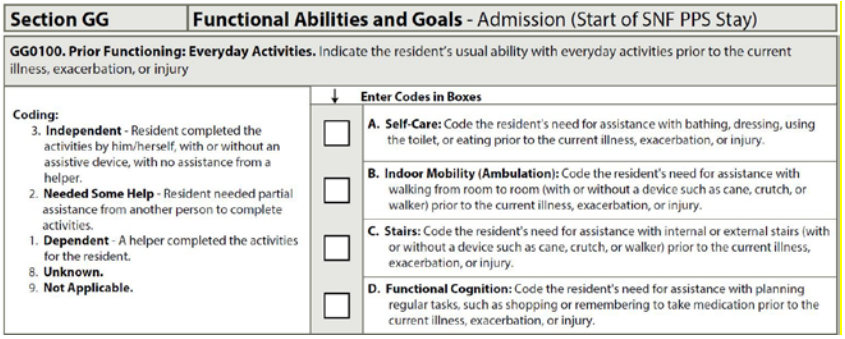
Track Changes
from Chapter 3 Section GG v1.15
to Chapter 3 Section GG v1.16

Chapter	Section	Page	Change
3	GG0100–GG0110	GG-1–GG-6	Intent: This section ~~assesses~~ includes items about functional abilities and goals. It includes items focused on prior functioning, admission performance, discharge goals, and discharge performance. Functional status is assessed based on the need for assistance ~~with~~when performing self-care and mobility activities.

GG0100. Prior Functioning: Everyday Activities



Section GG	**Functional Abilities and Goals** - Admission (Start of SNF PPS Stay)

GG0100. Prior Functioning: Everyday Activities. Indicate the resident's usual ability with everyday activities prior to the current illness, exacerbation, or injury

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.**

Enter Codes in Boxes

- **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.
- **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.
- **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.
- **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.

Item Rationale

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

Steps for Assessment

1. 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

Chapter	Section	Page	Change
			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. **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** 3. **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, Self Care, 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. 4. **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

Chapter	Section	Page	Change
			off his shoes and socks. The assistance needed was due to severe arthritis lumbar pain upon bending, which limited his ability to access his feet. Coding: GG0100A, Self Care, 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. 5. **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, Self Care, 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. 6. **Self-Care:** Mr. F was admitted with a diagnosis of stroke and a severe communication disorder. Mr. F is unable to communicate with staff using alternative communication devices. Mr. F had been living alone prior to admission. 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, Self Care, 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. 7. **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

Chapter	Section	Page	Change
			because of joint stiffness and severe arthritis pain. Occasionally, Mr. C required steadying assistance during the day when walking from room to room. Coding: GG0110B, Indoor Mobility (Ambulation), 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. 8. **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 aspiration pneumonia and severe deconditioning. Prior to the most recent acute care hospitalization, Mr. K needed some assistance when walking. Coding: GG0100B, Indoor Mobility (Ambulation), 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 would be based on the time immediately before his most recent condition exacerbation that required acute care. 9. **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, Indoor Mobility (Ambulation), would be coded 9, Not Applicable. Rationale: The resident did not ambulate immediately prior to the current illness, injury, or exacerbation (the second stroke). 10. **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

Chapter	Section	Page	Change
			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, Stairs, would be coded 2, Needed Some Help. Rationale: Prior to admission, Mr. V required some help in order to manage internal and external stairs. 11. **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, Stairs, 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. 12. **Stairs:** Mr. P has continued to show signs and symptoms of possible delirium since admission to the SNF. 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, Stairs, would be coded 8, Unknown. Rationale: Attempts were made to seek information regarding Mr. P's prior functioning; however, no information was available. 13. **Functional Cognition:** Mr. K has mild dementia and recently sustained a fall resulting in complex multiple

Chapter	Section	Page	Change
			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, Functional Cognition, 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. 14. **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, and her self-report has been determined to be an unreliable source for the information required to code this activity. 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, Functional Cognition, 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. 15. **Functional Cognition:** Mrs. R had a stroke. Since hospitalization and continuing during her SNF stay, she has had a severe communication disorder. Her family members have not returned phone calls requesting information about Mrs. R's prior functional status. Her medical records do not include information about her functional cognition prior to the stroke. Coding: GG0100D, Functional Cognition, would be coded 8, Unknown. Rationale: Attempts to seek information regarding Mrs. R's prior functioning were made; however, no information was available.

GG0110. Prior Device Use

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

Item Rationale

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

Steps for Assessment

1. Ask the resident or his or her family or review the resident's medical records describing the resident's use of prior devices and aids.

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.

