

SECTION GG: FUNCTIONAL ABILITIES AND GOALS

Intent: This section includes items about functional abilities and goals. It includes items focused on prior function, 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 resident's usual ability with everyday activities prior to the current illness, exacerbation, or injury Complete only if A0310B = 01	
Coding: 3. Independent - Resident completed the activities by him/herself, with or without an assistive device, with no assistance from a helper. 2. Needed Some Help - Resident needed partial assistance from another person to complete activities. 1. Dependent - A helper completed the activities for the resident. 8. Unknown. 9. Not Applicable.	<div style="text-align: center;">↓ Enter Codes in Boxes</div> <div style="display: flex; align-items: center;"> <input style="width: 30px; height: 30px; margin-right: 10px;" type="checkbox"/> <div style="flex-grow: 1;"> <p>A. Self-Care: Code the resident's need for assistance with bathing, dressing, using the toilet, or eating prior to the current illness, exacerbation, or injury.</p> <p>B. Indoor Mobility (Ambulation): Code the resident'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.</p> <p>C. Stairs: Code the resident's need for assistance with internal or external stairs (with or without a device such as cane, crutch, or walker) prior to the current illness, exacerbation, or injury.</p> <p>D. Functional Cognition: Code the resident's need for assistance with planning regular tasks, such as shopping or remembering to take medication prior to the current illness, exacerbation, or injury.</p> </div> </div>

Item Rationale

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

Steps for Assessment

- Ask the resident or his or her family about, or review the resident's medical records describing, the resident's prior functioning with everyday activities.

Coding Instructions

- Code 3, Independent:** if the resident 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 resident needed partial assistance from another person to complete the activities.
- Code 1, Dependent:** if the helper completed the activities for the resident, or the assistance of two or more helpers was required for the resident to complete the activities.
- Code 8, Unknown:** if the resident'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 resident prior to the current illness, exacerbation, or injury.

GG0100. Prior Functioning: Everyday Activities (cont.)

Coding Tips

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

Examples for Coding Prior Functioning: Everyday Activities

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

Coding: GG0100A would be coded 3, Independent.

Rationale: Prior to her hip fracture, the resident completed the self-care tasks of eating, bathing, dressing, and using the toilet safely without any assistance from a helper. The resident may use an assistive device, such as a raised toilet seat, and still be coded as independent.

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

Coding: GG0100A would be coded 2, Needed Some Help.

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

3. **Self-Care:** Mr. R was diagnosed with a progressive neurologic condition five years ago. He lives in a long-term nursing facility and was recently hospitalized for surgery and has now been admitted to the SNF for skilled services. According to Mr. R's wife, prior to the surgery, Mr. R required complete assistance with self-care activities, including eating, bathing, dressing, and using the toilet.

Coding: GG0100A would be coded 1, Dependent.

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

GG0100. Prior Functioning: Everyday Activities (cont.)

4. **Self-Care:** Mr. F was admitted with a diagnosis of stroke and a severe communication disorder and is unable to communicate with staff using alternative communication devices. Mr. F had been living alone prior to admission. The staff has not been successful in contacting either Mr. F's family or his friends. Mr. F's prior self-care abilities are unknown.

Coding: GG0100A would be coded 8, Unknown.

Rationale: Attempts to seek information regarding Mr. F's prior functioning were made; however, no information was available. This item is coded 8, Unknown.

5. **Indoor Mobility (Ambulation):** Mr. C was admitted to an acute care hospital after experiencing a stroke. Prior to admission, he used a cane to walk from room to room. In the morning, Mr. C's wife would provide steadying assistance to Mr. C when he walked from room to room 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 would be coded 2, Needed Some Help.

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

6. **Indoor Mobility (Ambulation):** Approximately three months ago, Mr. K had a cardiac event that resulted in anoxia, and subsequently a swallowing disorder. Mr. K has been living at home with his wife and developed aspiration pneumonia. After this most recent hospitalization, he was admitted to the SNF for *a diagnosis of* aspiration pneumonia and severe deconditioning. Prior to the most recent acute care hospitalization, Mr. K needed some assistance when walking.

Coding: GG0100B would be coded 2, Needed Some Help.

Rationale: While the resident experienced a cardiac event three months ago, he recently had an exacerbation of a prior condition that required care in an acute care hospital and skilled nursing facility. The resident's prior functioning is based on the time immediately before his most recent condition exacerbation that required acute care.

7. **Indoor Mobility (Ambulation):** Mrs. L had a stroke one year ago that resulted in her using a wheelchair to self-mobilize, as she was unable to walk. Mrs. L subsequently had a second stroke and was transferred from an acute care unit to the SNF for skilled services.

Coding: GG0100B would be coded 9, Not Applicable.

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

GG0100. Prior Functioning: Everyday Activities (cont.)

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

Coding: GG0100C would be coded 2, Needed Some Help.

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

9. **Stairs:** Mrs. E lived alone prior to her hospitalization for sepsis and has early stage multiple sclerosis. She has now been admitted to a SNF for rehabilitation as a result of deconditioning. Mrs. E reports that she used a straight cane to ascend and descend her indoor stairs at home and small staircases within her community. Mrs. E reports that she did not require any human assistance with the activity of using stairs prior to her admission.

Coding: GG0100C would be coded 3, Independent.

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

10. **Stairs:** Mr. P has expressive aphasia and difficulty communicating. SNF staff have not received any response to their phone messages to Mr. P's family members requesting a return call. Mr. P has not received any visitors since his admission. The medical record from his prior facility does not indicate Mr. P's prior functioning. There is no information to code item GG0100C, but there have been attempts at seeking this information.

Coding: GG0100C would be coded 8, Unknown.

Rationale: Attempts were made to seek information regarding Mr. P's prior functioning; however, no information was available.

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

Coding: GG0100D would be coded 2, Needed Some Help.

Rationale: Mr. K required some help to recall, perform, and plan regular daily activities as a result of cognitive impairment.

GG0100. Prior Functioning: Everyday Activities (cont.)

12. **Functional Cognition:** Ms. L recently sustained a brain injury from a fall at home. Prior to her recent hospitalization, she had been living in an apartment by herself. Ms. L's cognition is currently impaired. Ms. L's cousin, who had visited her frequently prior to her recent hospitalization, indicated that Ms. L did not require any help with taking her prescribed medications, planning her daily activities, and managing money when shopping.

Coding: GG0100D would be coded 3, Independent.

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

13. **Functional Cognition:** Mrs. R had a stroke, resulting in a severe communication disorder. Her family members have not returned phone calls requesting information about Mrs. R's prior functional status, and her medical records do not include information about her functional cognition prior to the stroke.

Coding: GG0100D would be coded 8, Unknown.

Rationale: Attempts to seek information regarding Mrs. R's prior functioning were made; however, no information was available.

GG0110. Prior Device Use

GG0110. Prior Device Use. Indicate devices and aids used by the resident prior to the current illness, exacerbation, or injury	
Complete only if A0310B = 01	
↓ Check all that apply	
<input type="checkbox"/>	A. Manual wheelchair
<input type="checkbox"/>	B. Motorized wheelchair and/or scooter
<input type="checkbox"/>	C. Mechanical lift
<input type="checkbox"/>	D. Walker
<input type="checkbox"/>	E. Orthotics/Prosthetics
<input type="checkbox"/>	Z. None of the above

Item Rationale

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

Steps for Assessment

- Ask the resident or his or her family or review the resident's medical records to determine the resident's use of prior devices and aids.

GG0110. Prior Device Use (cont.)

Coding Instructions

- Check all devices that apply.
- **Check Z, None of the above:** if the resident did not use any of the listed devices or aids immediately prior to the current illness, exacerbation, or injury.

Coding Tips

- For GG0110D, Prior Device Use - Walker: “Walker” refers to all types of walkers (for example, pickup walkers, hemi-walkers, rolling walkers, and platform walkers).
- GG0110C, Mechanical lift, includes sit-to-stand, stand assist, *stair lift*, and full-body-style lifts.

Example for Coding Prior Device Use

1. Mrs. M is a bilateral lower extremity amputee and has multiple diagnoses, including diabetes, obesity, and peripheral vascular disease. 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 would be checked.

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

GG0130: Self-Care (3-day assessment period) Admission (Start of Medicare Part A Stay)

GG0130. Self-Care (Assessment period is days 1 through 3 of the SNF PPS Stay starting with A2400B)

Complete only if A0310B = 01

Code the resident's usual performance at the start of the SNF PPS stay (admission) for each activity using the 6-point scale. If activity was not attempted at the start of the SNF PPS stay (admission), code the reason. Code the resident's end of SNF PPS stay (discharge) goal(s) using the 6-point scale. Use of codes 07, 09, 10, or 88 is permissible to code end of SNF PPS stay (discharge) goal(s).

Coding:

Safety and Quality of Performance - If helper assistance is required because resident'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** - Resident completes the activity by him/herself with no assistance from a helper.
- 05. **Setup or clean-up assistance** - Helper sets up or cleans up; resident 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 resident 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. Resident does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the resident to complete the activity.

If activity was not attempted, code reason:

- 07. **Resident refused**
- 09. **Not applicable** - Not attempted and the resident 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 ↓		
<input type="text"/>	<input type="text"/>	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 resident.
<input type="text"/>	<input type="text"/>	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.
<input type="text"/>	<input type="text"/>	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.
<input type="text"/>	<input type="text"/>	E. Shower/bathe self: The ability to bathe self, including washing, rinsing, and drying self (excludes washing of back and hair). Does not include transferring in/out of tub/shower.
<input type="text"/>	<input type="text"/>	F. Upper body dressing: The ability to dress and undress above the waist; including fasteners, if applicable.
<input type="text"/>	<input type="text"/>	G. Lower body dressing: The ability to dress and undress below the waist, including fasteners; does not include footwear.
<input type="text"/>	<input type="text"/>	H. Putting on/taking off footwear: The ability to put on and take off socks and shoes or other footwear that is appropriate for safe mobility; including fasteners, if applicable.

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

Interim Performance (Interim Payment Assessment - Optional)

GG0130. Self-Care (Assessment period is the last 3 days)	
Code the resident's usual performance for each activity using the 6-point scale. If an activity was not attempted, code the reason.	
<p>Coding:</p> <p>Safety and Quality of Performance - If helper assistance is required because resident's performance is unsafe or of poor quality, score according to amount of assistance provided.</p> <p><i>Activities may be completed with or without assistive devices.</i></p> <p>06. Independent - Resident completes the activity by him/herself with no assistance from a helper.</p> <p>05. Setup or clean-up assistance - Helper sets up or cleans up; resident completes activity. Helper assists only prior to or following the activity.</p> <p>04. Supervision or touching assistance - Helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity. Assistance may be provided throughout the activity or intermittently.</p> <p>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.</p> <p>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.</p> <p>01. Dependent - Helper does ALL of the effort. Resident does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the resident to complete the activity.</p> <p>If activity was not attempted, code reason:</p> <p>07. Resident refused</p> <p>09. Not applicable - Not attempted and the resident did not perform this activity prior to the current illness, exacerbation, or injury.</p> <p>10. Not attempted due to environmental limitations (e.g., lack of equipment, weather constraints)</p> <p>88. Not attempted due to medical condition or safety concerns</p>	
<p>5. Interim Performance</p> <p>Enter Codes in Boxes</p> <p>↓</p>	
<div style="border: 1px solid black; width: 40px; height: 20px; margin-bottom: 5px;"></div> <div style="border: 1px solid black; width: 40px; height: 20px; margin-bottom: 5px;"></div> <div style="border: 1px solid black; width: 40px; height: 20px;"></div>	<p>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 resident.</p>
	<p>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.</p>
	<p>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.</p>

GG0130: Self-Care (3-day assessment period) Discharge (End of Medicare Part A Stay)

GG0130. Self-Care (Assessment period is the last 3 days of the SNF PPS Stay ending on A2400C) Complete only if A0310G is not = 2 and A0310H = 1 and A2400C minus A2400B is greater than 2 and A2100 is not = 03	
Code the resident's usual performance at the end of the SNF PPS stay for each activity using the 6-point scale. If an activity was not attempted at the end of the SNF PPS stay, code the reason.	
Coding: Safety and Quality of Performance - If helper assistance is required because resident's performance is unsafe or of poor quality, score according to amount of assistance provided. <i>Activities may be completed with or without assistive devices.</i>	
06. Independent - Resident completes the activity by him/herself with no assistance from a helper. 05. Setup or clean-up assistance - Helper sets up or cleans up; resident 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 resident 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. Resident does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the resident to complete the activity.	
If activity was not attempted, code reason: 07. Resident refused 09. Not applicable - Not attempted and the resident 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	
3. Discharge Performance Enter Codes in Boxes ↓	
<input type="text"/> <input type="text"/>	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 resident.
<input type="text"/> <input type="text"/>	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.
<input type="text"/> <input type="text"/>	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.
<input type="text"/> <input type="text"/>	E. Shower/bathe self: The ability to bathe self, including washing, rinsing, and drying self (excludes washing of back and hair). Does not include transferring in/out of tub/shower.
<input type="text"/> <input type="text"/>	F. Upper body dressing: The ability to dress and undress above the waist; including fasteners, if applicable.
<input type="text"/> <input type="text"/>	G. Lower body dressing: The ability to dress and undress below the waist, including fasteners; does not include footwear.
<input type="text"/> <input type="text"/>	H. Putting on/taking off footwear: The ability to put on and take off socks and shoes or other footwear that is appropriate for safe mobility; including fasteners, if applicable.

