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.	
Coding: **3. Independent** - Patient completed the activities by him/herself, with or without an assistive device, with no assistance from a helper. **2. Needed Some Help** - Patient needed partial assistance from another person to complete activities. **1. Dependent** - A helper completed the activities for the patient. **8. Unknown** **9. Not Applicable**	↓ **Enter Codes in Boxes** ☐ **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.

Item Rationale

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

Steps for Assessment

1. Ask the patient or family member, or review the patient's medical record, for details describing the patient's prior functioning with everyday activities.

Coding Instructions

Complete only if A0250 = 01 Admission. Complete during the 3-day admission assessment period.

- **Code 3, Independent,** if the patient completed the activities by himself or 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 the activities.
- **Code 1, Dependent,** if the helper completed the activities for the patient, or the assistance of two or more helpers was required for the patient to complete the activities.
- **Code 8, Unknown**, if the patient's usual ability prior to the current illness, exacerbation, or injury is unknown.
- **Code 9, Not Applicable**, if the activities were not applicable to the patient prior to the current illness, exacerbation, or injury.

Coding Tips

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

Examples for Coding Prior Functioning: Everyday Activities

1. Indoor Mobility (Ambulation): Mrs. G had a stroke 1 year ago and has now experienced a second stroke. She needs assistance to complete many everyday activities. She did not walk immediately prior to the second stroke as a result of her first stroke.

   Coding: GG0100B, Prior Functioning - Indoor Mobility (Ambulation), would be coded 9, Not Applicable.

   Rationale: The patient did not ambulate immediately prior to the current illness, injury, or exacerbation (the second stroke).

2. Indoor Mobility (Ambulation): Mr. C was admitted to an LTCH after experiencing a stroke. Prior to the stroke, 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 because of joint stiffness and severe arthritis pain. Occasionally, Mr. C required steadying assistance during the day when walking from room to room.

   Coding: GG0100B, 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 immediately prior to his stroke.

GG0110. Prior Device Use

GG0110. Prior Device Use. Indicate devices and aids used by the patient prior to the current illness, exacerbation, or injury.	
↓ Check all that apply	
☐	A. Manual wheelchair
☐	B. Motorized wheelchair and/or scooter
☐	C. Mechanical lift
☐	Z. None of the above

Item Rationale

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

Steps for Assessment

1. Ask the patient or family member, or review the patient's medical record, for details describing the patient's use of prior devices and aids.

Coding Instructions

Complete only if A0250 = 01 Admission.

- **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.

Example for Coding Prior Device Use

1. Mrs. G has a diagnosis of tetraplegia complete. She is unable to walk and did not walk prior to the current episode of care, which started because of a pressure ulcer and respiratory infection. She uses a motorized wheelchair to mobilize.

   Coding: GG0110B, Motorized wheelchair and/or scooter, would be checked.

   Rationale: Mrs. G used a motorized wheelchair prior to the current illness/injury.

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

GG0130. Self-Care (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. Use of codes 07, 09, 10, or 88 is permissible to code discharge goal(s).

Coding:
Safety and **Quality of Performance** - If helper assistance is required because patient's performance is unsafe or of poor quality, score according to amount of assistance provided.

Activities may be completed with or without assistive devices.

06. **Independent** - Patient completes the activity by 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 and/or touching/steadying and/or contact guard assistance as patient completes activity. Assistance may be provided throughout the activity or intermittently.
03. **Partial/moderate assistance** - Helper does LESS THAN HALF the effort. Helper lifts, holds or supports trunk or limbs, but provides less than half the effort.
02. **Substantial/maximal assistance** - Helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs and provides more than half the effort.
01. **Dependent** - Helper does ALL of the effort. Patient does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the patient to complete the activity.

If activity was not attempted, code reason:
07. **Patient refused**
09. **Not applicable** - Not attempted and the patient did not perform this activity prior to the current illness, exacerbation, or injury.
10. **Not attempted due to environmental limitations** (e.g., lack of equipment, weather constraints)
88. **Not attempted due to medical condition or safety concerns**

1. Admission Performance	2. Discharge Goal	
↓ Enter Codes in Boxes ↓		
☐☐	☐☐	**A. Eating:** The ability to use suitable utensils to bring food and/or liquid to the mouth and swallow food and/or liquid once the meal is placed before the patient.
☐☐	☐☐	**B. Oral hygiene:** The ability to use suitable items to clean teeth. Dentures (if applicable): The ability to insert and remove dentures into and from the mouth, and manage denture soaking and rinsing with use of equipment.
☐☐	☐☐	**C. Toileting hygiene:** The ability to maintain perineal hygiene, adjust clothes before and after voiding or having a bowel movement. If managing an ostomy, include wiping the opening but not managing equipment.
☐☐	☐☐	**D. Wash upper body:** The ability to wash, rinse, and dry the face, hands, chest, and arms while sitting in a chair or bed.

Item Rationale

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

Steps for Assessment

1. Assess the patient's self-care performance based on direct observation, as well as the patient's self-report and reports from clinicians, care staff, or family documented in the patient's medical record during the 3-day assessment period. CMS anticipates that an interdisciplinary team of clinicians is involved in assessing the patient 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 the 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. Refer to facility, Federal, and State policies and procedures to determine which LTCH 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 2 days following the day of admission, ending at 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 admission functional assessment, when possible, should occur prior to the patient benefiting from treatment interventions in order to determine the patient's true admission baseline status. Even if treatment started on the day of admission, a baseline functional status assessment can still be conducted. Treatment should not be withheld in order to conduct the functional assessment. The discharge assessment period includes the day of discharge and the 2 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.

DEFINITION

Usual performance
A patient's functional status can be impacted by the environment or situations encountered at the facility. Observing the patient's interactions with others in different locations and circumstances is important for a comprehensive understanding of the patient's functional status. If the patient's 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.