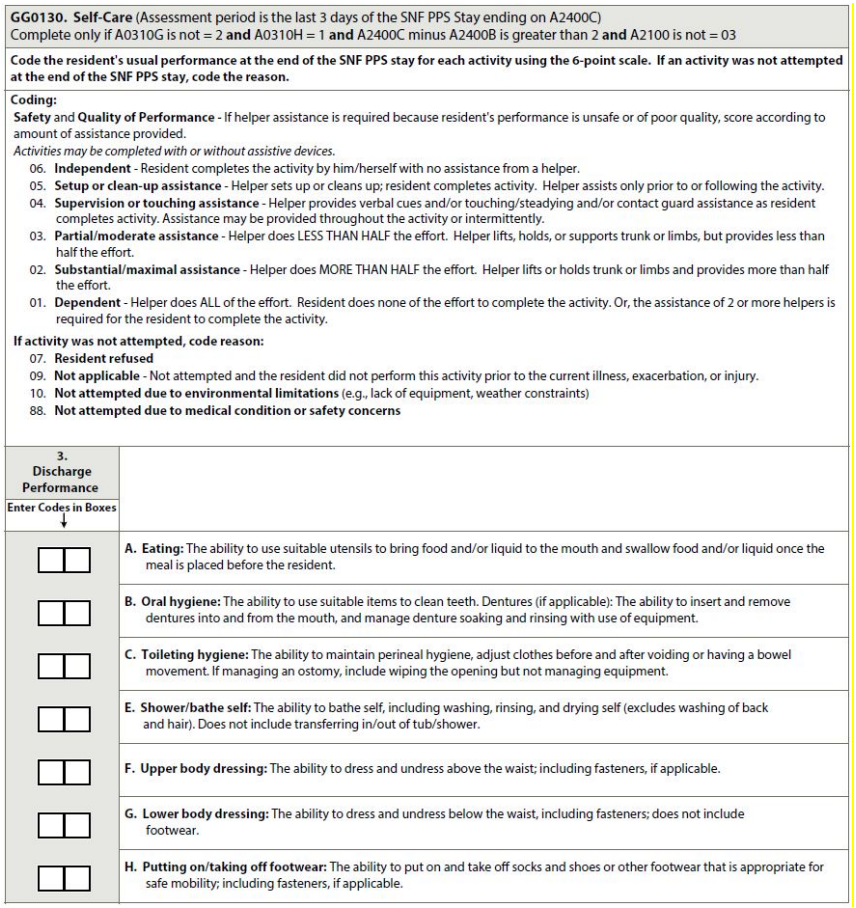
Coding Tips

- For GG0110D, Prior Device Use - Walker: "Walker" refers to all types of walkers (for example, pickup walkers, hemi-walkers, rolling walkers, and platform walkers).

Example for Coding Prior Device Use

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, Motorized wheelchair and/or scooter, would be checked.

Chapter	Section	Page	Change
			Rationale: Mrs. M used a motorized wheelchair prior to the current illness/injury.
3	GG0100–GG0170	GG-1–GG-64	Page length changed due to revised content on pages GG-1–GG-64
3	GG0130	GG-7–GG-8	GG0130: Self-Care (3-day assessment period) Admission (Start of Medicare Part A Stay)  Updated graphic

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.

Activities may be completed with or without assistive devices.

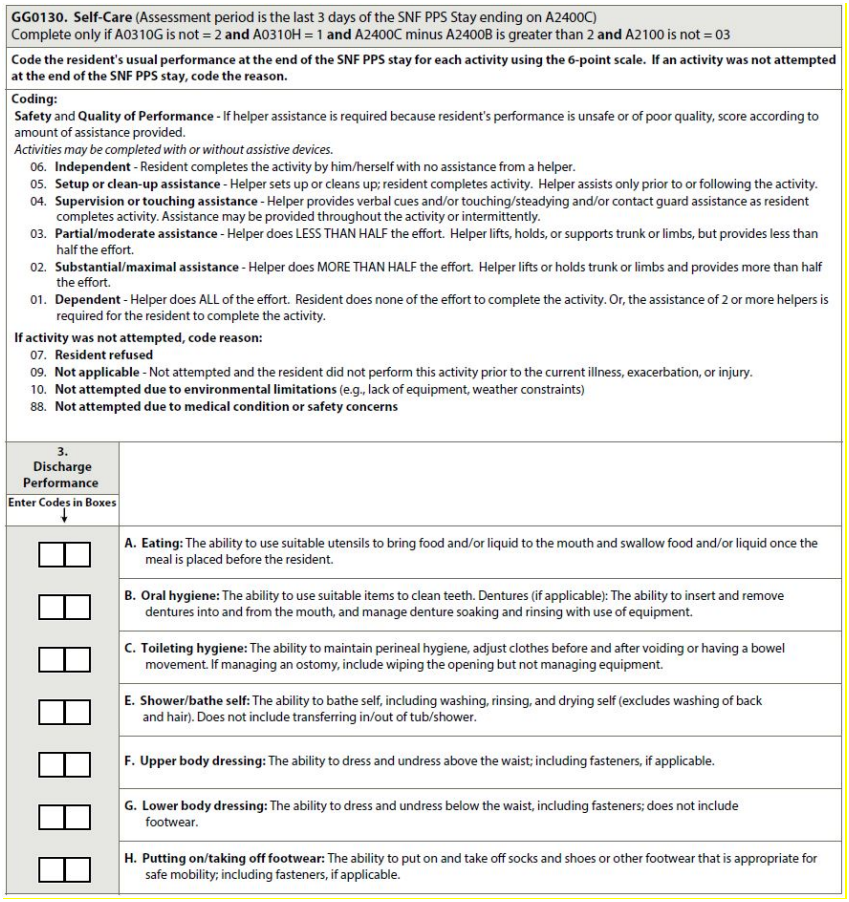
06. **Independent** - Resident completes the activity by him/herself with no assistance from a helper.
05. **Setup or clean-up assistance** - Helper sets up or cleans up; resident completes activity. Helper assists only prior to or following the activity.
04. **Supervision or touching assistance** - 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 ↓	
☐☐	**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.
☐☐	**B. Oral hygiene:** The ability to use suitable items to clean teeth. Dentures (if applicable): The ability to insert and remove dentures into and from the mouth, and manage denture soaking and rinsing with use of equipment.
☐☐	**C. Toileting hygiene:** The ability to maintain perineal hygiene, adjust clothes before and after voiding or having a bowel movement. If managing an ostomy, include wiping the opening but not managing equipment.
☐☐	**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.
☐☐	**F. Upper body dressing:** The ability to dress and undress above the waist; including fasteners, if applicable.
☐☐	**G. Lower body dressing:** The ability to dress and undress below the waist, including fasteners; does not include footwear.
☐☐	**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.

Track Changes
from Chapter 3 Section GG v1.15
to Chapter 3 Section GG v1.16

Chapter	Section	Page	Change
			 Updated graphic
3	GG0130	GG-9	## Steps for Assessment 1. ~~Licensed clinicians may a~~Assess the resident's self-care ~~status~~performance based on direct observation, as well as the resident's self-report ~~, family~~and reports~~, and direct~~ from qualified clinicians, care staff ~~reports~~, 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

Chapter	Section	Page	Change
			date in A2400B, ~~which is the~~ Start of M~~m~~ost R~~r~~ecent Medicare S~~s~~tay. On admission, these items are completed only when A0310B = 01 (5-Day PPS assessment). 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, ~~only~~ 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. ~~Section GG coding on admission should reflect the person's baseline admission functional status, and is based on a clinical assessment that occurs soon after the resident's admission.~~ ~~6.~~ The admission functional assessment, when possible, should be conducted prior to the person benefitting from treatment interventions in order to determine a true baseline functional status on admission. 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. ~~7. If the resident performs the activity more than once~~

Track Changes
from Chapter 3 Section GG v1.15
to Chapter 3 Section GG v1.16

Chapter	Section	Page	Change
			~~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 3-day assessment period to obtain the resident's usual performance.~~ 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 admission or discharge 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. 6~~8~~. 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.
3	GG0130	GG-10	• 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.