Item Rationale

- During a Medicare Part A SNF stay, residents may have self-care limitations on admission. In addition, residents may be at risk of further functional decline during their stay in the SNF.

GG0130: Self-Care (3-day assessment period) Admission/*Interim*/Discharge (Start/*Interim*/End of Medicare Part A Stay) (cont.)

Steps for Assessment

1. Assess the resident's self-care performance based on direct observation, *incorporating* resident self-reports and reports from qualified clinicians, care staff, or family documented in the resident's medical record during the three-day assessment period. CMS anticipates that an interdisciplinary team of qualified clinicians is involved in assessing the resident during the three-day assessment period. For Section GG, the admission assessment period is the first three days of the Part A stay starting with the date in A2400B, the Start of Most Recent Medicare Stay. On admission, these items are completed only when A0310B = 01 (5-Day PPS assessment). *For the Interim Payment Assessment (A0310B=08), the assessment period for Section GG is the last 3 days (i.e., the ARD and two days prior).*
2. Residents should be allowed to perform activities as independently as possible, as long as they are safe.
3. For the purposes of completing Section GG, a "helper" is defined as facility staff who are direct employees and facility-contracted employees (e.g., rehabilitation staff, nursing agency staff). Thus, "helper" does not include individuals hired, compensated or not, by individuals outside of the facility's management and administration such as hospice staff, nursing/certified nursing assistant students, etc. Therefore, when helper assistance is required because a resident's performance is unsafe or of poor quality, consider only facility staff when scoring 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. The admission functional assessment, when possible, should be conducted prior to the *resident* benefitting from treatment interventions in order to *reflect the resident's* true *admission* baseline functional status. If treatment has started, for example, 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.
6. Refer to facility, Federal, and State policies and procedures to determine which staff members may complete an assessment. Resident assessments are to be done in compliance with facility, Federal, and State requirements.

DEFINITION

USUAL PERFORMANCE

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

QUALIFIED CLINICIAN

Healthcare professionals practicing within their scope of practice and consistent with Federal, State, and local law and regulations.

GG0130: Self-Care (3-day assessment period) Admission/*Interim*/Discharge (Start/*Interim*/End of Medicare Part A Stay) (cont.)

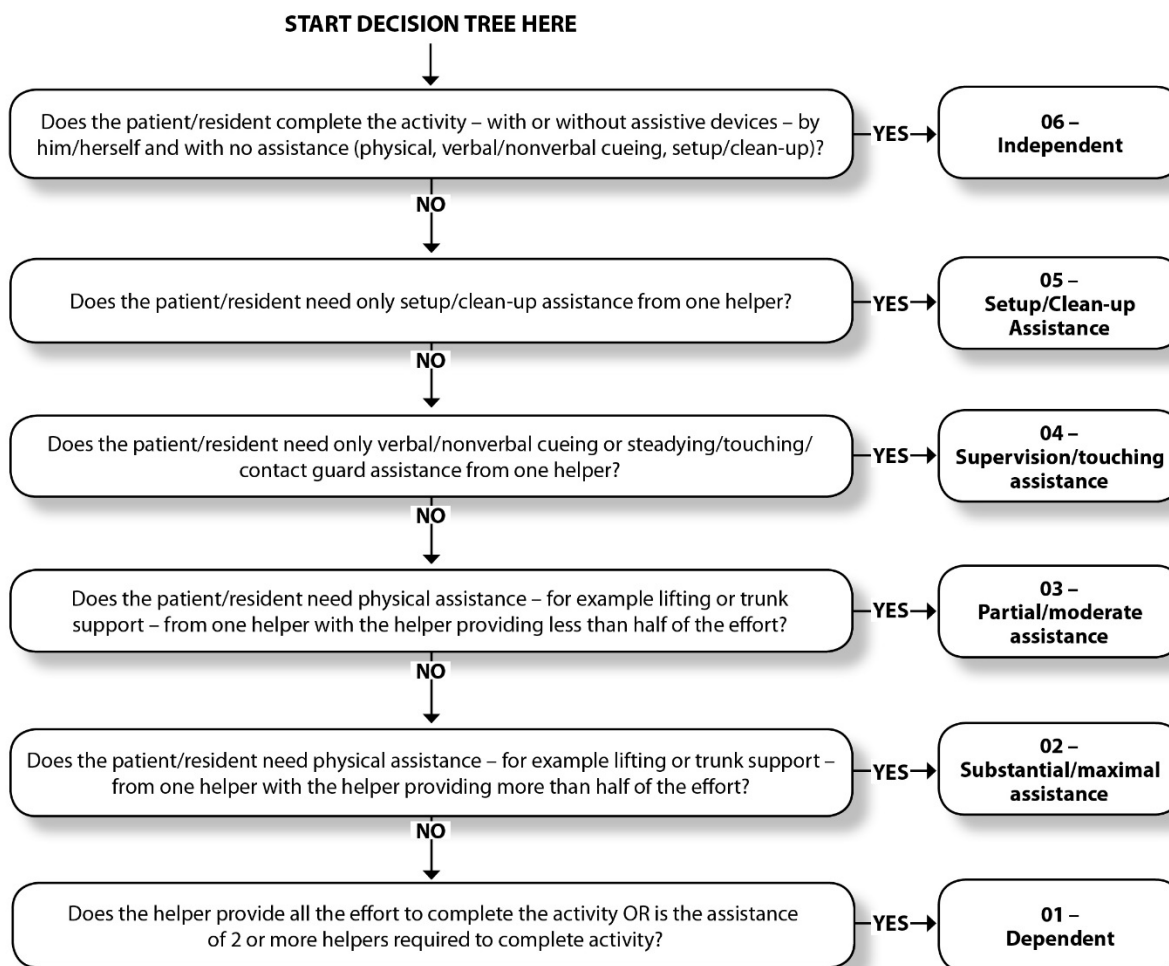
Admission, *Interim*, or Discharge Performance Coding Instructions

- When coding the resident's usual performance and discharge goal(s), use the six-point scale, or use one of the four "activity was not attempted" codes to specify the reason why an activity was not attempted.
- **Code 06, Independent:** if the resident 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; resident completes activity. Helper assists only prior to or following the activity, but not during the activity. For example, the resident 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 or touching/steadying/*contact guard* assistance as resident completes activity. Assistance may be provided throughout the activity or intermittently. For example, the resident requires verbal cueing, coaxing, or general supervision for safety to complete activity; or resident may require only incidental help such as contact guard or steadying assist during the activity.
- **Code 03, Partial/moderate assistance:** if the helper does LESS THAN HALF the effort. Helper lifts, holds, or supports trunk or limbs, but provides less than half the effort.
- **Code 02, Substantial/maximal assistance:** if the helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs and provides more than half the effort.
- **Code 01, Dependent:** if the helper does ALL of the effort. Resident does none of the effort to complete the activity; or the assistance of two or more helpers is required for the resident to complete the activity.
- **Code 07, Resident refused:** if the resident refused to complete the activity.
- **Code 09, Not applicable:** if the activity was not attempted and the resident did not perform this activity prior to the current illness, exacerbation, or injury.
- **Code 10, Not attempted due to environmental limitations:** if the resident 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.

GG0130: Self-Care (3-day assessment period) Admission/*Interim*/Discharge (Start/*Interim*/End of Medicare Part A Stay) (cont.)

Decision Tree

Use this decision tree to code the resident's performance on the assessment instrument. If helper assistance is required because the resident's performance is unsafe or of poor quality, score according to the amount of assistance provided. Only use the "activity not attempted codes" if the activity did not occur; that is, the resident did not perform the activity and a helper did not perform that activity for the resident.



GG0130: Self-Care (3-day assessment period) Admission/*Interim*/Discharge (Start/*Interim*/End of Medicare Part A Stay) (cont.)

Assessment Period

- **Admission:** The 5-Day PPS assessment (A0310B = 01) is the first Medicare-required assessment to be completed when the resident is admitted for a SNF Part A stay.
 - For the 5-Day PPS assessment, code the resident's functional status based on a clinical assessment of the resident's performance that occurs soon after the resident's admission. This functional assessment must be completed within the first three days (3 calendar days) of the Medicare Part A stay, starting with the date in A2400B, Start of Most Recent Medicare Stay, and the following two days, ending at 11:59 PM on day 3. The admission function scores are to reflect the resident's admission baseline status and are to be based on an assessment. The scores should reflect the resident's status prior to any benefit from interventions. The assessment should occur, when possible, prior to the resident benefitting from treatment interventions in order to determine the resident'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.
- ***Interim Performance (Optional):*** *The Interim Payment Assessment (IPA) is an optional assessment that may be completed by providers in order to report a change in the resident's PDPM classification. For Section GG on the IPA, providers will use the same 6-point scale and activity not attempted codes to complete the column "Interim Performance," which will capture the interim functional performance of the resident. The ARD for the IPA is determined by the provider, and the assessment period is the last 3 days (i.e., the ARD and the 2 calendar days prior). It is important to note that the IPA changes payment beginning on the ARD and continues until the end of the Medicare Part A stay or until another IPA is completed. The IPA does not affect the variable per diem schedule.*
- **Discharge:** The Part A PPS Discharge assessment is required to be completed when the resident's Medicare Part A Stay ends (as documented in A2400C, End of Most Recent Medicare Stay), either as a standalone assessment when the resident's Medicare Part A stay ends, but the resident remains in the facility; or may be combined with an OBRA Discharge if the Medicare Part A stay ends on the day of, or one day before the resident's Discharge Date (A2000). Please see Chapter 2 and Section A of the RAI Manual for additional details regarding the Part A PPS Discharge assessment.
 - For the Discharge assessment (i.e., standalone Part A PPS or combined OBRA/Part A PPS), code the resident's discharge functional status, based on a clinical assessment of the resident's performance that occurs as close to the time of the resident's discharge from Medicare Part A as possible. This functional assessment must be completed within the last three calendar days of the resident's Medicare Part A stay, which includes the day of discharge from Medicare Part A and the two days prior to the day of discharge from Medicare Part A.

GG0130: Self-Care (3-day assessment period) Admission/*Interim*/Discharge (Start/*Interim*/End of Medicare Part A Stay) (cont.)