Coding Instructions

Complete only if A0250 = 01 Admission or A0250 = 10 Planned 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 setup of hygiene item(s) or assistive device(s).
- **Code 04, Supervision or touching assistance,** if the helper provides verbal cues and/or touching/steadying and/or contact guard assistance as patient completes activity. Assistance may be provided throughout the activity or intermittently. 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 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.
- **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 attempt to perform the activity and did not perform this activity prior to the current illness, exacerbation, or injury.
- **Code 10, Not attempted due to environmental limitations,** if the patient did not attempt this activity due to environmental limitations. Examples include lack of equipment, and weather constraints.
- **Code 88, Not attempted due to medical condition or safety concerns,** if the activity was not attempted due to medical condition or safety concerns.

Admission and Discharge Performance Coding Tips

General coding tips:

- When reviewing the patient's 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 and liquid once the meal is placed in front of the patient.

- The assessment timeframe is 3 calendar days. During the assessment time frame, some activities may be performed by the patient multiple times, whereas other activities may only occur once.
- Licensed clinicians may assess the patient's performance based on direct observation as well as reports from patient's self-report, clinicians, care staff, or family during the 3-day assessment period. We anticipate that a multidisciplinary team of clinicians is involved in assessing the patient during the 3-day assessment period.
- To clarify your own understanding of the patient's performance of an activity, ask direct care staff probing questions about the patient's abilities, beginning with the general and proceeding to the more specific. See examples of using probing questions when talking with staff at the end of this section.
- Patients with cognitive impairments/limitations may need physical and/or verbal assistance when completing an activity. Code based on the patient's need for assistance to perform the activity safely (for example, choking risk due to rate of eating, amount of food placed into mouth, risk of falling).
- If two or more helpers are required to assist the patient in completing 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 during the entire 3-day assessment period, code the reason the activity was not attempted. For example, code as 07 if the patient refused to attempt the activity during the entire 3-day assessment period, code as 09 if the activity is not applicable for the patient (the activity did not occur at the time of the assessment, and prior to the current illness, injury, or exacerbation), code as 10 if the patient was not able to attempt the activity due to environmental limitations, or code as 88 if the patient was not able to attempt the activity due to medical condition or safety concerns.
- A dash (–) indicates *"No information."* CMS expects dash use to be a rare occurrence.
- 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 patient'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 performance:

- When coding the patient's usual performance and the patient's discharge goal(s), use the 6-point scale, or one of the four "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.

- Code based on the patient's performance. Do not record the care staff's assessment of the patient's potential capability to perform the activity.
- 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.
- If the helper needs to retrieve the device/adaptive equipment, such as an adaptive eating utensil, then enter code 05, Setup or clean-up assistance.
- Assess the patient's self-care performance based on direct observation, as well as the patient self-report and reports from clinicians, care staff, or family documented in the patient's medical record during the 3-day assessment period. CMS anticipates that an interdisciplinary team of clinicians is involved in assessing the patient during the 3-day assessment period.
- 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 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 due to an unplanned discharge:

- The self-care items are not included on the Unplanned Discharge Assessment or the Expired Assessment.

Examples and Specific Coding Tips for Admission Performance or Discharge Performance

Note: The following are coding examples and coding tips 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 GG0130A, Eating

- Patient receives tube feedings or total parenteral nutrition (TPN):
  - If the patient does not eat or drink by mouth and relies **solely** on nutrition and liquids through tube feedings or TPN due to a **new (recent-onset) medical condition,** code GG0130A as 88, Not attempted due to medical condition or safety concerns. Assistance with tube feedings or TPN is not considered when coding the item, Eating.
  - If the patient does not eat or drink by mouth at the time of the assessment, and the patient did not eat or drink by mouth **prior to the current** illness, injury or exacerbation, code GG0130A as 09, Not applicable– Not attempted and the patient

did not perform this activity prior to the current illness, exacerbation, or injury. Assistance with tube feedings or TPN is not considered when coding the item, Eating.

- If the patient eats and drinks by mouth, and relies **partially** on obtaining nutrition and liquids via tube feedings or TPN, code eating based on the amount of assistance the patient requires to eat and drink by mouth. Assistance with tube feedings or TPN is not considered when coding the item, Eating.

Examples for GG0130A, Eating

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 for all meals.

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 and liquids 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 at each meal.

3. **Eating:** Mr. A eats meals without any physical assistance or supervision from a helper. He has a 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. In this scenario, 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 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 provides setup assistance only prior to the activity.

5. **Eating:** Mrs. H does not have any food consistency restrictions, but often needs to swallow two or three 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 the patient had restrictions related to food consistency.

6. **Eating:** Mrs. V has difficulty seeing on her left side since her stroke. During meals, a helper must remind her to view 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 cueing 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 cueing 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 1 week ago. He receives nutrition and fluids through a gastronomy 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 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.

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

Coding Tip for GG0130B, Oral hygiene

- If a patient does not perform oral hygiene during therapy, determine the patient's abilities based on performance on the care unit.

Examples for GG0130B, Oral hygiene

1. **Oral hygiene:** In the morning and at night, Mrs. F brushes her teeth while sitting on the side of the bed. Each time, 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.

2. **Oral hygiene:** Before bedtime, the nurse provides steadying 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 and provides steadying 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.*

3. **Oral hygiene:** Before bedtime, 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 provides less than half the effort to complete oral hygiene.

4. **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.

5. **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 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 provides more than half the effort for the patient to complete the activity of oral hygiene.

6. **Oral Hygiene:** Ms. T has Lewy body dementia 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.

Coding Tips for GG0130C, Toileting hygiene

- Toileting hygiene includes the tasks of managing undergarments, clothing and incontinence products and performing perineal cleansing before and after voiding or having a bowel movement. If the patient does not usually use undergarments, then assess the patient's need for assistance to manage lower-body clothing and perineal hygiene.
- Toileting hygiene (managing clothing and perineal cleansing) takes place before and after use of the toilet, commode, bedpan, or urinal. If the patient completes a bowel toileting program in bed, code the item, Toileting hygiene, based on the patient's need for assistance for managing clothing and perineal cleansing.
- If the patient has an indwelling urinary catheter and has bowel movements, code the Toileting hygiene item based on the amount of assistance needed by the patient when moving his or her bowels.

Examples for GG0130C, Toileting hygiene

1. **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.