Chapter	Section	Page	Change
3	GG0130	GG-11	**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. o 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~~three~~. 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.
	GG0130	GG-11–GG-13	**Coding Tips: Admission or 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 (e.g., eating, oral hygiene). For example, when assessing Eating (item GG0130A), determine the type and amount of assistance required to bring food to the mouth and swallow food once the meal is presented on a table/tray. • ~~When coding the resident's usual performance, use the 6-point scale or one of the 3 "activity was not attempted" codes to specify the reason why an activity was not attempted.~~

Track Changes
from Chapter 3 Section GG v1.15
to Chapter 3 Section GG v1.16

Chapter	Section	Page	Change
			• ~~When coding the resident's usual performance, "effort" refers to the type and amount of assistance the helper provides in order for the activity to be completed. The 6-point rating scale definitions include the following types of assistance: setup/cleanup, touching assistance, verbal cueing, and lifting assistance.~~ • Residents with cognitive impairments/limitations may need physical and/or verbal assistance when ~~coding for the resident's Discharge Goal(s), use the same 6-point scale. Instructions about coding Discharge Goals are provided below under Discharge Goal(s): Coding Tips.~~ • ~~On discharge, use the same 6-point scale or "~~completing an activity ~~was not attempted codes that are used for the admission assessment to identify the resident's usual performance~~. Code based on the ~~Discharge assessment.~~ • ~~Do not record the staff's assessment of the~~ resident's ~~potential capability~~ 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 ~~perform this activity~~ occur at the time of the assessment and prior to the current illness, injury, or 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 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 int~~o~~ completing~~e~~ the activity, code as 01, Dependent.

Chapter	Section	Page	Change
			• 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. • ~~Clinicians may code the eating item using the appropriate response codes if the resident eats using his/her hands rather than using utensils (e.g., can feed himself/herself using finger foods). If the resident eats finger foods with his/her hands independently, for example, the resident would be coded as 06, Independent.~~ • ~~Coding~~A dash ("-") ~~in these items~~ indicates "No information." CMS expects dash use ~~for SNF QRP items~~ to be a rare occurrence. ~~Use of dashes for these items may result in a reduction in the annual payment update.~~ Do not use a dash if the reason the item was not assessed was ~~that~~ because the resident refused (code 07), the item is not applicable because the resident did not perform this activity prior to the current illness, exacerbation, or injury (code 09), the activity was not attempted due to environmental limitations (code 10), or the activity was not attempted due to medical condition or safety concerns (code 88)~~ use these codes instead of a dash ("-"). Please note that **a dash may be used for GG0130 Discharge Goal items provided that at least one Self-Care or one Mobility item has a Discharge Goal coded using the 6-point scale**. Using the dash in this allowed instance does not affect APU determination. Further information about the use of a dash ("-") for Discharge Goals is provided below under Discharge Goal(s): Coding Tips~~. • ~~For the cross-setting quality measure, the *Application of Percent of Long-Term Care Hospital Patients with an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function*, a minimum of one Self-Care or Mobility Discharge Goal must be coded per resident stay on the 5-Day PPS assessment. Even though only one Discharge Goal is required, the facility may choose to code more than one Discharge Goal for a resident.~~

Chapter	Section	Page	Change
			• 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 health care personnel as defined by facility policy and in accordance with State and Federal regulations. • ~~Completion of the Self-Care items is not required if the resident has an unplanned discharge to an acute-care hospital, or if the SNF PPS Part A Stay is less than 3 days.~~ *Coding Tips for Coding the Resident's Usual Performance* • When coding the resident's usual performance and discharge goal(s), use the six-point scale, or use one of the 4 "activity was not attempted" codes to specify the reason why an activity was not attempted. • 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

Chapter	Section	Page	Change
			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** • Resident receives tube feedings or total parenteral nutrition (TPN): o If the resident does not eat or drink by mouth and relies **solely** on nutrition and liquids through tube feedings or 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 the Eating item. o 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. Assistance with tube feedings or TPN is not considered when coding the Eating item. o If the resident eats and drinks by mouth, and relies **partially** on obtaining nutrition and liquids via tube feedings or TPN, code the Eating item based on the amount of assistance the resident requires to eat and drink by mouth. Assistance with tube feedings or TPN is not considered when coding the Eating item. • If the resident eats finger foods using his or her hands, then code the Eating item 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.
3	GG0130	GG-16	**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.
3	GG0130	GG-17	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

Chapter	Section	Page	Change
			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~~tooth brushing~~ and the certified nursing assistant ~~usually~~ completes the activity by ~~performing more than half of this activity~~ brushing the rest of his teeth.
3	GG0130	GG-18	**Coding Tips for GG0130C, Toileting hygiene** • Toileting hygiene includes the tasks of managing undergarments, clothing, and incontinence products and performing perineal cleansing before and after voiding or having a bowel movement. If the resident does not usually use undergarments, then assess the resident's need for assistance to manage lower-body clothing and perineal hygiene. • Toileting hygiene (managing clothing and perineal cleansing) can take 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 when moving his or her bowels.
3	GG0130	GG-20–GG-26	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 owing to her coordination impairment. After voiding, Ms. Q wipes her perineal area without assistance while sitting on the commode. When Ms. Q has a bowel movement, a certified nursing assistant performs perianal 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.