Coding Tips: Admission, *Interim*, or Discharge Performance

General Coding Tips

- When reviewing the medical record, interviewing staff, and observing the resident, be familiar with the definition for each activity (e.g., eating, oral hygiene). For example, when assessing Eating (item GG0130A), determine the type and amount of assistance required to bring food and/or liquid to the mouth and swallow food and/or liquid once the meal is placed before the resident.
- Residents with cognitive impairments/limitations may need physical and/or verbal assistance when completing an activity. Code based on the resident'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 resident does not attempt the activity and a helper does not complete the activity for the resident during the entire assessment period, code the reason the activity was not attempted. For example, code as 07 if the resident refused to attempt the activity; code as 09 if the activity is not applicable for the resident (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 resident was not able to attempt the activity due to environmental limitations; or code as 88 if the resident was not able to attempt the activity due to medical condition or safety concerns.
- An activity can be completed independently with or without devices. If the resident uses adaptive equipment and uses the device independently when performing an activity, enter code 06, Independent.
- If two or more helpers are required to assist the resident to complete the activity, code as 01, Dependent.
- To clarify your own understanding of the resident's performance of an activity, ask probing questions to the care staff about the resident, beginning with the general and proceeding to the more specific. See examples of probing questions at the end of this section.
- 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 resident's medical record. This assessment can be conducted by appropriate healthcare personnel as defined by facility policy and in accordance with State and Federal regulations.

GG0130: Self-Care (3-day assessment period) Admission/*Interim*/Discharge (Start/*Interim*/End of Medicare Part A Stay) (cont.)

Tips for Coding the Resident's Usual Performance

- When coding the resident's usual performance, "effort" refers to the type and amount of assistance a helper provides in order for the activity to be completed. The six-point rating scale definitions include the following types of assistance: setup/cleanup, touching assistance, verbal cueing, and lifting assistance.
- Do not record the resident's best performance, and do not record the resident's worst performance, but rather record the resident's usual performance during the assessment period.
- Code based on the resident's performance. Do not record the staff's assessment of the resident's potential capability to perform the activity.
- If the resident performs the activity more than once during the assessment period and the resident's performance varies, coding in Section GG should be based on the resident's "usual performance," which is identified as the resident's usual activity/performance for any of the Self-Care or Mobility activities, not the most independent or dependent performance over the assessment period. Therefore, if the resident's Self-Care performance varies during the assessment period, report the resident's usual performance, not the resident's most independent performance and not the resident's most dependent performance. A provider may need to use the entire three-day assessment period to obtain the resident's usual performance.

Coding Tips for GG0130A, Eating

- *GG0130A, Eating involves bringing food and liquids to the mouth and swallowing food. The administration of tube feedings and parenteral nutrition is not considered when coding this activity. The following is guidance for some situations in which a resident receives tube feedings or parenteral nutrition:*
 - If the resident does not eat or drink by mouth and relies **solely** on nutrition and liquids through tube feedings or *total parenteral nutrition (TPN)* because of 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 Eating.
 - If the resident does not eat or drink by mouth at the time of the assessment, and the resident 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 resident did not perform this activity prior to the current illness, exacerbation, or injury. Assistance with tube feedings or *parenteral nutrition* is not considered when coding Eating.
 - If the resident eats and drinks by mouth, and relies **partially** on obtaining nutrition and liquids via tube feedings or *parenteral nutrition*, code Eating based on the amount of assistance the resident requires to eat and drink by mouth. Assistance with tube feedings or *parenteral nutrition* is not considered when coding Eating.

GG0130: Self-Care (3-day assessment period) Admission/*Interim*/Discharge (Start/*Interim*/End of Medicare Part A Stay) (cont.)

- If the resident eats finger foods using his or her hands, then code Eating based upon the amount of assistance provided. If the resident eats finger foods with his or her hands independently, for example, the resident would be coded as 06, Independent.

Examples for Coding Admission, *Interim*, or Discharge Performance

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

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. During all meals, after eating three-fourths of the 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 would be coded 03, Partial/moderate assistance.

Rationale: The certified nursing assistant provides less than half the effort for the resident 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 would be coded 02, Substantial/maximal assistance.

Rationale: The helper provides more than half the effort for the resident to complete the activity of eating at each meal.

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

Coding: GG0130A would be coded 06, Independent.

Rationale: The resident 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 dietary aide 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 would be coded 05, Setup or clean-up assistance.

Rationale: The helper provided setup assistance prior to the eating activity.

GG0130: Self-Care (3-day assessment period) Admission/*Interim*/Discharge (Start/*Interim*/End of Medicare Part A Stay) (cont.)

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

Coding: GG0130A 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.

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

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

Rationale: The helper provides verbal cueing assistance during meals 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, the certified nursing assistant 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 would be coded 04, Supervision or touching assistance.

Rationale: The resident requires supervision and touching assistance in order to eat safely.

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

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

Rationale: The resident 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. Since eating and drinking did not occur due to his recent-onset medical condition, the activity is coded as 88, Not attempted due to medical condition and safety concerns. Assistance with G-tube feedings is not considered when coding this item.

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

Coding: GG0130A would be coded 01, Dependent.

Rationale: The helper does all of the effort for each meal. The resident does not contribute any effort to complete the eating activity.

GG0130: Self-Care (3-day assessment period) Admission/*Interim*/Discharge (Start/*Interim*/End of Medicare Part A Stay) (cont.)

10. **Eating:** Mr. J had a stroke that affects his left side. He is left-handed and feeds himself more than half of his meals, but tires easily. Mr. J requests assistance from the certified nursing assistant with the remainder of his meals.

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

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

11. **Eating:** Mrs. M has osteoporosis, which contributed to the fracture of her right wrist and hip during a recent fall. She is right-handed. Mrs. M starts eating on her own, but she does not have the coordination in her left hand to manage the eating utensils to feed herself without great effort. Mrs. M tires easily and cannot complete eating the meal. The certified nursing assistant feeds her more than half of the meal.

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

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

Coding Tip for GG0130B, Oral hygiene

- If a resident does not perform oral hygiene during therapy, determine the resident's abilities based on performance on the nursing 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 would be coded 05, Setup or clean-up assistance.

Rationale: The helper provides setup and clean-up assistance. The resident 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 resident walks back to his bed.

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

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

GG0130: Self-Care (3-day assessment period) Admission/*Interim*/Discharge (Start/*Interim*/End of Medicare Part A Stay) (cont.)

3. **Oral hygiene:** At night, 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 would be coded 03, Partial/moderate assistance.

Rationale: The helper provided 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. In the morning and evening, 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 certified nursing assistant completes the activity of oral hygiene by brushing his back upper gums and his lower gums.

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

Rationale: The resident 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 by brushing his upper and lower front teeth and the certified nursing assistant completes the activity by brushing the rest of his teeth.

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

Rationale: The helper provided more than half the effort for the resident 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 would be coded 01, Dependent.

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

GG0130: Self-Care (3-day assessment period) Admission/*Interim*/Discharge (Start/*Interim*/End of Medicare Part A Stay) (cont.)

7. **Oral hygiene:** Mr. D has experienced a stroke. He can brush his teeth while sitting on the side of the bed, but when the certified nursing assistant hands him the toothbrush and toothpaste, he looks up at her puzzled what to do next. The certified nursing assistant cues Mr. D to put the toothpaste on the toothbrush and instructs him to brush his teeth. Mr. D then completes the task of brushing his teeth.

Coding: GG0130B would be coded 04, Supervision or touching assistance.

Rationale: The helper provides verbal cues to assist the resident in completing the activity of brushing his teeth.

8. **Oral hygiene:** Ms. K suffered a stroke a few months ago that resulted in cognitive limitations. She brushes her teeth at the sink, but is unable to initiate the task on her own. The occupational therapist cues Ms. K to put the toothpaste onto the toothbrush, brush all areas of her teeth, and rinse her mouth after brushing. The occupational therapist remains with Ms. K providing verbal cues until she has completed the task of brushing her teeth.

Coding: GG0130B would be coded 04, Supervision or touching assistance.

Rationale: The helper provides verbal cues to assist the resident in completing the activity of brushing her teeth.

9. **Oral hygiene:** Mrs. N has early stage amyotrophic lateral sclerosis. She starts brushing her teeth and completes cleaning her upper teeth and part of her lower teeth when she becomes fatigued and asks the certified nursing assistant to help her finish the rest of the brushing.

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

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

Coding Tips for GG0130C, Toileting hygiene

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

GG0130: Self-Care (3-day assessment period) Admission/*Interim*/Discharge (Start/*Interim*/End of Medicare Part A Stay) (cont.)

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 pants and underwear before sitting down on the *commode*. 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 pants and underwear without assistance.

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

Rationale: The helper provides steadying (touching) assistance to the resident 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 would be coded 04, Supervision or touching assistance.

Rationale: The helper provides supervision as the resident performs the toilet hygiene activity. The resident 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, pulls her underwear back up, *and adjusts her gown*.

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

Rationale: The helper provides more than touching assistance. The resident performs more than half the effort; the helper does less than half the effort. The resident completes two of the three toileting hygiene tasks.

4. **Toileting hygiene:** Mr. J is morbidly obese and has a diagnosis of debility. He requests the use of a bedpan 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 would be coded 01, Dependent.

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

GG0130: Self-Care (3-day assessment period) Admission/*Interim*/Discharge (Start/*Interim*/End of Medicare Part A Stay) (cont.)

5. **Toileting hygiene:** Mr. C has Parkinson's disease and significant tremors that cause intermittent difficulty for him to perform perineal hygiene after having a bowel movement in the toilet. He walks to the bathroom with close supervision and lowers his pants, but asks the certified nursing assistant to help him with perineal hygiene after moving his bowels. He then pulls up his pants without assistance.

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

Rationale: The helper provides less than half the effort. The resident performs two of the three toileting hygiene tasks by himself. Walking to the bathroom is not considered when scoring toileting hygiene.

6. **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 a bedside commode as she steadies herself in standing with one hand and initiates pulling down her underwear with the other hand but needs assistance to complete this activity due to her coordination impairment. After voiding, Ms. Q wipes her perineal area without assistance while sitting on the commode. When Ms. Q has a bowel movement, 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 would be coded 02, Substantial/maximal assistance.

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

Coding Tips for GG0130E, Shower/bathe self

- Shower/bathe self includes the ability to wash, rinse, and dry the face, upper and lower body, perineal area, and feet. Do not include washing, rinsing, and drying the resident's back or hair. Shower/bathe self does not include transferring in/out of a tub/shower.
- Assessment of Shower/bathe self can take place in a shower or bath or at a sink (i.e., full body sponge bath).
- If the resident bathes himself or herself and a helper sets up materials for bathing/showering, then code as 05, Setup or clean-up assistance.
- If the resident cannot bathe his or her entire body because of a medical condition, then code Shower/bathe self based on the amount of assistance needed to complete the activity.

GG0130: Self-Care (3-day assessment period) Admission/*Interim*/Discharge (Start/*Interim*/End of Medicare Part A Stay) (cont.)

Examples for GG0130E, Shower/bathe self

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

Coding: GG0130E would be coded 04, Supervision or touching assistance.

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

2. **Shower/bathe self:** Mrs. E has a severe and progressive neurological condition that has affected her endurance as well as her fine and gross motor skills. She is transferred to the shower bench with partial/moderate assistance. Mrs. E showers while sitting on a *shower* bench and washes her arms and chest using a wash mitt. A certified nursing assistant then must help wash the remaining parts of her body, as a result of Mrs. E's fatigue, to complete the activity. Mrs. E uses a *hand-held showerhead* to rinse herself but tires halfway through the task. The certified nursing assistant dries Mrs. E's entire body.

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

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

3. **Shower/bathe self:** Mr. Y has limited mobility resulting from his multiple and complex medical conditions. He prefers to wash his body while sitting in front of the sink in his bathroom. A helper assists with washing, rinsing, and drying Mr. Y's arms/hands, upper legs, lower legs, buttocks, and back.