2. **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 toilet hygiene activity. The patient is unsteady, and the staff provide supervision for safety reasons.

3. **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 two of the three toileting hygiene tasks.

4. **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 owing 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, a certified nursing assistant performs perineal hygiene as Ms. Q 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 provides more than half the effort needed for the patient to complete the activity of toileting hygiene.

5. **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 pull down his pants and underwear and mobilize him onto and off the bedpan. Mr. J is unable to complete any of his perineal/perianal hygiene. Both certified nursing assistants help Mr. J pull up his underwear and pants.

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

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

6. **Toileting hygiene:** During the discharge assessment period, Mrs. W was incontinent and removes her wet incontinence briefs and elastic waistband slacks. Mrs. W cleans her perineal and other areas after the episode of incontinence. The helper pulls the new incontinence brief and slacks over Mrs. W's feet and ankles. Mrs. W completes the remaining clothing management tasks without further assistance.

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

   Rationale: The helper provides less than half the effort to complete the three steps of toileting hygiene (clothing management, hygiene, clothing management) to complete the activity.

Coding Tips for GG0130D, Wash upper body

- Wash upper body may be assessed based on a sponge bath at the patient's bedside, at the sink, or in the shower or tub.

Examples for GG0130D, Wash upper body

1. **Wash upper body:** After the helper places the wash basin filled with water, soap, and a towel on the bedside table, the helper leaves the room. Mrs. L washes, rinses, and dries her upper body. The helper returns and removes all of the items once Mrs. L is done.

   Coding: GG0130D, Wash upper body, would be coded 05, Setup or clean-up assistance.

   Rationale: The helper provides setup and cleanup assistance. Assistance with washing, rinsing, and drying the back is not considered when coding this item.

2. **Wash upper body:** Mr. C is sitting in his bed where the certified nursing assistant provides him with a washcloth and then opens the soap container to enable Mr. C to wash his face,

hands, chest, and arms. Due to arthritis, Mr. C is unable to manage fine motor tasks such as container management. Mr. C then completes the activity safely without verbal or physical assistance or supervision.

Coding: GG0130D, Wash upper body, would be coded 05, Setup or clean-up assistance.

Rationale: The helper provides setup only prior to the activity.

3. **Wash upper body:** Mrs. L has severe rheumatoid arthritis and peripheral vascular disease that affects her hands with joint pain, weakness, numbness, and tingling. Mrs. L uses a wash mitt to wash her upper arms and part of her chest. The certified nursing assistant helps to wash and rinse her face and part of her chest. Mrs. L rinses her arms and chest after the certified nursing assistant places a rinsed mitt on her hand. She soaks her hands in soapy water and rinses them under the faucet that is set up for her use. Mrs. L slowly wipes herself with a towel.

   Coding: GG0130D, Wash upper body, would be coded 03, Partial/moderate assistance.

   Rationale: The helper provides less than half the effort for the patient to complete the activity of wash upper body.

4. **Wash upper body:** Mr. D has amyotrophic lateral sclerosis and has upper extremity weakness and uncontrollable twitching. Mr. D is very motivated to perform the activity of washing his upper body. The nurse always offers to work with Mr. T hand-over-hand for the activity to manage his twitching while he washes, rinses, and dries his face, hands, arms, and chest. Mr. D requires the nurse to move his hands and contain his tremors during this activity, thus the majority (more than half) of the activity effort is performed by the nurse.

   Coding: GG0130D, Wash upper body, would be coded 02, Substantial/maximal assistance.

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

5. **Wash upper body:** Mr. W is unable to sit on the side of the bed or assist with washing his upper body due to severe weakness. The certified nursing assistant raises the head of the bed and washes Mr. W's face, hands, chest, and arms.

   Coding: GG0130D, Wash upper body, would be coded 01, Dependent.

   Rationale: The helper completes the activity. The patient does not assist with washing of the upper body.

Examples of Probing 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 are 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?"

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 he 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 with 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 from the certified nursing assistant 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?"

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 that 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 provides more than half the effort for the patient to complete the activity of toileting hygiene.

4. **Wash upper body:** Example of a probing conversation between a nurse and a certified nursing assistant regarding the patient's washing upper body routine:

   Nurse: "Describe how Mr. C usually washes his upper body. Specifically, does he wash, rinse, and dry his face, hands, chest, and arms while sitting in a chair or bed?"

   Certified nursing assistant: "He has to sit in his bed because he's too weak in the morning to get to the sink, and I have to help him do most of it."

   Nurse: "What can Mr. C complete for himself when washing, rinsing, and drying his upper body? Does he need instructions, safety reminders, setup, or physical help?"

   Certified nursing assistant: "I have to give him a basin of water, washcloth, and open his soap container, lather his washcloth and place it in his hand. I encourage him to wash his arms, but he always gets tired after washing one of his arms. I then do all the remaining washing, rinsing, and drying of his upper body. I've tried giving him a little rest break before asking him to continue washing himself, but he then complains of feeling cold and wants me to finish washing him. After washing his upper body, I have to clean up the wash basin, washcloth, and soap for him."

   In this example, the nurse inquired specifically how Mr. C washes his upper body. The nurse specifically asked about instructions, safety reminders, and physical assistance.

   Coding: GG0130D, Wash upper body, would be coded 02, Substantial/maximal assistance.

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

Discharge Goal: Coding Tips

- Discharge Goal(s) is (are) coded with each Admission assessment.
- A minimum of one self-care or mobility discharge goal must be coded. However, facilities may choose to code more than one self-care or mobility discharge goal. Code the patient's discharge goal(s) using the 6-point scale. Use of the "activity was not attempted" codes (07, 09, 10, and 88) is permissible to code discharge goal(s). Use of a

dash is permissible for any remaining self-care or mobility goals that were not coded. Using the dash in this allowed instance after the coding of at least one goal does not affect Annual Payment Update (APU) determination.

