking 150 feet prior to his current injury.

GG0170Q3. Does the patient use a wheelchair and/or scooter?

- **Coding:** 1, Yes.
- **Rationale:** Mr. K used a manual wheelchair.

GG0170R. Wheel 50 feet with two turns

- **Discharge Performance Coding:** 06, Independent.
- **Rationale:** Mr. K wheeled himself approximately 60 feet and completed two turns without any type of assistance.

GG0170RR3: Indicate the type of wheelchair or scooter used

- **Coding:** 1, Manual.
- **Rationale:** Mr. K used a manual wheelchair.

GG0170S: Wheel 150 feet

- **Discharge Performance Coding:** 02, Substantial/maximal assistance.
- **Rationale:** Mr. K wheeled himself 60 feet, which is close to his prior level of function. A helper was needed to propel his wheelchair 90 feet, which is the remaining distance of the 150 feet. The helper does more than half of the effort to complete this activity.

GG0170SS3: Indicate the type of wheelchair or scooter used

- **Coding:** 1, Manual.
- **Rationale:** Mr. K used a manual wheelchair.

Section M: Skin Conditions (Discharge Assessment)

M0210. Unhealed Pressure Ulcers/Injuries

- **Coding**: 1. Yes *Continue to M0300, Current Number of Unhealed Pressure Ulcers/Injuries at Each Stage.*
- **Rationale:** At discharge, Mr. K had one unstageable pressure ulcer on his right lateral malleolus.

M0300: Current Number of Unhealed Pressure Ulcers/Injuries at Each Stage

- M0300A1. Stage 1: **Code as 0.**
- M0300B1. Stage 2: **Code as 0.**

  M0300B2. Number of **these** Stage 2 pressure ulcers that were present upon admission: **Skip.**
- M0300C1. Stage 3: **Code as 0.**

  M0300C2. Number of **these** Stage 3 pressure ulcers that were present upon admission: **Skip.**
- M0300D1. Stage 4: **Code as 0.**

  M0300D2. Number of **these** Stage 4 pressure ulcers that were present upon admission: **Skip.**
- M0300E1. Unstageable – Non-removable dressing/device: **Code as 0.**

  M0300E2. Number of **these** unstageable pressure ulcers/injuries that were present upon admission: **Skip.**
- M0300F1. Unstageable – Slough and/or eschar: **Code as 1.**

  M0300F2. Number of **these** unstageable pressure ulcers that were present upon admission: **Code as 0.**
- M0300G1. Unstageable – DTI: **Code as 0.**

  M0300G2. Number of **these** unstageable pressure injuries that were present upon admission: **Skip.**

Rationale:

- Mr. K had an unstageable pressure ulcer due to slough and/or eschar on his right lateral malleolus at discharge. This pressure ulcer was identified as a DTI at admission. During the patient's IRF stay, it was reclassified as a Stage 4. However, at discharge, slough, completely covered this pressure ulcer, preventing visualization of the wound bed. Therefore, it is considered not present on admission. A numerically staged pressure ulcer/injury that becomes unstageable due to slough or eschar at discharge would not be coded as present on admission in M0300F2.

- The healing Stage 4 pressure ulcer observed at admission on the coccyx has closed. It is now considered to be a healed Stage 4 and would not be coded in M0300 on the Discharge Assessment.

Section N. Medications (Discharge Assessment)

N2005. Medication Intervention: Did the facility contact and complete a physician's (or physician-designee's) prescribed/recommended actions by midnight of the next calendar day each time that potential clinically significant medication issues were identified since the admission?

- **Coding:** 1. Yes.
- **Rationale:** The clinically significant medication issue identified by the pharmacist on the day of admission was communicated to the physician, and the physician's recommended actions were completed by midnight of the next calendar day. On day 5 of the IRF stay, Mr. K had a clinically significant medication issue related to hydrocodone bitartrate and acetaminophen. A physician was immediately contacted, and the physician's recommended actions of administering diphenhydramine, providing nasal oxygen, discontinuing the hydrocodone bitartrate and acetaminophen, and monitoring for bleeding were addressed by midnight of the next calendar day. No other clinically significant medication issues were identified during the patient's IRF stay.