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

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

GG0130: Self-Care (3-day assessment period) Admission/*Interim*/Discharge (Start/*Interim*/End of Medicare Part A Stay) (cont.)

Coding Tips for GG0130F, Upper body dressing, GG0130G, Lower body dressing, and GG0130H, Putting on/taking off footwear

- For upper body dressing, lower body dressing, and putting on/taking off footwear, if the resident dresses himself or herself and a helper retrieves or puts away the resident's clothing, then code 05, Setup or clean-up assistance.
- When coding upper body dressing and lower body dressing, helper assistance with buttons and/or fasteners is considered touching assistance.
- If donning and doffing an elastic bandage, elastic stockings, or an orthosis or prosthesis occurs while the resident is dressing/undressing, then count the elastic bandage/elastic stocking/orthotic/prosthesis as a piece of clothing when determining the amount of assistance the resident needs when coding the dressing item.
- The following items are considered a piece of clothing when coding the dressing items:
 - Upper body dressing examples: thoracic-lumbar-sacrum orthosis (TLSO), abdominal binder, back brace, stump sock/shrinker, upper body support device, neck support, hand or arm prosthetic/orthotic.
 - Lower body dressing examples: knee brace, elastic bandage, stump sock/shrinker, lower-limb prosthesis.
 - Footwear examples: ankle-foot orthosis (AFO), elastic bandages, foot orthotics, orthopedic walking boots, compression stockings (considered footwear because of dressing don/doff over foot).
- Upper body dressing items used for coding include bra, undershirt, T-shirt, button-down shirt, pullover shirt, dresses, sweatshirt, sweater, nightgown (not hospital gown), and pajama top. Upper body dressing cannot be assessed based solely on donning/doffing a hospital gown.
- Lower body dressing items used for coding include underwear, incontinence brief, slacks, shorts, capri pants, pajama bottoms, and skirts.
- Footwear dressing items used for coding include socks, shoes, boots, and running shoes.

GG0130: Self-Care (3-day assessment period) Admission/*Interim*/Discharge (Start/*Interim*/End of Medicare Part A Stay) (cont.)

- For residents with bilateral lower extremity amputations with or without use of prostheses, the activity of putting on/taking off footwear may not occur. For example, the socks and shoes may be attached to the prosthesis associated with the upper or lower leg.
 - If the resident performed the activity of putting on/taking off footwear immediately prior to the current illness, exacerbation, or injury, code as 88, Not attempted due to medical condition or safety concerns.
 - If the resident did not perform the activity of putting on/taking off footwear immediately prior to the current illness, exacerbation, or injury because the resident had bilateral lower-extremity amputations and the activity of putting on/taking off footwear was not performed during the assessment period, code as 09, Not applicable - Not attempted and the resident did not perform this activity prior to the current illness, exacerbation, or injury.
- For residents with a single lower extremity amputation with or without use of a prosthesis, the activity of putting on/taking off footwear could apply to the intact limb or both the limb with the prosthesis and the intact limb.
 - If the resident performed the activity of putting on/taking off footwear for the intact limb only, then code based upon the amount of assistance needed to complete the activity.
 - If the resident performed the activity of putting on/taking off footwear for both the intact limb and the prosthetic limb, then code based upon the amount of assistance needed to complete the activity.

Examples for GG0130F, Upper body dressing

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

Coding: GG0130F would be coded 05, Setup or clean-up assistance.

Rationale: Mrs. Y dresses and undresses her upper body and requires a helper only to retrieve *and put away* her clothing, that is, setting up the clothing for her use. The description refers to Mrs. Y as “independent” (when removing clothes), but she needs setup assistance, so she is not independent with regard to the entire activity of upper body dressing.

GG0130: Self-Care (3-day assessment period) Admission/*Interim*/Discharge (Start/*Interim*/End of Medicare Part A Stay) (cont.)

2. **Upper body dressing:** Mrs. Z wears a bra and a sweatshirt most days while in the SNF. She requires assistance from a certified nursing assistant to initiate the threading of her arms into her bra. Mrs. Z completes the placement of the bra over her chest. The helper hooks the bra clasps. Mrs. Z pulls the sweatshirt over her arms, head, and trunk. When undressing, Mrs. Z removes the sweatshirt, with the helper assisting her with one sleeve. Mrs. Z slides the bra off, once it has been unclashed by the helper.

Coding: GG0130F would be coded 03, Partial/moderate assistance.

Rationale: The helper provides assistance with threading Mrs. Z's arms into her bra and hooking and unhooking her bra clasps and assistance with removing one sleeve of the sweatshirt. Mrs. Z performs more than half of the effort.

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

Coding: GG0130F would be coded 02, Substantial/maximal assistance.

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

Examples for GG0130G, Lower body dressing

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

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

Rationale: A helper steadies Mr. D when he is standing and performing the activity of lower body dressing, which is supervision or touching assistance. Putting on and taking off socks and shoes is not considered when coding lower body dressing.

GG0130: Self-Care (3-day assessment period) Admission/*Interim*/Discharge (Start/*Interim*/End of Medicare Part A Stay) (cont.)

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

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

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

3. **Lower body dressing:** Mrs. R has peripheral neuropathy in her upper and lower extremities. Each morning, Mrs. R needs assistance from a helper to place her lower limb into, or to take it out of (don/doff), her lower limb prosthesis. She needs no assistance to put on and remove her underwear or slacks.

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

Rationale: A helper performs less than half the effort of lower body dressing (with a prosthesis considered a piece of clothing). The helper lifts, holds, or supports Mrs. R's trunk or limbs, but provides less than half the effort for the task of lower body dressing.

Examples for GG0130H, Putting on/taking off footwear

1. **Putting on/taking off footwear:** Mr. M is undergoing rehabilitation for right-side upper and lower body weakness following a stroke. He has made significant progress toward his independence and will be discharged to home tomorrow. Mr. M wears an ankle-foot orthosis that he puts on his foot and ankle after he puts on his socks but before he puts on his shoes. He always places his AFO, socks, and shoes within easy reach of his bed. While sitting on the bed, he needs to bend over to put on and take off his AFO, socks, and shoes, and he occasionally loses his sitting balance, requiring staff to place their hands on him to maintain his balance while performing this task.

Coding: GG0130H would be coded 04, Supervision or touching assistance.

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

GG0130: Self-Care (3-day assessment period) Admission/*Interim*/Discharge (Start/*Interim*/End of Medicare Part A Stay) (cont.)

2. **Putting on/taking off footwear:** Mrs. F was admitted to the SNF for a neurologic condition and experiences visual impairment and fine motor coordination and endurance issues. She requires setup for retrieving her socks and shoes, which she prefers to keep in the closet. Mrs. F often drops her shoes and socks as she attempts to put them onto her feet or as she takes them off. Often a certified nursing assistant must first thread her socks or shoes over her toes, and then Mrs. F can complete the task. Mrs. F needs the certified nursing assistant to initiate taking off her socks and unstrapping the Velcro used for fastening her shoes.

Coding: GG0130H would be coded *02, Substantial/maximal assistance*.

Rationale: A helper provides Mrs. F with assistance in initiating putting on and taking off her footwear because of her limitations regarding fine motor coordination when putting on/taking off footwear. The helper completes more than half of the effort with this activity.

Examples of Probing Conversations with Staff

1. **Eating:** Example of a probing conversation between a nurse and a certified nursing assistant regarding the resident'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 for food and liquid."

In this example, the nurse inquired specifically how Mr. S requires assistance to eat his meals. The nurse asked about instructions and physical assistance. If this nurse had not asked 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 would be coded 01, Dependent.

Rationale: The resident requires complete assistance from the certified nursing assistant to eat his meals.

GG0130: Self-Care (3-day assessment period) Admission/*Interim*/Discharge (Start/*Interim*/End of Medicare Part A Stay) (cont.)

2. **Oral hygiene:** Example of a probing conversation between a nurse determining a resident's oral hygiene score and a certified nursing assistant regarding the resident'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 resident performed the activity. If this nurse had not asked probing questions, he/she would not have received enough information to make an accurate assessment of the actual assistance Mrs. K received.

Coding: GG0130B 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.

Discharge Goals: Coding Tips

Discharge goals are coded with each Admission (Start of SNF PPS Stay) assessment.

- For the SNF Quality Reporting Program (QRP), a minimum of one self-care or mobility discharge goal must be coded. However, facilities may choose to complete more than one self-care or mobility discharge goal. Code the resident's discharge goal(s) using the six-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. Of note, at least one Discharge Goal must be indicated for either Self-Care or Mobility. Using the dash in this allowed instance after the coding of at least one goal does not affect Annual Payment Update (APU) determination.
- Licensed, qualified clinicians can establish a resident's Discharge Goal(s) at the time of admission based on the resident's prior medical condition, admission assessment self-care and mobility status, discussions with the resident and family, professional judgment, the professional's standard of practice, expected treatments, the resident's motivation to improve, anticipated length of stay, and the resident's discharge plan. Goals should be established as part of the resident'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 resident is expected to be able to perform the activity by discharge.

GG0130: Self-Care (3-day assessment period) Admission/*Interim*/Discharge (Start/*Interim*/End of Medicare Part A Stay) (cont.)

Discharge Goal: Coding Examples

1. Discharge Goal Code Is Higher than 5-Day PPS Assessment Admission Performance Code

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

2. Discharge Goal Code Is the Same as 5-Day PPS Assessment Admission Performance Code

The qualified clinician determines that a medically complex resident is not expected to progress to a higher level of functioning during the SNF Medicare Part A stay; however, the qualified clinician determines that the resident would be able to maintain her admission functional performance level. The qualified clinician discusses functional status goals with the resident and her family and they agree that maintaining functioning is a reasonable goal. In this example, the Discharge Goal is coded at the same level as the resident's admission performance code.

Oral Hygiene 5-Day PPS Assessment Admission Performance: In this example, the qualified clinician anticipates that the resident will have the same level of function for oral hygiene at admission and discharge. The resident's 5-Day PPS admission performance code is coded and the Discharge Goal is coded at the same level. Mrs. E has stated her preference for participation twice daily in her oral hygiene activity. Mrs. E has severe arthritis, Parkinson's disease, diabetic neuropathy, and renal failure. These conditions result in multiple impairments (e.g., limited endurance, weak grasp, slow movements, and tremors). The qualified clinician observes Mrs. E's 5-Day PPS admission performance and discusses her usual performance with qualified 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 qualified clinician codes Mrs. E's 5-Day PPS assessment admission performance as 02, Substantial/maximal assistance. The helper performs more than half the effort when lifting or holding her limb.

Oral Hygiene 5-Day PPS Assessment Discharge Goal: The qualified clinician anticipates Mrs. E's discharge performance will remain 02, Substantial/maximal assistance. Due to Mrs. E's progressive and degenerative condition, the qualified clinician and resident 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.

GG0130: Self-Care (3-day assessment period) Admission/*Interim*/Discharge (Start/*Interim*/End of Medicare Part A Stay) (cont.)

3. Discharge Goal Code Is *Lower* than 5-Day PPS Assessment Admission Performance Code

The qualified clinician determines that a resident 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 resident's 5-Day PPS assessment 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 resident's Discharge Goal code will be lower than the 5-Day PPS Admission Performance code.

Toileting Hygiene 5-Day PPS Assessment Admission Performance: Mrs. T has a progressive neurological illness that affects her strength, coordination, and endurance. Mrs. T prefers to use a bedside commode rather than incontinence undergarments for as long as possible. 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 qualified clinician codes the 5-Day PPS assessment admission performance as 03, Partial/moderate assistance. The certified nursing assistant provides less than half the effort for Mrs. T'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 qualified clinician codes her Discharge Goal as 02, Substantial/maximal assistance.