- Licensed clinicians can establish a patient's discharge goal(s) at the time of admission based on the patient's prior medical condition, admission assessment self-care and mobility status, discussions with the patient and family, professional judgment, the professional's standard of practice, expected treatments, the patient's motivation to improve, anticipated length of stay, and the patient's discharge plan. Goals should be established as part of the patient's care 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 entered using the 6-point scale if the patient is expected to be able to perform the activity by discharge.
- If the patient is in the LTCH for less than 3 calendar days, for Self-Care and Mobility Discharge Goals, a minimum of one self-care or mobility goal must be coded per patient stay on the LTCH CARE Data Set. Code at least one goal to the best of your ability based on the predicted plan of care for the patient.

Discharge Goal Coding Examples

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

If the clinician determines that the patient is expected to make *gains* in function by discharge, the code reported for Discharge Goal will be higher than the patient's admission performance code.

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

Wash Upper Body Discharge Goal: The clinician reflects on 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 upper body washing. 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 LTCH 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/her 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: 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 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.

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

Example 3: Discharge Goal Code Is *Lower* than Admission Performance Code

The clinician determines that a patient with a progressive neurologic condition is expected to rapidly decline and that skilled therapy services may slow the decline of function. In this scenario, the discharge goal code is lower than the patient's admission performance code.

Toileting Hygiene: Mrs. T's participation in skilled therapy is expected to slow down the pace of her anticipated functional deterioration. The patient's *discharge goal* code will be lower than the *admission performance* code.

Toileting Hygiene Admission Performance: Mrs. T has a progressive neurological illness that affects her strength, coordination, and endurance. Mrs. T prefers to use a bedside commode for as long as possible rather than using incontinence undergarments. The certified nursing assistant currently supports Mrs. T while she is standing so that Mrs. T can release her hand from the grab bar (next to her bedside commode) and pull down her underwear before sitting onto the bedside commode. When Mrs. T has finished voiding, she wipes her perineal area. Mrs. T then requires the helper to support her trunk while Mrs. T pulls up her underwear. The clinician codes the admission performance as 03, Partial/moderate assistance. The certified nursing assistant provides less than half the effort for Mrs. K's toileting hygiene.

Toileting Hygiene Discharge Goal: By discharge, it is expected that Mrs. T will need assistance with toileting hygiene and that the helper will perform more than half the effort. The clinician codes her discharge goal as 02, Substantial/maximal assistance.

GG0170. Mobility (3-day assessment period)

Section GG	Functional Abilities and Goals

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. Use of codes 07, 09, 10, or 88 is permissible to code discharge goal(s).

Coding:
Safety and **Quality of Performance** - If helper assistance is required because patient's performance is unsafe or of poor quality, score according to amount of assistance provided.

Activities may be completed with or without assistive devices.

06. **Independent** - Patient completes the activity by 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 and/or touching/steadying and/or contact guard assistance as patient completes activity. Assistance may be provided throughout the activity or intermittently.
03. **Partial/moderate assistance** - Helper does LESS THAN HALF the effort. Helper lifts, holds or supports trunk or limbs, but provides less than half the effort.
02. **Substantial/maximal assistance** - Helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs and provides more than half the effort.
01. **Dependent** - Helper does ALL of the effort. Patient does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the patient to complete the activity.

If activity was not attempted, code reason:
07. **Patient refused**
09. **Not applicable** - Not attempted and the patient did not perform this activity prior to the current illness, exacerbation, or injury.
10. **Not attempted due to environmental limitations** (e.g., lack of equipment, weather constraints)
88. **Not attempted due to medical condition or safety concerns**

1. Admission Performance	2. Discharge Goal	
↓ Enter Codes in Boxes ↓		
☐☐	☐☐	**A. Roll left and right:** The ability to roll from lying on back to left and right side, and return to lying on back on the bed.
☐☐	☐☐	**B. Sit to lying:** The ability to move from sitting on side of bed to lying flat on the bed.
☐☐	☐☐	**C. Lying to sitting on side of bed:** The ability to move from lying on the back to sitting on the side of the bed with feet flat on the floor, and with no back support.
☐☐	☐☐	**D. Sit to stand:** The ability to come to a standing position from sitting in a chair, wheelchair, or on the side of the bed.
☐☐	☐☐	**E. Chair/bed-to-chair transfer:** The ability to transfer to and from a bed to a chair (or wheelchair).
☐☐	☐☐	**F. Toilet transfer:** The ability to get on and off a toilet or commode.
☐☐	☐☐	**I. Walk 10 feet:** Once standing, the ability to walk at least 10 feet in a room, corridor, or similar space. *If admission performance is coded 07, 09, 10, or 88 → Skip to GG0170Q1, Does the patient use a wheelchair and/or scooter?*
☐☐	☐☐	**J. Walk 50 feet with two turns:** Once standing, the ability to walk 50 feet and make two turns.

(continued)

1. Admission Performance	2. Discharge Goal	
↓ Enter Codes in Boxes ↓		
☐☐	☐☐	**K. Walk 150 feet:** Once standing, the ability to walk at least 150 feet in a corridor or similar space.
	☐	**Q1. Does the patient use a wheelchair and/or scooter?** **0. No** → *Skip to H0350, Bladder Continence* **1. Yes** → *Continue to GG0170R, Wheel 50 feet with two turns*
☐☐	☐☐	**R. Wheel 50 feet with two turns:** Once seated in wheelchair/scooter, the ability to wheel at least 50 feet and make two turns.
	☐	**RR1. Indicate the type of wheelchair or scooter used.** **1. Manual** **2. Motorized**
☐☐	☐☐	**S. Wheel 150 feet:** Once seated in wheelchair/scooter, the ability to wheel at least 150 feet in a corridor or similar space.
	☐	**SS1. Indicate the type of wheelchair or scooter used.** **1. Manual** **2. Motorized**

Item Rationale

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

Steps for Assessment

1. Assess the patient's mobility performance based on direct observation, as well as the patient's self-report, and reports from clinicians, care staff, or family documented in the patient's medical record during the 3-day assessment period. CMS anticipates that an interdisciplinary team of clinicians is involved in assessing the patient 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 the patient's performance is unsafe or of poor quality, score according to the 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. Refer to facility, Federal, and State policies and procedures to determine which LTCH staff members may complete an assessment. Patient assessments are to be done in compliance with facility, Federal, and State requirements.