Chapter	Section	Page	Change
			Coding: GG0130C, Toileting hygiene, 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, at a sink, or at the bedside (i.e., 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. **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, Shower/bathe self, would be coded 04, Supervision or touching assistance. Rationale: The helper provides supervision as Mr. J washes, rinses, and dries himself. The transfer onto or off 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

Chapter	Section	Page	Change
			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 tub 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 long-handled shower to rinse herself but tires halfway through the task. The certified nursing assistant dries Mrs. E's entire body. Coding: GG0130E, Shower/bathe self, would be coded 02, Substantial/maximal assistance. 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 sponge-bathe at his bedside. Mr. Y washes, rinses, and dries his face, chest, and abdomen. A helper assists with washing, rinsing, and drying Mr. Y's arms/hands, upper legs, lower legs, buttocks, and back. Coding: GG0130E, Shower/bathe self, would be coded 02, Substantial/maximal assistance. Rationale: The helper completed more than half the activity. Bathing may occur at the bedside. When coding this activity, do not include assistance provided with washing, rinsing, or drying the person's back. **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. • 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

Chapter	Section	Page	Change
			bandage/elastic stocking/orthotic/prosthetic 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: o Upper body dressing examples: thoracic-lumbar-sacrum orthotic (TLSO), abdominal binder, back brace, elastic stockings, stump sock/shrinker, upper body support device, neck support, hand or arm prosthetic. o Lower body dressing examples: knee brace, elastic bandage, elastic stockings, stump sock/shrinker, lower-limb prosthetic. o 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, 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. • For residents with bilateral lower extremity amputations with or without use of prosthetics, the activity of putting on/taking off footwear may not occur. For example, the socks and shoes may be attached to the prosthetic associated with the upper or lower leg. o 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. o 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

Chapter	Section	Page	Change

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.

- For residents with a single lower extremity amputation with or without use of a prosthetic, the activity of putting on/taking off footwear could apply to the intact limb or both the limb with the prosthetic 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, Upper body dressing, 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 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.

2. **Upper body dressing:** Mrs. Z wears a bra and a

Chapter	Section	Page	Change
			sweatshirt most days while in the SNF. Mrs. Z 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 and unhooks the bra clasps. Mrs. Z pulls the sweatshirt over her arms, head, and trunk and slides the bra off, once it has been unclasped by the helper. Coding: GG0130F, Upper body dressing, would be coded 03, Partial/moderate assistance. Rationale: The helper provides assistance with threading Mrs. Z's arms into upper body garments and hooking and unhooking bra clasps, but 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, Upper body dressing, would be coded 02, Substantial/maximal assistance. Rationale: Mr. K can perform a small portion of the activity of upper body dressing 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. 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.

Chapter	Section	Page	Change
			Coding: GG0130G, Lower body dressing, 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 **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, Lower body dressing, 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, Lower body dressing, 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.* In contrast,

Chapter	Section	Page	Change
			coding level 04, Supervision or touching assistance, is used if the helper provides either verbal cues and/or only touching/steadying assistance as the resident completes the activity. **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, Putting on/taking off footwear, 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. 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, Putting on/taking off footwear, would be coded 03, Partial/moderate assistance.

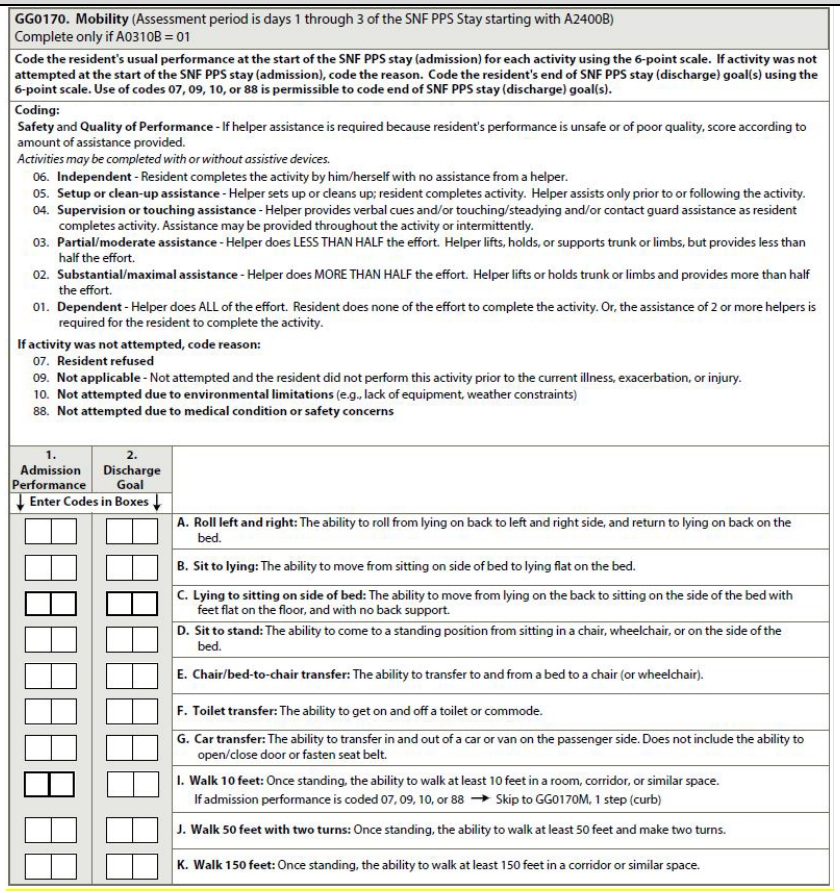
Chapter	Section	Page	Change
			Rationale: A helper provides Mrs. F with assistance in initiating putting on and taking off her footwear because of her limitations regarding fine motor coordination when putting on/taking off footwear. The helper completes more than half of the effort with this activity.
3	GG0130	GG-27–GG-29	**Discharge Goal~~(~~s~~)~~: Coding Tips** ~~Use the 6-point scale~~**Discharge goal(s) 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)~~. Do not use~~ using the six-point scale. Use of the "activity was not attempted" codes (07, 09, 10, and~~or~~ 88) is permissible to code discharge goal(s). Use of a dash ~~(-) to indicate~~ is permissible for any remaining self-care or mobility goals that ~~a specific activity is not a Discharge Goal. Of note, at least one Discharge Goal must be indicated for either Self-Care or Mobility.~~ were not coded. Using the dash in this allowed instance after the coding of at least one goal does not affect APU determination. • Licensed, qualified clinicians can establish a resident's discharge goal(s) at the time of admission based on the ~~5 Day PPS~~resident's prior medical condition, admission assessment self-care and mobility status, discussions with the resident and family, professional judgment, ~~and~~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. • ~~For the cross-setting quality measure, the Application of Percent of Long-Term Care Hospital Patients with an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function, a minimum of one Self-Care or Mobility Discharge Goal must be coded per resident stay on the 5-Day PPS assessment. Even though only one Discharge Goal is required, the facility may choose to code more than one Discharge Goal for a resident.~~