GG0170: Mobility (3-day assessment period) Admission (Start of Medicare Part A Stay)

GG0170. Mobility (Assessment period is days 1 through 3 of the SNF PPS Stay starting with A2400B)
Complete only if A0310B = 01

Code the resident's usual performance at the start of the SNF PPS stay (admission) for each activity using the 6-point scale. If activity was not attempted at the start of the SNF PPS stay (admission), code the reason. Code the resident's end of SNF PPS stay (discharge) goal(s) using the 6-point scale. Use of codes 07, 09, 10, or 88 is permissible to code end of SNF PPS stay (discharge) goal(s).

Coding:

Safety and Quality of Performance - If helper assistance is required because resident'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** - Resident completes the activity by him/herself with no assistance from a helper.
- 05. **Setup or clean-up assistance** - Helper sets up or cleans up; resident 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 resident 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. Resident does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the resident to complete the activity.

If activity was not attempted, code reason:

- 07. **Resident refused**
- 09. **Not applicable** - Not attempted and the resident 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 ↓		
<input type="text"/>	<input type="text"/>	A. Roll left and right: The ability to roll from lying on back to left and right side, and return to lying on back on the bed.
<input type="text"/>	<input type="text"/>	B. Sit to lying: The ability to move from sitting on side of bed to lying flat on the bed.
<input type="text"/>	<input type="text"/>	C. Lying to sitting on side of bed: The ability to move from lying on the back to sitting on the side of the bed with feet flat on the floor, and with no back support.
<input type="text"/>	<input type="text"/>	D. Sit to stand: The ability to come to a standing position from sitting in a chair, wheelchair, or on the side of the bed.
<input type="text"/>	<input type="text"/>	E. Chair/bed-to-chair transfer: The ability to transfer to and from a bed to a chair (or wheelchair).
<input type="text"/>	<input type="text"/>	F. Toilet transfer: The ability to get on and off a toilet or commode.
<input type="text"/>	<input type="text"/>	G. Car transfer: The ability to transfer in and out of a car or van on the passenger side. Does not include the ability to open/close door or fasten seat belt.
<input type="text"/>	<input type="text"/>	I. Walk 10 feet: Once standing, the ability to walk at least 10 feet in a room, corridor, or similar space. If admission performance is coded 07, 09, 10, or 88 → Skip to GG0170M, 1 step (curb)
<input type="text"/>	<input type="text"/>	J. Walk 50 feet with two turns: Once standing, the ability to walk at least 50 feet and make two turns.
<input type="text"/>	<input type="text"/>	K. Walk 150 feet: Once standing, the ability to walk at least 150 feet in a corridor or similar space.

GG0170: Mobility (3-day assessment period) Admission (Start of Medicare Part A Stay) (cont.)

GG0170. Mobility (Assessment period is days 1 through 3 of the SNF PPS Stay starting with A2400B) - Continued		
Complete only if A0310B = 01		
<p>Code the resident's usual performance at the start of the SNF PPS stay (admission) for each activity using the 6-point scale. If activity was not attempted at the start of the SNF PPS stay (admission), code the reason. Code the resident's end of SNF PPS stay (discharge) goal(s) using the 6-point scale. Use of codes 07, 09, 10, or 88 is permissible to code end of SNF PPS stay (discharge) goal(s).</p>		
<p>Coding:</p> <p>Safety and Quality of Performance - If helper assistance is required because resident's performance is unsafe or of poor quality, score according to amount of assistance provided.</p> <p><i>Activities may be completed with or without assistive devices.</i></p> <p>06. Independent - Resident completes the activity by him/herself with no assistance from a helper.</p> <p>05. Setup or clean-up assistance - Helper sets up or cleans up; resident completes activity. Helper assists only prior to or following the activity.</p> <p>04. Supervision or touching assistance - Helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity. Assistance may be provided throughout the activity or intermittently.</p> <p>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.</p> <p>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.</p> <p>01. Dependent - Helper does ALL of the effort. Resident does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the resident to complete the activity.</p> <p>If activity was not attempted, code reason:</p> <p>07. Resident refused</p> <p>09. Not applicable - Not attempted and the resident did not perform this activity prior to the current illness, exacerbation, or injury.</p> <p>10. Not attempted due to environmental limitations (e.g., lack of equipment, weather constraints)</p> <p>88. Not attempted due to medical condition or safety concerns</p>		
1. Admission Performance	2. Discharge Goal	
↓ Enter Codes in Boxes ↓		
<input type="text"/>	<input type="text"/>	L. Walking 10 feet on uneven surfaces: The ability to walk 10 feet on uneven or sloping surfaces (indoor or outdoor), such as turf or gravel.
<input type="text"/>	<input type="text"/>	M. 1 step (curb): The ability to go up and down a curb and/or up and down one step. If admission performance is coded 07, 09, 10, or 88 → Skip to GG0170P, Picking up object
<input type="text"/>	<input type="text"/>	N. 4 steps: The ability to go up and down four steps with or without a rail. If admission performance is coded 07, 09, 10, or 88 → Skip to GG0170P, Picking up object
<input type="text"/>	<input type="text"/>	O. 12 steps: The ability to go up and down 12 steps with or without a rail.
<input type="text"/>	<input type="text"/>	P. Picking up object: The ability to bend/stoop from a standing position to pick up a small object, such as a spoon, from the floor.
<input type="text"/>	<input type="text"/>	<input type="checkbox"/> Q1. Does the resident use a wheelchair and/or scooter? 0. No → Skip to GG0130, Self Care (Discharge) 1. Yes → Continue to GG0170R, Wheel 50 feet with two turns
<input type="text"/>	<input type="text"/>	R. Wheel 50 feet with two turns: Once seated in wheelchair/scooter, the ability to wheel at least 50 feet and make two turns.
<input type="text"/>	<input type="text"/>	<input type="checkbox"/> RR1. Indicate the type of wheelchair or scooter used. 1. Manual 2. Motorized
<input type="text"/>	<input type="text"/>	S. Wheel 150 feet: Once seated in wheelchair/scooter, the ability to wheel at least 150 feet in a corridor or similar space.
<input type="text"/>	<input type="text"/>	<input type="checkbox"/> SS1. Indicate the type of wheelchair or scooter used. 1. Manual 2. Motorized

GG0170: Mobility (3-day assessment period) Interim Performance (Interim Payment Assessment - Optional)

GG0170. Mobility (Assessment period is the last 3 days)	
Code the resident's usual performance for each activity using the 6-point scale. If an activity was not attempted, code the reason.	
<p>Coding:</p> <p>Safety and Quality of Performance - If helper assistance is required because resident's performance is unsafe or of poor quality, score according to amount of assistance provided.</p> <p><i>Activities may be completed with or without assistive devices.</i></p> <ul style="list-style-type: none"> 06. Independent - Resident completes the activity by him/herself with no assistance from a helper. 05. Setup or clean-up assistance - Helper sets up or cleans up; resident 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 resident 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. Resident does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the resident to complete the activity. <p>If activity was not attempted, code reason:</p> <ul style="list-style-type: none"> 07. Resident refused 09. Not applicable - Not attempted and the resident 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 	
5. Interim Performance Enter Codes in Boxes ↓	
<div style="border: 1px solid black; width: 30px; height: 20px; margin: 2px;"></div> <div style="border: 1px solid black; width: 30px; height: 20px; margin: 2px;"></div> <div style="border: 1px solid black; width: 30px; height: 20px; margin: 2px;"></div> <div style="border: 1px solid black; width: 30px; height: 20px; margin: 2px;"></div> <div style="border: 1px solid black; width: 30px; height: 20px; margin: 2px;"></div> <div style="border: 1px solid black; width: 30px; height: 20px; margin: 2px;"></div> <div style="border: 1px solid black; width: 30px; height: 20px; margin: 2px;"></div> <div style="border: 1px solid black; width: 30px; height: 20px; margin: 2px;"></div>	<p>B. Sit to lying: The ability to move from sitting on side of bed to lying flat on the bed.</p> <p>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.</p> <p>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.</p> <p>E. Chair/bed-to-chair transfer: The ability to transfer to and from a bed to a chair (or wheelchair).</p> <p>F. Toilet transfer: The ability to get on and off a toilet or commode.</p> <p>I. Walk 10 feet: Once standing, the ability to walk at least 10 feet in a room, corridor, or similar space. If interim performance is coded 07, 09, 10, or 88 → Skip to H0100C, Appliances</p> <p>J. Walk 50 feet with two turns: Once standing, the ability to walk at least 50 feet and make two turns.</p> <p>K. Walk 150 feet: Once standing, the ability to walk at least 150 feet in a corridor or similar space.</p>

GG0170: Mobility (3-day assessment period) Discharge (End of Medicare Part A Stay)

GG0170. Mobility (Assessment period is the last 3 days of the SNF PPS Stay ending on A2400C)

Complete only if A0310G is not = 2 and A0310H = 1 and A2400C minus A2400B is greater than 2 and A2100 is not = 03

Code the resident's usual performance at the end of the SNF PPS stay for each activity using the 6-point scale. If an activity was not attempted at the end of the SNF PPS stay, code the reason.

Coding:

Safety and Quality of Performance - If helper assistance is required because resident'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** - Resident completes the activity by him/herself with no assistance from a helper.
- 05. **Setup or clean-up assistance** - Helper sets up or cleans up; resident 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 resident 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. Resident does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the resident to complete the activity.

If activity was not attempted, code reason:

- 07. **Resident refused**
- 09. **Not applicable** - Not attempted and the resident 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**

3. Discharge Performance	
Enter Codes in Boxes	
<input type="text"/>	A. Roll left and right: The ability to roll from lying on back to left and right side, and return to lying on back on the bed.
<input type="text"/>	B. Sit to lying: The ability to move from sitting on side of bed to lying flat on the bed.
<input type="text"/>	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.
<input type="text"/>	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.
<input type="text"/>	E. Chair/bed-to-chair transfer: The ability to transfer to and from a bed to a chair (or wheelchair).
<input type="text"/>	F. Toilet transfer: The ability to get on and off a toilet or commode.
<input type="text"/>	G. Car transfer: The ability to transfer in and out of a car or van on the passenger side. Does not include the ability to open/close door or fasten seat belt.
<input type="text"/>	I. Walk 10 feet: Once standing, the ability to walk at least 10 feet in a room, corridor, or similar space. If discharge performance is coded 07, 09, 10, or 88 → Skip to GG0170M, 1 step (curb)
<input type="text"/>	J. Walk 50 feet with two turns: Once standing, the ability to walk at least 50 feet and make two turns.
<input type="text"/>	K. Walk 150 feet: Once standing, the ability to walk at least 150 feet in a corridor or similar space.

GG0170: Mobility (3-day assessment period) Discharge (End of Medicare Part A Stay) (cont.)