DEFINITION

Usual performance
A patient's functional status can be impacted by the environment or situations encountered at the facility. Observing the patient's interaction with others in different locations and circumstances is important for a comprehensive understanding of the patient's functional status. If the patient's 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.

Assessment period: The 3-day assessment period for the admission assessment includes the day of admission and the 2 days following the day of admission, ending at 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 admission functional assessment, when possible, should occur prior to the patient benefiting from treatment interventions in order to determine the patient's true admission baseline status. Even if treatment started on the day of admission, a baseline functional status assessment can still be conducted. Treatment should not be withheld in order to conduct the functional assessment. The discharge assessment period includes the day of discharge and the 2 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.

Coding Instructions

Complete only if A0250 = 01 Admission or A0250 = 10 Planned 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 setup of a leg lifter or other assistive devices.
- **Code 04, Supervision or touching assistance,** if the helper provides verbal cues and/or touching/steadying and/or contact guard assistance as patient completes activity. Assistance may be provided throughout the activity or intermittently. 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.
- **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 attempt to perform the activity and did not perform this activity prior to the current illness, exacerbation, or injury.

- **Code 10, Not attempted due to environmental limitations,** if the patient did not attempt this activity due to environmental limitations. Examples include lack of equipment, and weather constraints.
- **Code 88, Not attempted due to medical condition or safety concerns,** if the activity was not attempted due to medical condition or safety concerns.

Admission and Discharge Performance Coding Tips

General coding tips:

- When reviewing the patient's medical record, interviewing staff, and observing the patient, be familiar with the definition for each 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.
- The assessment timeframe is 3 calendar days. During the assessment time frame, some activities may be performed by the patient multiple times, whereas other activities may only occur once.
- Licensed clinicians may assess the patient's performance based on direct observation as well as reports from patient's self-report, clinicians, care staff, or family during the 3-day assessment period. We anticipate that a multidisciplinary team of clinicians is involved in assessing the patient during the 3-day assessment period.
- To clarify your own understanding of the patient's performance of an activity, ask direct care staff probing questions about the patient's abilities, beginning with the general and proceeding to the more specific. See examples of using probing questions when talking with staff at the end of this section.
- Patients with cognitive impairments/limitations may need physical and/or verbal assistance when completing an activity. Code based on the patient's need for assistance to perform the activity safely (for example, choking risk due to rate of eating, amount of food placed into mouth, risk of falling).
- If the patient does not attempt the activity and a helper does not complete the activity for the patient during the entire 3-day assessment period, code the reason the activity was not attempted. For example, code as 07 if the patient refused to attempt the activity during the entire 3-day assessment period, code as 09 if the activity is not applicable for the patient (the activity did not occur at the time of the assessment, and prior to the current illness, injury, or exacerbation), code as 10 if the patient was not able to attempt the activity due to environmental limitations, or code as 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 in completing the activity, code as 01, Dependent.
- A dash (–) indicates *"No information."* CMS expects dash use to be a rare occurrence.
- 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

patient'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 performance:

- When coding the patient's usual performance and the patient's discharge goal(s), use the 6-point scale, or one of the four "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.
- Code based on the patient's performance. Do not record the care staff's assessment of the patient's potential capability to perform the activity.
- 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.
- If the helper needs to retrieve the device/adaptive equipment, such as a walker or cane for walking, then enter code 05, Setup or clean-up assistance.
- Assess the patient's mobility performance based on direct observation, as well as the patient self-report and reports from clinicians, care staff, or family documented in the patient's medical record during the 3-day assessment period. CMS anticipates that an interdisciplinary team of clinicians is involved in assessing the patient during the 3-day assessment period.
- 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 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 tip for patients with incomplete stays due to an unplanned discharge:

- The mobility items are not included on the Unplanned Discharge Assessment or the Expired Assessment.

Examples and Specific Coding Tips for Admission Performance or Discharge Performance

Note: The following are coding examples and coding tips for each Mobility 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 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 condition or safety concerns. This can include patient refused due to intolerable pain for any tasks required of the activity.

Examples for GG0170A, Roll left and right

1. **Roll left and right:** Mr. R has a history of skin breakdown. A 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. Mr. R 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, Mr. R 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.

   Rationale: The nurse provides more than half of the effort needed for the patient to complete the activity of rolling left and right. This is because the nurse provided physical assistance to move Mr. R's body weight to turn onto his right side. The nurse provided the same assistance when Mr. R turned to his left side and when he returned to his back. Mr. R was able to return to lying on his back from his right side by himself.

2. **Roll left and right:** A physical therapist helps Mr. K turn onto his right side by instructing him to bend his left leg and roll onto his right side. He then instructs him on 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. K completes the activity without physical assistance from the physical therapist.

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

   Rationale: The physical therapist provides verbal cues (i.e., instructions) to Mr. K as he rolls from his back to his right side and returns to lying on his back, and then again as he performs the same activities with respect to his left side. 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. He requires the assistance of two certified nursing assistants when rolling onto his right side and returning to lying on his back and also when 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 are needed to help Mr. Z roll onto his left and right side and back while in bed.

4. **Roll left and right:** Mr. M fell and sustained left shoulder contusions and a fractured left hip and underwent an open reduction internal fixation of the left hip. A physician's order allows

him to roll onto his left hip as tolerated. A certified nursing assistant assists Mr. M rolling onto his right side by instructing him to bend his left leg while rolling to his right side. Mr. M needs physical assistance from the certified nursing assistant to initiate his rolling right because of his left arm weakness when grasping the right bedrail to assist in rolling. Mr. M 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 provides less than half the effort needed for the patient to complete the activity of rolling left and right.

Coding Tip for GG0170B, Sit to Lying

- If the clinician determines that bed mobility cannot be assessed because of the degree to which the head of the bed must be elevated because of a medical condition, then code the activities GG0170A, Roll left and right, GG0170B, Sit to lying, and GG0170C, Lying to sitting on side of bed, as 88, Not attempted due to medical condition or safety concern.