Chapter	Section	Page	Change
			• ~~Goals may be determined based on the resident's admission functional status, prior functioning, medical conditions/comorbidities, discussions with the resident and family concerning discharge goals, anticipated length of stay, and the clinician's consideration of expected treatments, and resident motivation to improve.~~ • 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. ## Discharge Goal: Coding Examples **~~Example~~ 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. **~~Example~~ 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 ~~and Discharge Goal~~:** 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

Chapter	Section	Page	Change
			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 ~~Admission Performance and~~ 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. **~~Example~~ 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

Chapter	Section	Page	Change
			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.
3	GG0170	GG-30–GG-33	GG0170: Mobility (3-day assessment period) Admission (Start of Medicare Part A Stay)

Track Changes
from Chapter 3 Section GG v1.15
to Chapter 3 Section GG v1.16

Chapter	Section	Page	Change
			 Updated graphic

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 ↓		
		A. **Roll left and right:** The ability to roll from lying on back to left and right side, and return to lying on back on the bed.
		B. **Sit to lying:** The ability to move from sitting on side of bed to lying flat on the bed.
		C. **Lying to sitting on side of bed:** The ability to move from lying on the back to sitting on the side of the bed with feet flat on the floor, and with no back support.
		D. **Sit to stand:** The ability to come to a standing position from sitting in a chair, wheelchair, or on the side of the bed.
		E. **Chair/bed-to-chair transfer:** The ability to transfer to and from a bed to a chair (or wheelchair).
		F. **Toilet transfer:** The ability to get on and off a toilet or commode.
		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.
		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)
		J. **Walk 50 feet with two turns:** Once standing, the ability to walk at least 50 feet and make two turns.
		K. **Walk 150 feet:** Once standing, the ability to walk at least 150 feet in a corridor or similar space.

Chapter	Section	Page	Change

GG0170. Mobility (Assessment period is days 1 through 3 of the SNF PPS Stay starting with A2400B) - Continued
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 ↓		
☐☐	☐☐	**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.
☐☐	☐☐	**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
☐☐	☐☐	**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
☐☐	☐☐	**O. 12 steps:** The ability to go up and down 12 steps with or without a rail.
☐☐	☐☐	**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.
		☐ **Q1. 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
☐☐	☐☐	**R. Wheel 50 feet with two turns:** Once seated in wheelchair/scooter, the ability to wheel at least 50 feet and make two turns.
		☐ **RR1. Indicate the type of wheelchair or scooter used.** 1. **Manual** 2. **Motorized**
☐☐	☐☐	**S. Wheel 150 feet:** Once seated in wheelchair/scooter, the ability to wheel at least 150 feet in a corridor or similar space.
		☐ **SS1. Indicate the type of wheelchair or scooter used.** 1. **Manual** 2. **Motorized**

Updated graphic

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.

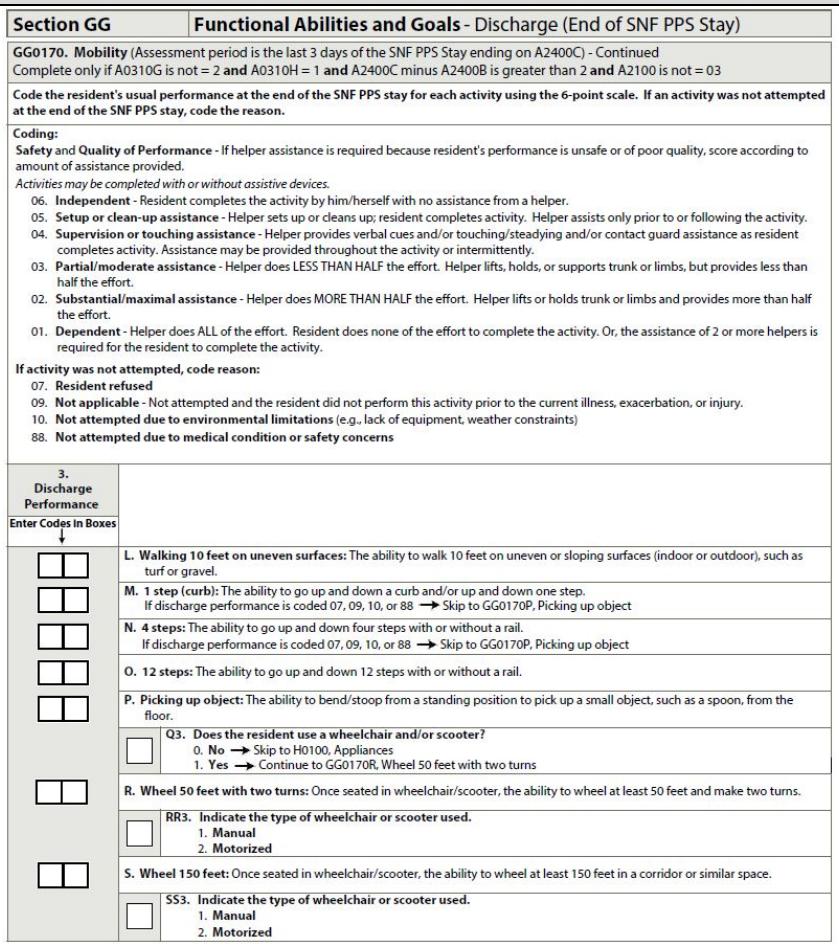
06. **Independent** - Resident completes the activity by him/herself with no assistance from a helper.
05. **Setup or clean-up assistance** - Helper sets up or cleans up; resident completes activity. Helper assists only prior to or following the activity.
04. **Supervision or touching assistance** - 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 ↓	
☐☐	**A. Roll left and right:** The ability to roll from lying on back to left and right side, and return to lying on back on the bed.
☐☐	**B. Sit to lying:** The ability to move from sitting on side of bed to lying flat on the bed.
☐☐	**C. Lying to sitting on side of bed:** The ability to move from lying on the back to sitting on the side of the bed with feet flat on the floor, and with no back support.
☐☐	**D. Sit to stand:** The ability to come to a standing position from sitting in a chair, wheelchair, or on the side of the bed.
☐☐	**E. Chair/bed-to-chair transfer:** The ability to transfer to and from a bed to a chair (or wheelchair).
☐☐	**F. Toilet transfer:** The ability to get on and off a toilet or commode.
☐☐	**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.
☐☐	**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)
☐☐	**J. Walk 50 feet with two turns:** Once standing, the ability to walk at least 50 feet and make two turns.
☐☐	**K. Walk 150 feet:** Once standing, the ability to walk at least 150 feet in a corridor or similar space.