GG0170. Mobility (Assessment period is the last 3 days of the SNF PPS Stay ending on A2400C) - Continued Complete only if A0310G is not = 2 and A0310H = 1 and A2400C minus A2400B is greater than 2 and A2100 is not = 03	
Code the resident's usual performance at the end of the SNF PPS stay for each activity using the 6-point scale. If an activity was not attempted at the end of the SNF PPS stay, code the reason.	
Coding: Safety and Quality of Performance - If helper assistance is required because resident's performance is unsafe or of poor quality, score according to amount of assistance provided. <i>Activities may be completed with or without assistive devices.</i>	
06. Independent - Resident completes the activity by him/herself with no assistance from a helper. 05. Setup or clean-up assistance - Helper sets up or cleans up; resident 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 resident 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. Resident does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the resident to complete the activity.	
If activity was not attempted, code reason: 07. Resident refused 09. Not applicable - Not attempted and the resident 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	
3. Discharge Performance Enter Codes in Boxes ↓	
<input type="text"/> <input type="text"/>	L. Walking 10 feet on uneven surfaces: The ability to walk 10 feet on uneven or sloping surfaces (indoor or outdoor), such as turf or gravel.
<input type="text"/> <input type="text"/>	M. 1 step (curb): The ability to go up and down a curb and/or up and down one step. If discharge performance is coded 07, 09, 10, or 88 → Skip to GG0170P, Picking up object
<input type="text"/> <input type="text"/>	N. 4 steps: The ability to go up and down four steps with or without a rail. If discharge performance is coded 07, 09, 10, or 88 → Skip to GG0170P, Picking up object
<input type="text"/> <input type="text"/>	O. 12 steps: The ability to go up and down 12 steps with or without a rail.
<input type="text"/> <input type="text"/>	P. Picking up object: The ability to bend/stoop from a standing position to pick up a small object, such as a spoon, from the floor.
<input type="checkbox"/>	Q3. Does the resident use a wheelchair and/or scooter? 0. No → Skip to H0100, Appliances 1. Yes → Continue to GG0170R, Wheel 50 feet with two turns
<input type="text"/> <input type="text"/>	R. Wheel 50 feet with two turns: Once seated in wheelchair/scooter, the ability to wheel at least 50 feet and make two turns.
<input type="checkbox"/>	RR3. Indicate the type of wheelchair or scooter used. 1. Manual 2. Motorized
<input type="text"/> <input type="text"/>	S. Wheel 150 feet: Once seated in wheelchair/scooter, the ability to wheel at least 150 feet in a corridor or similar space.
<input type="checkbox"/>	SS3. Indicate the type of wheelchair or scooter used. 1. Manual 2. Motorized

GG0170: Mobility (3-day assessment period) Admission/*Interim*/Discharge (Start/*Interim*/End of Medicare Part A Stay) (cont.)

Item Rationale

- During a Medicare Part A SNF stay, residents may have mobility limitations on admission. In addition, residents may be at risk of further functional decline during their stay in the SNF.

Steps for Assessment

- Assess the resident's mobility performance based on direct observation, *incorporating resident* self-reports *and reports from* qualified clinicians, care staff, or family *documented in the resident's medical record* during the three-day assessment period. CMS anticipates that a multidisciplinary team of qualified clinicians is involved in assessing the resident during the three-day assessment period. For Section GG, the assessment period is the first three days of the Part A stay, starting with the date in A2400B, Start of Most Recent Medicare Stay. On admission, these items are completed only when A0310B = 01 (5-Day PPS assessment). *For the Interim Payment Assessment (A0310B=08), the assessment period for Section GG is the last 3 days (i.e., the ARD and two days prior).*
- Residents should be allowed to perform activities as independently as possible, as long as they are safe.
- For the purposes of completing Section GG, a "helper" is defined as facility staff who are direct employees and facility-contracted employees (e.g., rehabilitation staff, nursing agency staff). Thus, does not include individuals hired, compensated or not, by individuals outside of the facility's management and administration, such as hospice staff, nursing/certified nursing assistant students, etc. Therefore, when helper assistance is required because a resident's performance is unsafe or of poor quality, only consider facility staff when scoring according to amount of assistance provided.
- Activities may be completed with or without assistive device(s). Use of assistive device(s) to complete an activity should not affect coding of the activity.
- The admission functional assessment, when possible, should be conducted prior to the *resident* benefitting from treatment interventions in order to *reflect the resident's* true *admission* baseline functional status. If treatment has started, for example, 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.
- Refer to facility, Federal, and State policies and procedures to determine which SNF staff members may complete an assessment. Resident assessments are to be done in compliance with facility, Federal, and State requirements.

DEFINITION

USUAL PERFORMANCE

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

GG0170: Mobility (3-day assessment period) Admission/*Interim*/Discharge (Start/*Interim*/End of Medicare Part A Stay) (cont.)

Admission, *Interim*, or Discharge Performance Coding Instructions

- When coding the resident's usual performance and the resident's discharge goal(s), use the six-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.
- **Code 06, Independent:** if the resident 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; resident completes activity. Helper assists only prior to or following the activity, but not during the activity. For example, the resident 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 or touching/steadying/*contact guard* assistance as resident completes activity. Assistance may be provided throughout the activity or intermittently. For example, the resident requires verbal cueing, coaxing, or general supervision for safety to complete the activity; or resident 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 resident 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. Resident does none of the effort to complete the activity. Or the assistance of two or more helpers is required for the resident to complete the activity.
- **Code 07, Resident refused:** if the resident refused to complete the activity.
- **Code 09, Not applicable:** if the activity was not attempted and the resident did not perform this activity prior to the current illness, exacerbation, or injury.
- **Code 10, Not attempted due to environmental limitations:** if the resident 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.
- *For additional information on coding the resident's performance on the assessment instrument, refer to the Decision Tree on page GG-12.*

GG0170: Mobility (3-day assessment period) Admission/*Interim*/Discharge (Start/*Interim*/End of Medicare Part A Stay) (cont.)

Admission, *Interim*, or Discharge Performance Coding Tips

- **Admission:** The 5-Day PPS assessment (A0310B = 01) is the first Medicare-required assessment to be completed when the resident is admitted for a SNF Part A stay.
 - For the 5-Day PPS assessment, code the resident's functional status based on a clinical assessment of the resident's performance that occurs soon after the resident's admission. This functional assessment must be completed within the first three days (three calendar days) of the Medicare Part A stay, starting with the date in A2400B, Start of Most Recent Medicare Stay, and the following two days, ending at 11:59 PM on day 3. The admission function scores are to reflect the resident's admission baseline status and are to be based on an assessment. The scores should reflect the resident's status prior to any benefit from interventions. The assessment should occur prior to the resident benefitting from treatment interventions in order to determine the resident'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.
- ***Interim Performance (Optional):*** *The Interim Payment Assessment (IPA) is an optional assessment that may be completed by providers in order to report a change in the resident's PDPM classification. For Section GG on the IPA, providers will use the same 6-point scale and activity not attempted codes to complete the column "Interim Performance," which will capture the interim functional performance of the resident. The ARD for the IPA is determined by the provider, and the assessment period is the last 3 days (i.e., the ARD and the 2 calendar days prior). It is important to note that the IPA changes payment beginning on the ARD and continues until the end of the Medicare Part A stay or until another IPA is completed. The IPA does not affect the variable per diem schedule.*
- **Discharge:** The Part A PPS Discharge assessment is required to be completed when the resident's Medicare Part A stay ends as documented in A2400C, End of Most Recent Medicare Stay, either as a standalone assessment when the resident's Medicare Part A stay ends, but the resident remains in the facility; or may be combined with an OBRA Discharge if the Medicare Part A stay ends on the day of, or one day before, the resident's Discharge Date (A2000). Please see Chapter 2 and Section A of the RAI Manual for additional details regarding the Part A PPS Discharge assessment.
 - For the Discharge assessment, (i.e., standalone Part A PPS or combined OBRA/Part A PPS), code the resident's discharge functional status, based on a clinical assessment of the resident's performance that occurs as close to the time of the resident's discharge from Medicare Part A as possible. This functional assessment must be completed within the last three calendar days of the resident's Medicare Part A stay, which includes the day of discharge from Medicare Part A and the two days prior to the day of discharge from Medicare Part A.

GG0170: Mobility (3-day assessment period) Admission/*Interim*/Discharge (Start/*Interim*/End of Medicare Part A Stay) (cont.)

Admission, *Interim*, and Discharge Performance Coding Tips

General Coding Tips

- When reviewing the medical record, interviewing staff, and observing the resident, be familiar with the definition for each activity. For example, when assessing GG0170J, Walk 50 feet with two turns, determine the type and amount of assistance required as the resident walks 50 feet *and negotiates two turns*.
- If the resident does not attempt the activity and a helper does not complete the activity for the resident during the entire assessment period, code the reason the activity was not attempted. For example, code as 07, if the resident refused to attempt the activity; code as 09, if the activity is not applicable for the resident (the activity did not occur at the time of the assessment, and prior to the current illness, exacerbation, or injury); code as 10, if the resident was not able to attempt the activity due to environmental limitations; or code as 88, if the resident was not able to attempt the activity due to a medical condition or safety concerns.
- An activity can be completed independently with or without devices. If the resident has adaptive equipment, retrieves the equipment without assistance, and performs the activity independently using the device, enter code 06, Independent.
- If two or more helpers are required to assist the resident to complete the activity, code as 01, Dependent.
- To clarify your own understanding and observations about a resident's performance of an activity, ask probing questions, beginning with the general and proceeding to the more specific. See examples of using probes when talking with staff at the end of this section.
- 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 resident's medical record. This assessment can be conducted by appropriate healthcare personnel as defined by facility policy and in accordance with local, State, and Federal regulations.

GG0170: Mobility (3-day assessment period) Admission/*Interim*/Discharge (Start/*Interim*/End of Medicare Part A Stay) (cont.)

Tips for Coding the Resident's Usual Performance

- When coding the resident's usual performance, "effort" refers to the type and amount of assistance a helper provides in order for the activity to be completed. The six-point rating scale definitions include the following types of assistance: setup/cleanup, touching assistance, verbal cueing, and lifting assistance.
- Do not record the resident's best performance, and do not record the resident's worst performance, but rather record the resident's usual performance during the assessment period.
- Code based on the resident's performance. Do not record the staff's assessment of the resident's potential capability to perform the activity.
- If the resident performs the activity more than once during the assessment period and the resident's performance varies, coding in Section GG is based on the resident's "usual performance," which is identified as the resident's usual activity/performance for any of the Self-Care or Mobility activities, not the most independent or dependent performance over the assessment period. A provider may need to use the entire three-day assessment period to obtain the resident's usual performance.

Examples and Coding Tips for Admission, *Interim*, or Discharge Performance

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

Examples for GG0170A, Roll left and right

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

Coding: GG0170A would be coded 02, Substantial/maximal assistance.

Rationale: The nurse provides more than half of the effort needed for the resident to complete the activity of rolling left and right. This is because the nurse provides physical assistance to move Mrs. R's body weight to turn onto her right side. The nurse provides the same assistance when Mrs. R turns to her left side and when she returns to her back. Mrs. R is able to return to lying on her back from her right side by herself.

GG0170: Mobility (3-day assessment period) Admission/*Interim*/Discharge (Start/*Interim*/End of Medicare Part A Stay) (cont.)

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 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 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 in 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 would be coded 03, Partial/moderate assistance.

Rationale: The helper provides less than half the effort needed for the resident to complete the activity of rolling left and right.

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 and lowers herself to a lying position flat on her back.

Coding: GG0170B 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.

GG0170: Mobility (3-day assessment period) Admission/*Interim*/Discharge (Start/*Interim*/End of Medicare Part A Stay) (cont.)

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 would be coded 02, Substantial/maximal assistance.

Rationale: The helper provided more than half the effort for the resident 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 would be coded 01, Dependent.

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

4. **Sit to lying:** Mr. F had a stroke about 2 weeks ago and is unable to sequence the necessary movements to complete an activity (apraxia). He can maneuver himself when transitioning from sitting on the side of the bed to lying flat on the bed if the certified nursing assistant provides verbal instructions as to the steps needed to complete this task.

Coding: GG0170B would be coded 04, Supervision or touching assistance.

Rationale: A helper provides verbal cues in order for the resident to complete the activity of sit to lying flat on the bed.

5. **Sit to lying:** Mrs. G suffered a traumatic brain injury three months prior to admission. She requires the certified nursing assistant to steady her movements from sitting on the side of the bed to lying flat on the bed. Mrs. G requires steadying (touching) assistance throughout the completion of this activity.

Coding: GG0170B would be coded 04, Supervision or touching assistance.

Rationale: A helper provides steadying assistance in order for the resident to complete the activity of sit to lying flat on her bed.

GG0170: Mobility (3-day assessment period) Admission/*Interim*/Discharge (Start/*Interim*/End of Medicare Part A Stay) (cont.)

6. **Sit to lying:** Mrs. E suffered a pelvic fracture during a motor vehicle accident. Mrs. E requires the certified nursing assistant to lift and position her left leg when she transfers from sitting at the edge of the bed to lying flat on the bed due to severe pain in her left pelvic area. Mrs. E uses her arms to position and lower her upper body to lying flat on the bed.