Examples for GG0170B, Sit to lying

1. **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; the helper performs less than half of the effort.

2. **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 provides more than half the effort for the patient to complete the activity of sit to lying.

3. **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 when 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 is 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.

4. **Sit to lying and Lying to sitting:** Ms. M has Multiple Sclerosis and a swallowing disorder. A medical order requires the head of her bed to be **slightly elevated** at all times and serves as her lying position. Ms. M needs help to transition from sitting to lying and lying to sitting. For sit to lying, the certified nursing assistant lifts and swivels Ms. M's legs from the side of the bed to the middle of the bed while simultaneously supporting and lifting her trunk. The certified nursing assistant then provides the same amount of assistance while Ms. M moves from a lying to sitting position. In both transitions, Ms. M assists by scooting herself toward the middle or toward edge of the bed. She begins or ends the activities by balancing herself while sitting at the edge of the bed with her feet on the floor.

   Coding: GG0170B, Sit to lying, and GG0170C. Lying to sitting on side of bed would be coded 02, Substantial, maximal assistance.

   Rationale: The helper completes more than half the effort in transitioning the patient from sitting to lying and lying to sitting on the side of the bed. The patient scoots toward the middle of the bed or toward the edge of the bed for each of these activities.

Coding Tips for GG0170C, Lying to sitting on side of bed

- The activity includes patient transitions from lying on his or her back to sitting on the side of the bed with his or her feet flat on the floor and sitting upright on the bed without back support. The patient's ability to perform each of the tasks within this activity and how much support the patient requires to complete the tasks within this activity is assessed.
- For item GG0170C, Lying to sitting on side of bed, clinical judgment should be used to determine what is considered a "lying" position for a particular patient.
- If the patient's feet do not reach the floor upon lying to sitting, the clinician will determine if a bed height adjustment is required to accommodate foot placement on the floor.
- Back support refers to an object or person providing support for the patient's back.
- If the clinician determines that bed mobility cannot be assessed because of the degree to which the head of the bed must be elevated because of a medical condition, then code the activities GG0170A, Roll left and right, GG0170B, Sit to lying, and GG0170C, Lying to sitting on side of bed, as 88, Not attempted due to medical condition or safety concern.

Examples for GG0170C, Lying to sitting on side of bed

1. **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.

2. **Lying to sitting on side of bed:** Mr. B pushes up on the bed to attempt to get himself from a lying to sitting position as the occupational therapist provides much of the lifting assistance necessary for him to sit upright. 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.

3. **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.

4. **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 completes the activity of lying to sitting on the side of bed for the patient.

Coding Tips for GG0170D, Sit to stand

- If a mechanical lift is used to assist in transferring a patient for a chair/bed-to-chair transfer, and the patient is not able to complete Sit to stand due to medical condition or safety issues, then GG0170D, Sit to stand would be coded 88, Not attempted due to medical condition or safety issues. However, if the patient did not attempt to perform sit to stand during the assessment and did not perform this activity prior to the current illness, exacerbation, or injury, then use code 09, Not applicable.
- If a sit to stand lift is used and two helpers are needed to assist with the sit-to-stand lift, then code as 01, Dependent.

Examples for GG0170D, Sit to stand

1. **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.

2. **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.

3. **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.

4. **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 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 provides lifting assistance and more than half of the effort for the patient to complete the activity of sit to stand.

Coding Tips for GG0170E, Chair/bed-to-chair transfer

- Item GG0170E, Chair/bed-to-chair transfer, begins with the patient sitting in a chair or wheelchair or sitting upright at the edge of the bed and returning to sitting in a chair or wheelchair or sitting upright at the edge of the bed. The activities of GG0170B, Sit to lying and GG0170C, Lying to sitting on side of bed are two separate activities that are not assessed as part of GG0170E.
- If a mechanical lift is used to assist in transferring a patient for a chair/bed-to-chair transfer and two helpers are needed to assist with the mechanical lift transfer, then code as 01, Dependent, even if the patient assists with any part of the chair/bed-to-chair transfer.
- If a patient performs a stand pivot transfer due to inability to fully stand upon rising and instead rises to a squat, then pivots, turns and sits, this style of chair/bed-to-chair transfer

is acceptable and should be coded based upon the amount of assistance required to perform this style of transfer.

Examples for GG0170E, Chair/bed-to-chair transfer

1. **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.

2. **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.

3. **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 complete 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.

4. **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 with weight-bearing assistance. Once standing, Ms. P shuffles her feet, turns, and slowly sits down into the wheelchair with the therapist providing trunk support with weight-bearing assistance. 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 provides less than half of the effort for the patient to complete the activity of chair/bed-to-chair transfer.

Coding Tips for GG0170F, Toilet transfer

- Toilet transfer includes the patient's ability to get on and off a toilet (with or without a raised toilet seat), or bedside commode. Do not consider or include GG0130C, Toileting hygiene item tasks (managing clothing, undergarments, or perineal hygiene) when assessing the Toilet transfer item. Transferring on and off a bedpan is not included in Toilet transfer.
- If the patient usually needs a helper to position/set-up the bedside commode before and/or after the patient's bed to commode transfers (place at an accessible angle/location next to the bed) and the patient does not need helper assistance during Toilet transfers, then use code 05, Setup or clean-up assistance.

Examples for GG0170F, Toilet transfer

1. **Toilet transfer:** The certified nursing assistant moves the wheelchair foot rests up so that Ms. T can transfer from the wheelchair 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 from the toilet back to the wheelchair, 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.

2. **Toilet transfer:** Mrs. Q transfers on 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 on and off the toilet. The patient may use an assistive device.

3. **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 on and off the toilet.

4. **Toilet transfer:** The certified nursing assistant provides steadying (touching) assistance as Mrs. Z lowers her underwear and then transfers onto the toilet. After voiding, Mrs. Z cleanses herself. She then stands up as the helper steadies her, and 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 steadying assistance as the patient transfers on 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.

5. **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.

6. **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. Ms. W contributes less than half of the effort to transfer onto the toilet.