Updated graphic

<table>
<tr><th>Chapter</th><th>Section</th><th>Page</th><th>Change</th></tr>
<tr><td></td><td></td><td></td><td>


Updated graphic</td></tr>
<tr><td>3</td><td>GG0170</td><td>GG-34</td><td>

Item Rationale

- ~~Residents in~~During a Medicare Part A SNF ~~stays~~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

1. Assess the resident's mobility ~~status~~performance based on direct observation, as well as the resident's self-report and the reports of~~, family reports, and direct~~ qualified clinicians, direct care staff ~~reports documented in the resident's medical record~~, or family during the three-day assessment period. CMS anticipates that a multidisciplinary team of qualified clinicians is involved

</td></tr>
</table>

Chapter	Section	Page	Change
			in assessing the resident during the three-day assessment period. For Section GG ~~on admission~~, the assessment period is the first three days of the Part A stay, starting with the date in A2400B, ~~which is the s~~Start of M~~m~~ost R~~r~~ecent Medicare S~~s~~tay. On admission, these items are completed only when A0310B = 01 (5-Day PPS assessment). 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, 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. 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. Section GG coding on admission should reflect the person's baseline admission functional status, and is based on a clinical assessment that occurs soon after the resident's admission.~~ ~~6~~5. The admission functional assessment, when possible, should be conducted prior to the person benefitting from treatment interventions in order to determine a true baseline functional status on admission. 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. ~~7. 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~~

Chapter	Section	Page	Change
			~~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 Mobility 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 3-day assessment period to obtain the resident's usual performance.~~ ~~8~~6. 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.
3	GG0170	GG-35	• 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.
3	GG0170	GG-36	**Admission 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. o 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 including the following two days, ending at 11:59 PM on day 3~~three~~. 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

Chapter	Section	Page	Change
			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.
3	GG0170	GG-36–GG-39	**Admission and Discharge Performance Coding Tips** *General Coding Tips* 1. When reviewing the resident's medical record, interviewing staff, and observing the resident, be familiar with the definition ~~of~~for each activity. For example, when assessing GG0170J, Walk 50 feet with two~~2~~ turns ~~(item GG0170J)~~, determine the ~~level~~type and amount of assistance required ~~to walk 50 feet while making 2 turns~~ as the resident walks 50 feet. ~~2. When coding the resident's usual performance, use the 6-point scale or one of the 3 "activity was not attempted" codes to specify the reason why an activity was not attempted.~~ ~~3. When coding the resident's usual performance, "effort" refers to the type and amount of assistance the helper provides in order for the activity to be completed. The 6-point rating scale definitions include the following types of assistance: setup/cleanup, touching assistance, verbal cueing, and lifting assistance.~~ ~~4. At admission, when coding the resident's Discharge Goal(s), use the same 6-point scale. **Instructions above related to coding Discharge Goals for the Mobility items (GG0170) are the same as those for coding Discharge Goals for the Self-Care items (GG0130)**.~~ ~~5. On discharge, use the same 6-point scale or "activity was not attempted" codes that are used for the admission assessment to identify the resident's usual performance on the Discharge assessment.~~ ~~6. Do not record the staff's assessment of the resident's~~

Chapter	Section	Page	Change
			~~potential capability to perform the activity.~~ 7. If the resident does not attempt the activity and a helper does not complete the activity for the resident during the entire three-day assessment period, code the reason the activity was not attempted. For example, enter code 07, Resident refused, if the resident refused to attempt the activity during the entire assessment period; enter code 09, Not applicable, if the activity is not applicable for the resident (because the ~~resident did not perform~~ this activity did not occur during the assessment period, and prior to the current illness, exacerbation, or injury); enter code 10, Not attempted due to environmental limitations, if the resident was not able to attempt the activity due to environmental limitations; or enter code 88, Not attempted due to medical condition or safety concerns, if the resident was not able to attempt the activity due to a medical condition or safety concerns. 8. 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. 9. If two or more helpers are required to assist the resident to complete the activity, code as 01, Dependent. 10. 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. ~~11. The turns included in the items GG0170J and GG0170R (walking or wheeling 50 feet with 2 turns) are 90-degree turns. The turns may be in the same direction (two 90-degree turns to the right or two 90-degree turns to the left) or may be in different directions (one 90-degree turn to the left and one 90-degree turn to the right). The 90-degree turn should occur at the person's ability level and can include use of an assistive device (for example, cane or wheelchair).~~ 12. ~~Coding~~A dash ~~("–") in these items~~ ("-") indicates "No information." CMS expects dash use ~~for SNF QRP items~~ to be a rare occurrence. ~~Use of dashes for these items may~~