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

Rationale: A helper lifts Mrs. E's left leg and helps her position it as Mrs. E transitions from a seated to a lying position; the helper does less than half of the effort.

7. **Sit to lying:** Mr. A suffered multiple vertebral fractures due to a fall off a ladder. He requires assistance from a therapist to get from a sitting position to lying flat on the bed because of significant pain in his lower back. The therapist supports his trunk and lifts both legs to assist Mr. A from sitting at the side of the bed to lying flat on the bed. Mr. A assists himself a small amount by raising one leg onto the bed and then bending both knees while transitioning into a lying position.

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

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

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

- The activity includes resident 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 residents' ability to perform each of the tasks within this activity and how much support the residents require 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 resident.
- If the resident's feet do not reach the floor upon lying to sitting, the qualified 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 resident's back.
- If the qualified 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.

GG0170: Mobility (3-day assessment period) Admission/*Interim*/Discharge (Start/*Interim*/End of Medicare Part A Stay) (cont.)

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 would be coded 04, Supervision or touching assistance.

Rationale: The helper provides touching assistance as the resident 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 a seated position as the occupational therapist provides much of the lifting assistance necessary for him to sit upright. The occupational therapist provides additional lifting assistance as Mr. B scoots himself to the edge of the bed and lowers his feet to the floor.

Coding: GG0170C would be coded 02, Substantial/maximal assistance.

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

3. **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 would be coded 01, Dependent.

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

4. **Lying to sitting on side of bed:** Ms. H is recovering from a spinal fusion. She rolls to her right side and pushes herself up from the bed to get from a lying to a seated position. The therapist provides verbal cues as Ms. H safely uses her hands and arms to support her trunk and avoid twisting as she raises herself from the bed. Ms. H then maneuvers to the edge of the bed, finally lowering her feet to the floor to complete the activity.

Coding: GG0170C would be coded 04, Supervision or touching assistance.

Rationale: The helper provides verbal cues as the resident moves from a lying to sitting position and does not lift the resident during the activity.

GG0170: Mobility (3-day assessment period) Admission/*Interim*/Discharge (Start/*Interim*/End of Medicare Part A Stay) (cont.)

5. **Lying to sitting on side of bed:** Mrs. P is recovering from Guillain-Barre Syndrome with residual lower body weakness. The certified nursing assistant steadies Mrs. P's trunk as she gets to a fully upright sitting position on the bed and lifts each leg toward the edge of the bed. Mrs. P then scoots toward the edge of the bed and places both feet flat on the floor. Mrs. P completes most of the effort to get from lying to sitting on the side of the bed.

Coding: GG0170C would be coded 03, Partial/moderate assistance.

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

Coding Tip for GG0170D, Sit to stand

- If a sit-to-stand (stand assist) 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 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 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 would be coded 88, Not attempted due to medical condition or safety concerns.

Rationale: The activity is not attempted due to the resident'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 applies Ms. Z's AFO and places the platform walker in front of her; Ms. Z uses the walker to steady herself once standing. The certified nursing assistant provides lifting assistance to get Ms. Z

GG0170: Mobility (3-day assessment period) Admission/*Interim*/Discharge (Start/*Interim*/End of Medicare Part A Stay) (cont.)

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

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

Rationale: The helper provided lifting assistance and more than half of the effort for the resident to complete the activity of sit to stand.

5. **Sit to stand:** Ms. R has severe rheumatoid arthritis and uses forearm crutches to ambulate. The certified nursing assistant brings Ms. R her crutches and helps her to stand at the side of the bed. The certified nursing assistant provides some lifting assistance to get Ms. R to a standing position but provides less than half the effort to complete the activity.

Coding: GG0170D would be coded 03, Partial/moderate assistance.

Rationale: The helper provided lifting assistance and less than half the effort for the resident 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 resident 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 resident 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 resident assists with any part of the chair/bed-to-chair transfer.

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

1. **Chair/bed-to-chair transfer:** Mr. L had a stroke and currently is not 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 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.

GG0170: Mobility (3-day assessment period) Admission/*Interim*/Discharge (Start/*Interim*/End of Medicare Part A Stay) (cont.)

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 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 would be coded 01, Dependent.

Rationale: The two helpers completed all the effort for the activity of chair/bed-to-chair transfer. If two or more helpers are required to assist the resident 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 limited 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.

Coding: GG0170E would be coded 03, Partial/moderate assistance.

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

5. **Chair/bed-to-chair transfer:** Mr. U had his left lower leg amputated due to gangrene associated with his diabetes mellitus and he has reduced sensation and strength in his right leg. He has not yet received his below-the-knee prosthesis. Mr. U uses a transfer board for chair/bed-to-chair transfers. The therapist places the transfer board under his buttock. Mr. U then attempts to scoot from the bed onto the transfer board. Mr. U has reduced sensation in his hands and limited upper body strength, but assists with the transfer. The physical therapist assists him in side scooting by lifting his *buttocks*/trunk in a rocking motion across the transfer board and into the wheelchair.

Coding: GG0170E would be coded 02, Substantial/maximal assistance.

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

GG0170: Mobility (3-day assessment period) Admission/*Interim*/Discharge (Start/*Interim*/End of Medicare Part A Stay) (cont.)

Examples for GG0170F, Toilet transfer

1. **Toilet transfer:** The certified nursing assistant moves the wheelchair footrests up so that Mrs. 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 footrests back down herself.

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

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

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

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

Rationale: The helper provides supervision as the resident transfers onto and off the toilet. The resident 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 would be coded 04, Supervision or touching assistance.

Rationale: The helper provides supervision/verbal cues as Mrs. Y transfers onto 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 would be coded 04, Supervision or touching assistance.

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

GG0170: Mobility (3-day assessment period) Admission/*Interim*/Discharge (Start/*Interim*/End of Medicare Part A Stay) (cont.)

5. **Toilet transfer:** The therapist supports Mrs. M's trunk with a gait belt by providing weight-bearing as Mrs. M pivots and lowers herself onto the toilet.

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

Rationale: The helper provides less than half the effort to complete the activity. The helper provided weight-bearing assistance as the resident transferred on and off the toilet.

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 steady herself. The certified nursing assistant provides weight-bearing assistance as she slowly rotates and lowers Ms. W onto the bedside commode.

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

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

7. **Toilet transfer:** Mr. H has paraplegia incomplete, pneumonia, and a chronic respiratory condition. 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 would be coded 01, Dependent.

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

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

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

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

GG0170: Mobility (3-day assessment period) Admission/*Interim*/Discharge (Start/*Interim*/End of Medicare Part A Stay) (cont.)

Coding Tips for GG0170G, Car transfer

- *For item GG0170G, Car transfer, use of an indoor car can be used to simulate outdoor car transfers. These half or full cars would need to have similar physical features of a real car for the purpose of simulating a car transfer, that is, a car seat within a car cabin.*
- *The Car transfer item does not include transfers into the driver's seat, opening/closing the car door, fastening/unfastening the seat belt. The Car transfer item includes the resident's ability to transfer in and out of the passenger seat of a car or car simulator.*
- *In the event of inclement weather or if an indoor car simulator or outdoor car is not available during the entire 3-day assessment period, then use code 10, Not attempted due to environmental limitations.*
- *If at the time of the assessment the resident is unable to attempt car transfers, and could not perform the car transfers prior to the current illness, exacerbation or injury, code 09, Not applicable.*

Examples for GG0170G, Car transfer

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

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

Rationale: Although Mrs. W also contributes effort to complete the activity, the helper contributed more than half the effort needed to transfer Mrs. W into the car by providing lifting assistance and trunk support.

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

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

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

GG0170: Mobility (3-day assessment period) Admission/*Interim*/Discharge (Start/*Interim*/End of Medicare Part A Stay) (cont.)

Coding Tips for GG0170I–G0170L Walking Items

- Walking activities do not need to occur during one session. Allowing a resident 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 resident'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 item GG0170J, Walk 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).

Examples for GG0170I, Walk 10 feet

1. **Walk 10 feet:** Mrs. C has resolving sepsis and has not walked in three weeks because of her medical condition. A physical therapist determines that it is unsafe for Mrs. C to use a walker, and the resident 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 would be coded 88, Not attempted due to medical condition or safety concerns.

Rationale: When assessing a resident for GG0170 walking items, do not consider walking in parallel bars, as parallel bars are not a portable assistive device. If the resident 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.

2. **Walk 10 feet:** Mr. L had bilateral amputations three 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 would be coded 09, Not applicable, not attempted and the resident did not perform this activity prior to the current illness, exacerbation, or injury.

Rationale: When assessing a resident for GG0170I, Walk 10 feet, consider the resident's status prior to the current episode of care and current three-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 three-day assessment period. 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 resident's care plan.

GG0170: Mobility (3-day assessment period) Admission/*Interim*/Discharge (Start/*Interim*/End of Medicare Part A Stay) (cont.)

3. **Walk 10 feet:** Mrs. C has Parkinson's disease and walks with a walker. A 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.

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

Rationale: A helper provides more than half the effort as the resident completes the activity.

4. **Walk 10 feet:** Mr. O has bilateral upper extremity tremors, lower extremity weakness, and Parkinson's disease. A *physical therapist* 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 two feet of the 10-foot walk.

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

Rationale: The helper provides less than half the effort required for the resident 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 supported part of Mr. O's weight only for 2 of the 10 feet; thus Mr. O contributed more than half the effort.

5. **Walk 10 feet:** Mrs. U has an above-the-knee amputation and severe rheumatoid arthritis. Once a 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 would be coded 04, Supervision or touching assistance.

Rationale: A helper provides touching assistance in order for the resident 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:** A therapist provides 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 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).

GG0170: Mobility (3-day assessment period) Admission/*Interim*/Discharge (Start/*Interim*/End of Medicare Part A Stay) (cont.)

2. **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 would be coded 04, Supervision or touching assistance.

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

3. **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 makes two turns, the certified nursing assistant supports her trunk providing weight-bearing assistance.

Coding: GG0170J would be coded 03, Partial/moderate assistance.

Rationale: The helper provides trunk support as the resident walks more than 50 feet and makes two turns.

4. **Walk 50 feet with two turns:** Mr. T walks 50 feet with the therapist providing trunk support. *He also requires a second helper, the rehabilitation aide, who provides supervision and follows closely behind with a wheelchair for safety.* Mr. T walks the 50 feet with two turns *with the assistance of two helpers.*

Coding: GG0170J would be coded 01, Dependent.

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

5. **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 significant trunk support for about 30 to 35 feet.

Coding: GG0170J would be coded 02, Substantial/maximal assistance.

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

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 would be coded 04, Supervision or touching assistance.

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

GG0170: Mobility (3-day assessment period) Admission/*Interim*/Discharge (Start/*Interim*/End of Medicare Part A Stay) (cont.)

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 would be coded 88, Activity not attempted due to medical condition or safety concerns, and the resident's ability to walk a shorter distance would be coded in item GG0170I. The resident did not complete the activity, and a helper cannot complete the activity for the resident.

Rationale: The activity was not attempted.

3. **Walk 150 feet:** Mrs. T has an unsteady gait due to balance impairment. Mrs. T walks the length of the hallway using her quad cane in her right hand. The physical therapist supports her trunk, helping her to maintain her balance while ambulating. The therapist provides less than half of the effort to walk the 160-foot distance.

Coding: GG0170K would be coded 03, Partial/moderate assistance.

Rationale: The helper provides less than half of the effort for the resident to complete the activity of walking at least 150 feet.

4. **Walk 150 feet:** Mr. W, who has Parkinson's disease, walks the length of the hallway using his rolling walker. The physical therapist provides trunk support and advances Mr. W's right leg in longer strides with each step. The therapist occasionally prevents Mr. W from falling as he loses his balance during the activity.

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

Rationale: The helper provides more than half the effort for the resident to complete the activity of walk 150 feet.