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

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

7. **Toilet transfer:** Mr. H has paraplegia incomplete, pneumonia, and chronic obstructive pulmonary disease (COPD). Mr. H 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 requires the assistance of two or more helpers for the patient to complete the activity.

8. **Toilet transfer:** Mrs. S is on bedrest due to a newly acquired medical complication. She uses a bedpan for bladder and bowel management during the entire 3-day assessment period.

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

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

Coding Tips for Walking Items

- Walking activities do not need to occur during one session. Allowing a patient to rest between activities or completing activities at different times during the day or on different days may facilitate completion of the activities.

- When coding GG0170 walking items, **do not** consider the patient's mobility performance when using parallel bars. Parallel bars are not a portable assistive device. If safe, assess and code walking using a portable walking device.
- The turns included in the items GG0170J (walking 50 feet with two 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).

Examples for GG0170I, Walk 10 feet

1. **Walk 10 feet:** Mrs. C has resolving sepsis and has not walked in 3 weeks because of her medical condition. A physical therapist determines that it is unsafe for Mrs. C to use a walker, and the patient only walks using the parallel bars. On day 3 of the Admission assessment period, Mrs. C walks 10 feet using the parallel bars while the therapist provides substantial weight-bearing support throughout the activity.

   Coding: GG0170I, Walk 10 feet, would be coded 88, Not attempted due to medical condition or safety concerns.

   Rationale: When assessing a patient for GG0170, walking items, do not consider walking in parallel bars, as parallel bars are not a portable assistive device. If the patient is unable to walk without the use of parallel bars because of his or her medical condition or safety concerns, use code 88, Activity not attempted due to medical condition or safety concerns.
   Since GG0170I, Walk 10 feet, is coded 88, follow the skip pattern to GG0170Q1 (admission) or GG0170Q3 (planned discharge), Does the patient use a wheelchair and/or scooter?

2. **Walk 10 feet:** Mr. L had bilateral amputations 3 years ago, and prior to the current admission he used a wheelchair and did not walk. Currently Mr. L does not use prosthetic devices and uses only a wheelchair for mobility. Mr. L's care plan includes fitting and use of bilateral lower extremity prostheses.

   Coding: GG0170I, Walk 10 feet, would be coded 09, Not applicable – Not attempted and the patient did not perform this activity prior to the current illness, exacerbation, or injury.

   Rationale: When assessing a patient for GG0170I, Walk 10 feet, consider the patient's status prior to the current episode of care and current 3-day assessment status. Use code 09, Not applicable, because Mr. L did not walk prior to the current episode of care and did not walk during the 3-day assessment period.
   Because GG0170I, Walk 10 feet, is coded 09, follow the skip pattern to GG0170Q1 (admission) or GG0170Q3 (planned discharge), Does the patient use a wheelchair and/or scooter?
   Mr. L's care plan includes fitting and use of bilateral prostheses and walking as a goal. A discharge goal for any admission performance item skipped may be entered if a discharge goal is determined as part of the patient's care plan.

3. **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 helper assists Mrs. C by providing 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.

4. **Walk 10 feet:** Mr. O has bilateral upper extremity tremors, lower extremity weakness, and Parkinson's disease. The therapy assistant guides and steadies the 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 provides less than half the effort required for the patient to complete the activity, Walk 10 feet. While the helper guided and steadied the walker during the walk, Mr. O supported his own body weight with his arms and legs and propelled his legs forward for 8 of the 10 feet. The helper only supported part of Mr. O's weight 2 of the 10 feet, thus Mr. O did more than half the effort.

5. **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 while walking. The nurse places his hand on Mrs. U's back to steady her toward the last half of her 10-foot walk.

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

   Rationale: A helper provides touching assistance in order for the patient to complete the activity of Walk 10 feet. Assistance in donning the stump stock, prosthesis, and getting from a sitting to standing position is not coded as part of the Walk 10 feet item.

Examples for GG0170J, Walk 50 feet with two turns

1. **Walk 50 feet with two turns:** Mr. B is recovering from a stroke and has difficulty walking. He is able to walk only 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 GG0170I, Walk 10 feet.

2. **Walk 50 feet with two turns:** A therapist provides contact guard (steadying) 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).

3. **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 makes two turns. The patient may use an assistive device.

4. **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, the helper supports her trunk and provides less than half the effort.

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

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

5. **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 when provided with the assistance of two helpers.

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

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

6. **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 provides more than half of the effort for the patient to complete the activity of Walk 50 feet with two turns. Assistance with rising from a seated position to standing is not considered when coding this walking item.

Examples for GG0170K, Walk 150 feet

1. **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.

2. **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. The patient did not complete the activity, and a helper did not complete the activity for the patient. A patient who walks less than 50 feet would be coded in item GG0170I, Walk 10 feet.

Coding Tips for Wheelchair Items

- The intent of the wheelchair mobility items is to assess the ability of patients who are learning how to self-mobilize using a wheelchair or those who used a wheelchair prior to admission. Use clinical judgment to determine whether a patient's use of a wheelchair is for self-mobilization as a result of the patient's medical condition or safety, or used for convenience.
- Do not code wheelchair mobility if the patient uses a wheelchair only when transported between locations within the facility for staff convenience (e.g. because the patient walks slowly). Only code wheelchair mobility based on an assessment of the patient's ability to mobilize in the wheelchair.
- If the patient walks and is not learning how to mobilize in a wheelchair, and only uses a wheelchair for transport between locations within the facility, code the wheelchair gateway items at admission and/or discharge—GG0170Q1 and/or GG0170Q3, Does the patient use a wheelchair/scooter?—as 0, No, and skip all remaining wheelchair questions.
- Admission assessment for wheelchair items should be coded for patients who used a wheelchair prior to admission.
- The responses for gateway admission and discharge wheelchair items (GG0170Q1 and GG0170Q3) do not have to be the same on the Admission and Discharge assessments.
- If a wheelchair is used for transport purposes only, then GG0170Q1 and/or GG0170Q3, Does the patient use a wheelchair or scooter is coded as 0, No, then follow the skip pattern to continue coding the assessment.
  - Example of using a wheelchair for transport convenience: A patient is transported in a wheelchair by staff between her room and the therapy gym or by family to the facility cafeteria, but the patient is not expected to use a wheelchair after discharge.
- The turns included in the items GG0170R (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.