Chapter	Section	Page	Change
			~~result in a reduction in annual payment update.~~ Do not use a dash if the reason the item was not assessed was that the resident refused (code 07), the item is not applicable because the resident did not perform this activity prior to the current illness, exacerbation, or injury (code 09), the activity was not attempted due to environmental limitations (code 10), or the activity was not attempted due to medical condition or safety concerns (code 88)~~, use these codes instead of a dash (“-”). A dash may be used for GG0170 Discharge Goal items provided that at least one Self-Care or one Mobility item has a Discharge Goal coded using the 6-point scale. Using the dash in this allowed instance does not affect APU determination. Further information about use of a dash (“-”) for Discharge Goals is provided above under Discharge Goal(s): Coding Tips.~~. ~~13. For the cross-setting quality measure, the *Application of Percent of Long-Term Care Hospital Patients with an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function*, a minimum of one Self-Care or Mobility goal must be coded per resident stay on the 5-Day PPS assessment. Even though only one Discharge Goal is required, the facility may choose to code more than one Discharge Goal for a resident.~~ 14. 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. *Tips for Coding the Resident’s Usual Performance* 15. 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. 16. 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,

Chapter	Section	Page	Change
			verbal cueing, and lifting assistance. 17. 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. 18. Code based on the resident's performance. Do not record the staff's assessment of the resident's potential capability to perform the activity. 19. 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 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. ~~Some examples do not have coding tips.~~ **Examples for GG0170A, Roll left and right** 20. **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, Roll left and right, would be coded 02, Substantial/maximal assistance.

Chapter	Section	Page	Change
			Rationale: The nurse provides more than half of the effort needed for the resident to complete the activity of rolling left and right. 21. **Roll left and right:** A physical therapist helps Mr. K turn onto his right side by instructing him to bend his left leg and roll onto his right side. He then instructs him on how to position his limbs to return to lying on his back and then to repeat a similar process for rolling onto his left side and then return to lying on his back. Mr. K completes the activity without physical assistance from the physical therapist. Coding: GG0170A, Roll left and right, would be coded 04, Supervision or touching assistance. Rationale: The physical therapist provides verbal cues (i.e., instructions) to Mr. R 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. 22. **Roll left and right:** Mr. Z had a stroke that resulted in paralysis on his right side and is recovering from cardiac surgery. He requires the assistance of two certified nursing assistants when rolling onto his right side and returning to lying on his back and also when rolling onto his left side and returning to lying on his back. Coding: GG0170A, Roll left and right, would be coded 01, Dependent. Rationale: Two certified nursing assistants are needed to help Mr. Z roll onto his left and right side and back while in bed. 23. **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.

Chapter	Section	Page	Change
			Coding: GG0170A, Roll left and right, would be coded 03, Partial/moderate assistance. Rationale: The helper provides less than half the effort needed for the 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. ~~Overall, Mrs. H performs more than half of the effort.~~ 2. **Sit to lying:** Mrs. F requires assistance from a certified nursing assistant to get from a sitting position to lying flat on the bed because of postsurgical open reduction internal fixation healing fractures of her right hip and left and right wrists. The certified nursing assistant cradles and supports her trunk and right leg to transition Mrs. F from sitting at the side of the bed to lying flat on the bed. Mrs. F assists herself a small amount by bending her elbows and left leg while pushing her elbows and left foot into the mattress only to straighten her trunk while transitioning into a lying position. Coding: GG0170B 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.

Chapter	Section	Page	Change
			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. 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. ~~Overall, Mrs. E performs more than half of the effort.~~
3	GG0170	GG-41	**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 resident's ability to perform each of the tasks within this activity and how much support the resident requires to complete the tasks within this activity is assessed. • For item GG0170C, Lying to sitting on side of bed, clinical judgment should be used to determine what is

Chapter	Section	Page	Change
			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 or a footstool is required to accommodate foot placement on the floor/footstool. • 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.
3	GG0170	GG-42	**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. ~~Overall, the occupational therapist performs more than half of the effort.~~ 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	GG0170	GG-26	~~**Coding Tips for GG0170C, Lying to sitting on side of bed**~~ • ~~Item GG0170C, Lying to sitting on side of bed, indicates that the resident transitions from lying on his/her back to sitting on the side of the bed with feet flat on the floor and sitting upright on the bed without back support. The clinician is to assess the resident's ability to perform each of the tasks within this activity and determine how much support the resident requires to complete the activity.~~ • ~~For item GG0170C, Lying to sitting on the side of bed, clinical judgment should be used to determine what is considered a "lying" position for that resident.~~

Chapter	Section	Page	Change
			• ~~If the resident's feet do not reach the floor upon lying to sitting, the clinician will determine if a bed height adjustment or a foot stool is required to accommodate foot placement on the floor/footstool.~~ • ~~Back support refers to an object or person providing support of the resident's back.~~
3	GG0170	GG-44	**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.
3	GG0170	GG-45	**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. ~~Overall, the therapist provides less than half of the effort.~~ 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.

Chapter	Section	Page	Change
			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 trunk in a rocking motion ~~as Mr. U scoots~~ across the transfer board and into the wheelchair. ~~Overall, the therapist provides more than half of the effort.~~ 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.
3	GG0170	GG-29	~~**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.~~
3	GG0170	GG-47	**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. ~~The therapist provides less than half the effort during the toilet transfer.~~ Coding: GG0170F would be coded 03, Partial/moderate assistance.

Chapter	Section	Page	Change
			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. **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. ~~Ms. W contributes less than half of the effort to transfer onto the toilet.~~
3	GG0170	GG-48–GG-50	**Examples for ~~GG0170H1, Does the resident walk?~~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 steadying assistance from the therapist. She lifts her legs into the car with support from the therapist. Coding: GG0170G, Car transfer, 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.