Example for GG0170L, Walking 10 feet on uneven surfaces

1. **Walking 10 feet on uneven surfaces:** Mrs. N has severe joint degenerative disease and is recovering from sepsis. Upon discharge Mrs. N will need to be able to walk on the uneven and sloping surfaces of her driveway. During her SNF stay, a physical therapist takes Mrs. N outside to walk on uneven surfaces. Mrs. N requires the therapist's weight-bearing assistance less than half the time during walking in order to prevent Mrs. N from falling as she navigates walking 10 feet over uneven surfaces.

Coding: GG0170L would be coded 03, Partial/moderate assistance.

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

GG0170: Mobility (3-day assessment period) Admission/*Interim*/Discharge (Start/*Interim*/End of Medicare Part A Stay) (cont.)

Example for GG0170M, 1 step (curb)

1. **1 step (curb):** Mrs. Z has had a stroke; she must be able to step up and down one step to enter and exit her home. A physical therapist provides standby assistance as she uses her quad cane to support her balance in stepping up one step. The physical therapist provides steadying assistance as Mrs. Z uses her cane for balance and steps down one step.

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

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

Example for GG0170N, 4 steps

1. **4 steps:** Mr. J has lower body weakness, and a physical therapist provides steadying assistance when he ascends 4 steps. While descending 4 steps, the physical therapist provides trunk support (more than touching assistance) as Mr. J holds the stair railing.

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

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

Example for GG0170O, 12 steps

1. **12 steps:** Ms. Y is recovering from a stroke resulting in motor issues and poor endurance. Ms. Y's home has 12 stairs, with a railing, and she needs to use these stairs to enter and exit her home. Her physical therapist uses a gait belt around her trunk and supports less than half of the effort as Ms. Y ascends and then descends 12 stairs.

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

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

Examples for GG0170P, Picking up object

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

Coding: GG0170P would be coded 04, Supervision or touching assistance.

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

GG0170: Mobility (3-day assessment period) Admission/*Interim*/Discharge (Start/*Interim*/End of Medicare Part A Stay) (cont.)

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

Coding: GG0170P would be coded 05, Setup or clean-up assistance.

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

Coding Tips for GG0170R and GG0170S, Wheelchair Items

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

GG0170: Mobility (3-day assessment period) Admission/*Interim*/Discharge (Start/*Interim*/End of Medicare Part A Stay) (cont.)

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

1. **Does the resident use a wheelchair/scooter?** On admission, Mr. T wheels himself using a manual wheelchair, but with difficulty due to his severe osteoarthritis and COPD.

Coding: GG0170Q1 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 is indicated as code 1, Manual. If wheelchair goal(s) are clinically indicated, then wheelchair goals can be coded.

Rationale: The resident currently uses a wheelchair. Coding the resident's performance and 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/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 steady 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 would be coded 06, Independent.

Rationale: The resident 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. **Indicate the type of wheelchair/scooter used:** In the above example Mrs. M used a manual wheelchair during the 3-day assessment period.

Coding: GG0170RR would be coded 1, Manual.

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

3. **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 *physical therapist* assistant is required to walk next to Mr. R for frequent readjustments of his hand position to better control the steering and speed throttle. Mr. R often drives too close to corners, becoming stuck near doorways upon turning, preventing him from continuing to mobilize/wheel himself. The *physical therapist* assistant backs up Mr. R's wheelchair for him so that he may continue mobilizing/wheeling himself.

GG0170: Mobility (3-day assessment period) Admission/*Interim*/Discharge (Start/*Interim*/End of Medicare Part A Stay) (cont.)

Coding: GG0170R would be coded 03, Partial/moderate assistance.

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

4. **Indicate the type of wheelchair/scooter used:** In the above example Mr. R used a motorized wheelchair during the 3-day assessment period.

Coding: GG0170RR would be coded 2, Motorized.

Rationale: Mr. R used a motorized wheelchair during the 3-day assessment period.

5. **Wheel 50 feet with two turns:** Mr. V had a spinal tumor resulting in paralysis of his lower extremities. The *physical therapist* assistant provides verbal instruction for Mr. V to navigate his manual wheelchair in his room and into the hallway while making two turns.

Coding: GG0170R would be coded 04, Supervision or touching assistance.

Rationale: The helper provided verbal cues for the resident to complete the activity, Wheel 50 feet with two turns.

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

Coding: GG0170RR would be coded 1, Manual.

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

7. **Wheel 50 feet with two turns:** Once seated in the manual wheelchair, Ms. R wheels about 10 feet in the corridor, then asks the certified nursing assistant to push the wheelchair an additional 40 feet turning into her room and then turning into her bathroom.

Coding: GG0170R would be coded 02, Substantial/maximal assistance.

Rationale: The helper provides more than half the effort to assist the resident to complete the activity.

8. **Indicate the type of wheelchair/scooter used:** In the above example Ms. R used a manual wheelchair during the 3-day assessment period.

Coding: GG0170RR would be coded 1, Manual.

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

GG0170: Mobility (3-day assessment period) Admission/*Interim*/Discharge (Start/*Interim*/End of Medicare Part A Stay) (cont.)

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

1. **Wheel 150 feet:** Mr. G always uses a motorized scooter to mobilize himself down the hallway and the certified nursing assistant provides cues due to safety issues (to avoid running into the walls).

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

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

2. **Indicate the type of wheelchair/scooter used:** In the example above, Mr. G uses a motorized scooter.

Coding: GG0170SS would be coded 2, Motorized.

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

3. **Wheel 150 feet:** Mr. N uses a below-the-knee prosthetic limb. Mr. N has peripheral neuropathy and limited vision due to complications of diabetes. Mr. N's prior preference was to ambulate within the home and use a manual wheelchair when mobilizing himself within the community. Mr. N is assessed for the activity of 150 feet wheelchair mobility. Mr. N's usual performance indicates a helper is needed to provide verbal cues for safety due to vision deficits.

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

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

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

Coding: GG0170SS would be coded 1, Manual.

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

5. **Wheel 150 feet:** Mr. L has multiple sclerosis, resulting in extreme muscle weakness and minimal vision impairment. Mr. L uses a motorized wheelchair with an adaptive joystick to control both the speed and steering of the motorized wheelchair. 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 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.

GG0170: Mobility (3-day assessment period) Admission/*Interim*/Discharge (Start/*Interim*/End of Medicare Part A Stay) (cont.)

6. **Indicate the type of wheelchair/scooter used:** Mr. L used a motorized wheelchair during the 3-day assessment period.

Coding: GG0170SS would be coded 2, Motorized.

Rationale: Mr. L used a motorized wheelchair during the 3-day assessment period.

7. **Wheel 150 feet:** Mr. M has had a mild stroke, resulting in muscle weakness in his right upper and lower extremities. Mr. M uses a manual wheelchair. He usually can self-propel himself about 60 to 70 feet but needs assistance from a helper to complete the distance of 150 feet.

Coding: GG0170S would be coded 02, Substantial/Maximal assistance.

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

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

Coding: GG0170SS would be coded 1, Manual.

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

9. **Wheel 150 feet:** Mr. A has a cardiac condition with medical precautions that do not allow him to *propel his own* wheelchair. Mr. A is completely dependent on a helper to wheel him 150 feet using a manual wheelchair.

Coding: GG0170S would be coded 01, Dependent.

Rationale: The helper provides all the effort and the resident does none of the effort to complete the activity of wheel 150 feet.

10. **Indicate the type of wheelchair/scooter used:** In the above example, Mr. A is wheeled using a manual wheelchair during the 3-day assessment period.

Coding: GG0170SS would be coded 1, Manual.

Rationale: Mr. A is assisted using a manual wheelchair during the 3-day assessment period.

GG0170: Mobility (3-day assessment period) Admission/*Interim*/Discharge (Start/*Interim*/End of Medicare Part A Stay) (cont.)

Examples of Probing Conversations with Staff

1. **Sit to lying:** Example of a probing conversation between a nurse determining a resident's score for sit to lying and a certified nursing assistant regarding the resident'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 exactly how 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 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.

2. **Lying to sitting on side of bed:** Example of a probing conversation between a nurse determining a resident's score for lying to sitting on side of bed and a certified nursing assistant regarding the resident'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 would be coded 04, Supervision or touching assistance.

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

GG0170: Mobility (3-day assessment period) Admission/*Interim*/Discharge (Start/*Interim*/End of Medicare Part A Stay) (cont.)

3. **Sit to stand:** Example of a probing conversation between a nurse determining a resident's sit to stand score and a certified nursing assistant regarding the resident'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 a 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 would be coded 01, Dependent.

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

4. **Chair/bed-to-chair transfer:** Example of a probing conversation between a nurse determining a resident's score for chair/bed-to-chair transfer and a certified nursing assistant regarding the resident'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 cueing instructions. If this nurse had not asked probing questions, he/she would not have received enough information to make an accurate assessment of the actual assistance Mr. C received.

Coding: GG0170E 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.

GG0170: Mobility (3-day assessment period) Admission/*Interim*/Discharge (Start/*Interim*/End of Medicare Part A Stay) (cont.)

5. **Toilet transfer:** Example of a probing conversation between a nurse determining the resident's score and a certified nursing assistant regarding a resident'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 had not asked probing questions, he/she would not have received enough information to make an accurate assessment of the actual assistance Mrs. M received.

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

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

6. **Walk 50 feet with two turns:** Example of a probing conversation between a nurse determining a resident's score for walking 50 feet with two turns and a certified nursing assistant regarding the resident'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 had not asked probing questions, he/she would not have received enough information to make an accurate assessment of the actual assistance Mr. T received.

Coding: GG0170J would be coded 01, Dependent.

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

GG0170: Mobility (3-day assessment period) Admission/*Interim*/Discharge (Start/*Interim*/End of Medicare Part A Stay) (cont.)

7. **Walk 150 feet:** Example of a probing conversation between a nurse determining a resident's score for walking 150 feet and a certified nursing assistant regarding the resident'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 had not asked probing questions, he/she would not have received enough information to make an accurate assessment of the actual assistance Mrs. D received.

Coding: GG0170K 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.

8. **Wheel 50 feet with two turns:** Example of a probing conversation between a nurse determining a resident's score for wheel 50 feet with two turns and a certified nursing assistant regarding the resident'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."

GG0170: Mobility (3-day assessment period) Admission/*Interim*/Discharge (Start/*Interim*/End of Medicare Part A Stay) (cont.)

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 had not asked probing questions, he/she would not have received enough information to make an accurate assessment of the actual assistance Ms. R received.

Coding: GG0170R 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 resident.

9. **Wheel 150 feet:** Example of a probing conversation between a nurse determining a resident's score for wheel 150 feet and a certified nursing assistant regarding the resident'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 had not asked probing questions, he/she would not have received enough information to make an accurate assessment of the actual assistance Mr. G received.

Coding: GG0170S would be coded 06, Independent.

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

Discharge Goals: Coding Tips

Discharge goals are coded with each Admission (Start of SNF PPS Stay) assessment.

- For the SNF QRP, a minimum of one self-care or mobility goal must be coded. However, facilities may choose to complete more than one self-care or mobility discharge goal. Code the resident's discharge goal(s) using the six-point scale. Use of "activity not attempted" codes (07, 09, 10, and 88) is permissible to code discharge goal(s). The 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.

GG0170: Mobility (3-day assessment period) Admission/*Interim*/Discharge (Start/*Interim*/End of Medicare Part A Stay) (cont.)

- Licensed qualified clinicians can establish a resident's discharge goal(s) at the time of admission based on the resident's prior medical condition, Admission assessment self-care and mobility status, discussions with the resident and family, professional judgment, the profession's practice standards, expected treatments, resident motivation to improve, anticipated length of stay, and the resident's discharge plan. Goals should be established as part of the resident's care plan.
- If the performance of an activity was coded 88, Not attempted due to medical condition or safety concerns, during the Admission assessment, a discharge goal may be coded using the six-point scale if the resident is expected to be able to perform the activity by discharge.