Example for GG0170Q1, Does the patient use a wheelchair/scooter?

1. **Does the patient use a wheelchair/scooter?** On admission, Mr. T wheels himself using a manual wheelchair, but with difficulty due to his severe osteoarthritis and COPD. Item GG0170Q1, Does the patient use a wheelchair/scooter? will be coded 1, Yes.

   Coding: GG0170Q1, Does the patient use a wheelchair/scooter? would be coded 1, Yes. The admission performance codes for wheelchair items GG0170R and GG0170S are coded; in addition, the type of wheelchair Mr. T uses for GG0170RR1 and RR2 is indicated as code 1, Manual. If wheelchair goal(s) are clinically indicated, then wheelchair goals can be coded.

   Rationale: The patient currently uses a wheelchair. Coding all and coding the type of wheelchair (manual) is indicated. Wheeling goal(s) if clinically indicated may be coded.

Examples for GG0170R, Wheel 50 feet with two turns, and GG0170RR, Indicate the type of wheelchair or scooter used

1. **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.

2. **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 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 provides less than half of the effort for the patient to complete the activity, Wheel 50 feet with two turns.

3. **Wheel 50 feet with two turns:** Once seated in the manual wheelchair, Ms. R wheels about 10 feet, and 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 to complete the activity, Wheel 50 feel with two turns.

4. **Indicate the type of wheelchair or scooter used**. Patients may use a manual wheelchair or motorized wheelchair/scooter to accomplish mobilizing different distances. In example 3, Ms. R used a manual wheelchair during the 3-day assessment period.

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

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

Examples for GG0170S, Wheel 150 feet, and GG0170SS, Indicate the type of wheelchair or scooter used

1. **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). The length of the hallway is at least 150 feet.

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

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

2. **Indicate the type of wheelchair or scooter used.** In example 1, Mr. G always used 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: GG170SS, Indicate the type of wheelchair or scooter used, would be coded 2, Motorized.

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

3. **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 in the community. Mr. L is assessed performing the activity of mobilizing 150 feet in his wheelchair. A helper is needed to provide verbal cues for safety due to vision impairments.

   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.

4. **Wheel 150 feet:** Mr. P has multiple sclerosis, resulting in extreme muscle weakness and minimal vision impairment. Mr. P 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.

Examples for Unplanned Discharge

1. **Unplanned discharge:** Mr. C was admitted to the LTCH with healing, complex, post-surgery open reduction internal fixation fractures and sepsis. However, complications during the LTCH stay arise and Mr. C is unexpectedly hospitalized, resulting in his discharge from the LTCH.

   Coding: No discharge self-care or mobility data are reported.

   Rationale: The unplanned discharge assessment will be completed, and no discharge self-care or mobility data are reported as these data elements are not on the Unplanned Discharge Assessment.

2. **Unplanned discharge:** Mrs. A began to show signs and symptoms of a stroke while at the LTCH. Mrs. A was transferred to an emergency department of an acute hospital to diagnose and stabilize her. It was determined that an acute care admission was required based on the emergency department evaluation of Mrs. A, and she was discharged from the LTCH.

   Coding: No discharge self-care or mobility data are reported.

   Rationale: The unplanned discharge assessment will be completed, and no discharge self-care or mobility data are reported, as these data elements are not on the Unplanned Discharge Assessment.

3. **Unplanned discharge:** Mr. S was discussing the discharge plans with the LTCH discharge planner and voiced his intent to leave the LTCH despite the physician's recommendation to remain in the LTCH for continued treatment. The nursing staff and physician were made aware of his imminent intent to leave by the LTCH discharge planner. The patient, with the assistance of his family, promptly left the LTCH, leaving against medical advice. The staff was not able to conduct a discharge assessment for the patient due to his sudden decision to leave the LTCH.

   Coding: No discharge self-care or mobility data are reported.

   Rationale: The Unplanned Discharge Assessment will be completed, and no discharge self-care or mobility data are reported, as these data elements are not on the Unplanned Discharge Assessment.

4. **Unplanned discharge:** Mr. T voiced his discontent with his physician and the nursing staff at the LTCH facility where he was receiving chemotherapy. The patient refused all alternative treatment options presented and unexpectedly chose to forego all further treatment and return home. The staff was not able to conduct a discharge assessment of the patient due to his sudden decision to leave the LTCH.

   Coding: No discharge self-care or mobility data are reported.

   Rationale: The unplanned discharge assessment will be completed, and no discharge self-care or mobility data are reported, as these data elements are not on the Unplanned Discharge Assessment.

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."

   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 lie 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.

   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 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."

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 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 that is more than half the effort 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."

    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.

Discharge Goal: Coding Tips

- Discharge Goal(s) is (are) coded with each Admission assessment.
- A minimum of one self-care or mobility discharge goal must be coded. However, facilities may choose to code more than one self-care or mobility discharge goal. Code the patient's discharge goal(s) using the 6-point scale. Use of the "activity was not attempted" codes (07, 09, 10, and 88) is permissible to code discharge goal(s). Use of a dash is permissible for any remaining self-care or mobility goals that were not coded. Using the dash in this allowed instance after the coding of at least one goal does not affect APU determination.
- Licensed clinicians can establish a patient's discharge goal(s) at the time of admission based on the patient's prior medical condition, admission assessment self-care and mobility status, discussions with the patient and family, professional judgment, the professional's standard of practice, expected treatments, the patient's motivation to improve, anticipated length of stay, and the patient's discharge plan. Goals should be established as part of the patient's care 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 entered using the 6-point scale if the patient is expected to be able to perform the activity by discharge.
- If the patient is in the LTCH for less than 3 calendar days, for Self-Care and Mobility Discharge Goals, a minimum of one self-care or mobility goal must be coded per patient stay on the LTCH CARE Data Set. Code at least one goal to the best of your ability based on the predicted plan of care for the patient.

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