Chapter	Section	Page	Change
			Coding: GG0170G, Car transfer, 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. **Coding Tips for 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. **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, Walk 10 feet, 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. Since GG0170I, Walk 10 feet, is coded 88, follow the skip pattern to GG0170Q1 (admission) or GG0170Q3 (planned discharge), Does the resident use a wheelchair and/or scooter? 2. **Walk 10 feet:** Mr. L had bilateral amputations three years ago, and prior to the current admission he used a

Chapter	Section	Page	Change
			wheelchair and did not walk. Currently Mr. L does not use prosthetic devices and uses only a wheelchair for mobility. Mr. L's care plan includes fitting and use of bilateral lower extremity prostheses. Coding: GG0170I, Walk 10 feet, would be coded 09, Not applicable. 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. 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, Walk 10 feet, 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 therapy assistant secures Mr. O's arms onto his platform walker's arm supports to manage the tremors. The therapy assistant guides and steadies the shaking, rolling walker forward while cueing Mr. O to take larger steps. Mr. O requires steadying at the beginning of the walk and progressively requires some of his weight to be supported for the last 5 feet of the 10-foot walk. Coding: GG0170I, Walk 10 feet, 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. 5. **Walk 10 feet:** Mrs. U has an above-the-knee amputation and severe rheumatoid arthritis. Once a nurse has donned

Chapter	Section	Page	Change
			her stump sock and prosthesis, Mrs. U is assisted to stand and uses her rolling walker while walking. The nurse places his hand on Mrs. U's back to steady her toward the last half of her 10-foot walk. Coding: GG0170I, Walk 10 feet, would be coded 04, Supervision or touching assistance. Rationale: A helper provides touching assistance in order for the 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. ~~1.~~ ~~**Does the resident walk?** Mr. Z currently does not walk, but a walking goal is clinically indicated.~~ ~~Coding: GG0170H1, Does the resident walk? would be coded 1, No, and walking goal is clinically indicated. Discharge goal(s) for items J, Walk 50 feet with two turns and K, Walk 150 feet may be coded.~~ ~~Rationale: Resident does not currently walk. By indicating the resident does not walk, the admission performance walking items are skipped. However, a walking goal is clinically indicated and walking goals may be coded.~~ ~~•~~ ~~**Does the resident walk?** Ms. Y currently walks with great difficulty due to her progressive neurological disease. It is not expected that Ms. Y will continue to walk. Ms. Y also uses a wheelchair so both GG0170H1, Does the resident walk? and GG0170Q1, Does the resident use a wheelchair/scooter? will be coded Yes.~~ ~~Coding: GG0170H1, Does the resident walk? would be coded 2, Yes, and each walking admission performance activity for items J, Walk 50 feet with two turns and K, Walk 150 feet would then be coded.~~ ~~Rationale: The resident currently walks and admission performance codes are entered for each walking item.~~
3	GG0170	GG-51	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~~and provides less than half the effort~~. Coding: GG0170J would be coded 03, Partial/moderate assistance.

Chapter	Section	Page	Change
			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 and the therapy assistant providing supervision. Mr. T walks the 50 feet with two turns. 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 ~~more than half of the effort~~ significant trunk support for about 30 to 35 feet.
3	GG0170	GG-51	2. **Walk 150 feet:** Mr. R has endurance limitations due to heart failure and has only walked about 30 feet during the 3-day assessment period. He has not walked 150 feet or more during the assessment period, including with the physical therapist who has been working with Mr. R. The therapist speculates that Mr. R could walk this distance in the future with additional assistance. Coding: GG0170K, Walk 150 feet, would be coded 88, Activity not attempted due to medical 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. 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.

Chapter	Section	Page	Change
			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. ~~The therapist provides more than half the effort for 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.
3	GG0170	GG-52–GG-54	**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, Walking 10 feet on uneven surfaces, 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. **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.

Chapter	Section	Page	Change
			Coding: GG0170M, 1 step (curb), 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, 4 steps, 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, 12 steps, 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, Picking up object, 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.

- **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, Picking up object, 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.

Chapter	Section	Page	Change
			• 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, 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 or are expected to use a wheelchair during their stay in the SNF, even if the resident is also expected to ambulate during the stay or by discharge. o 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. o 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.
3	GG0170	GG-55	**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. Item GG0170Q1, Does the resident use a wheelchair/scooter? will be coded 1, Yes. Coding: GG0170QI, Does the resident use a wheelchair/scooter? would be coded 1, Yes. The admission performance codes for wheelchair items GG0170R and GG0170S are coded; in addition, the

Chapter	Section	Page	Change
			type of wheelchair Mr. T uses for GG0170RR1 and RR2 is indicated as code 1, Manual. If wheelchair goal(s) are clinically indicated, then wheelchair goals can be coded. Rationale: The resident currently uses a wheelchair. Coding ~~all admission assessment wheelchair items~~ the resident's performance and coding the type of wheelchair (manual) is indicated. Wheeling goal(s) if clinically indicated may be coded.
3	GG0170	GG-55	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 therapy assistant is required to walk next to Mr. R for frequent readjustments of his hand position to better control the steering and speed throttle. Mr. R often drives too close to corners, becoming stuck near doorways upon turning, preventing him from continuing to mobilize/wheel himself. The therapy assistant backs up Mr. R's wheelchair for him so that he may continue mobilizing/wheeling himself. ~~Overall, Mr. R provides more than half of the effort~~. 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 therapy 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.

Chapter	Section	Page	Change
			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.
3	GG0170	GG-38	~~**Coding Tips for GG0170R and GG0170S, Wheelchair Items**~~ • ~~The intention of the wheelchair items is to assess the resident's use of a wheelchair for self-mobilization at admission and discharge when appropriate. The clinician uses clinical judgment to determine if the resident's use of a wheelchair is appropriate for self-mobilization due to the resident's medical condition or safety.~~ • ~~Do not code wheelchair mobility if the resident only uses a wheelchair when transported between locations within the facility. 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, code the wheelchair gateway items at admission and/or discharge items – GG0170Q1 and/or GG0170Q3, Does the resident use a wheelchair/scooter – as 0, No. Answering the question in this way invokes a skip pattern which will skip all remaining wheelchair questions.~~ • ~~Admission assessment for wheelchair items should be coded for residents who used a wheelchair prior to admission or are anticipated to use a wheelchair during the~~

Chapter	Section	Page	Change
			~~stay, even if the resident is anticipated to ambulate during the stay or by discharge.~~ o ~~The responses for gateway admission and discharge walking items (GG0170H1 and GG0170H3) and the gateway admission and discharge wheelchair items (GG0170Q1 and GG0170Q3) do not have to be the same on the admission and discharge assessments.~~
3	GG0170	GG-64	**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. • 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.