SECTION GG: FUNCTIONAL ABILITIES AND GOALS

Intent: This section assesses the need for assistance with self-care and mobility activities.

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

GG0130. Self-Care (Assessment period is days 1 through 3 of the SNF PPS Stay starting with A2400B)
Complete only if A0310B = 01

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

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 or TOUCHING/STEADYING 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.**
88. Not attempted due to **medical condition or safety concerns.**

1. Admission Performance	2. Discharge Goal	
↓ Enter Codes in Boxes ↓		
☐☐	☐☐	**A. Eating:** The ability to use suitable utensils to bring food to the mouth and swallow food once the meal is presented on a table/tray. Includes modified food consistency.
☐☐	☐☐	**B. Oral hygiene:** The ability to use suitable items to clean teeth. [Dentures (if applicable): The ability to remove and replace dentures from and to the mouth, and manage equipment for soaking and rinsing them.]
☐☐	☐☐	**C. Toileting hygiene:** The ability to maintain perineal hygiene, adjust clothes before and after using the toilet, commode, bedpan, or urinal. If managing an ostomy, include wiping the opening but not managing equipment.

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

GG0130. Self-Care (Assessment period is the last 3 days of the SNF PPS Stay ending on A2400C)
Complete only if A0310G is not = 2 **and** A0310H = 1 **and** A2400C minus A2400B is greater than 2 **and** A2100 is not = 03

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

Coding:

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

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 or TOUCHING/STEADYING 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.**
88. Not attempted due to **medical condition or safety concerns.**

3. Discharge Performance	
Enter Code ☐☐	**A. Eating:** The ability to use suitable utensils to bring food to the mouth and swallow food once the meal is presented on a table/ tray. Includes modified food consistency.
Enter Code ☐☐	**B. Oral hygiene:** The ability to use suitable items to clean teeth. [Dentures (if applicable): The ability to remove and replace dentures from and to the mouth, and manage equipment for soaking and rinsing them.]
Enter Code ☐☐	**C. Toileting hygiene:** The ability to maintain perineal hygiene, adjust clothes before and after using the toilet, commode, bedpan, or urinal. If managing an ostomy, include wiping the opening but not managing equipment.

Item Rationale

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

Steps for Assessment

1. Assess the resident's self-care status based on direct observation, the resident's self-report, family reports, and direct care staff reports documented in the resident's medical record during the assessment period. For Section GG, the admission assessment period is the first three days of the Part A stay starting with the date in A2400B, which is the Start of most recent Medicare stay. 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.

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

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. 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 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.
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.

DEFINITION

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

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

Admission or Discharge Performance Coding Instructions

- Code 06, Independent: if the resident completes the activity by him/herself with no assistance from a helper.
- Code 05, Setup or clean-up assistance: if the helper SETS UP or CLEANS UP; resident completes activity. Helper assists only prior to or following the activity, but not during the activity. For example, the resident requires assistance cutting up food or opening container, or requires setup of hygiene item(s) or assistive device(s).
- Code 04, Supervision or touching assistance: if the helper provides VERBAL CUES or TOUCHING/ STEADYING assistance as resident completes activity. Assistance may be provided throughout the activity or intermittently. For example, the resident requires verbal cueing, coaxing, or general supervision for safety to complete activity; or resident may require only incidental help such as contact guard or steadying assist during the activity.
- Code 03, Partial/moderate assistance: if the helper does LESS THAN HALF the effort. Helper lifts, holds, or supports trunk or limbs, but provides less than half the effort.
- Code 02, Substantial/maximal assistance: if the helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs and provides more than half the effort.
- Code 01, Dependent: if the helper does ALL of the effort. Resident does none of the effort to complete the activity; or the assistance of two or more helpers is required for the resident to complete the activity.
- Code 07, Resident refused: if the resident refused to complete the activity.
- Code 09, Not applicable: if the resident did not perform this activity prior to the current illness, exacerbation, or injury.
- Code 88, Not attempted due to medical condition or safety concerns: if the activity was not attempted due to medical condition or safety concerns.

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

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.
    - 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 three. 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.

- **Discharge:** The Part A PPS Discharge assessment is required to be completed when the resident's Medicare Part A Stay ends (as documented in A2400C, End of Most Recent Medicare Stay), either as a standalone assessment when the resident's Medicare Part A stay ends, but the resident remains in the facility; or may be combined with an OBRA Discharge if the Medicare Part A stay ends on the day of, or one day before the resident's Discharge Date (A2000). Please see Chapter 2 and Section A of the RAI Manual for additional details regarding the Part A PPS Discharge assessment.
    - For the Discharge assessment (i.e., standalone Part A PPS or combined OBRA/Part A PPS), code the resident's discharge functional status, based on a clinical assessment of the resident's performance that occurs as close to the time of the resident's discharge from Medicare Part A as possible. This functional assessment must be completed within the last three calendar days of the resident's Medicare Part A stay, which includes the day of discharge from Medicare Part A and the two days prior to the day of discharge from Medicare Part A.
- 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.
- 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.

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

- At admission, 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 "activity was not attempted" codes that are used for the admission assessment to identify the resident's usual performance on the Discharge assessment.
- Do not record the staff's assessment of the resident's potential capability to perform the activity.
- If the resident does not attempt the activity and a helper does not complete the activity for the resident, code the reason the activity was not attempted. For example, Code 07 if the resident refused to attempt the activity, Code 09 if the resident did not perform this activity prior to the current illness, exacerbation, or injury, or Code 88 if the resident was not able to attempt the activity due to medical condition or safety concerns.
- If two or more helpers are required to assist the resident to complete the activity, code as 01, Dependent.
- To clarify your own understanding of the resident's performance of an activity, ask probing questions to 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. 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), 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 <u>at least one</u> 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.

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

- Documentation in the medical record is used to support assessment coding of Section GG. Data entered should be consistent with the clinical assessment documentation in the resident's medical record. This assessment can be conducted by appropriate healthcare personnel as defined by facility policy and in accordance with State and Federal regulations.
- 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.

Examples for Coding Admission Performance or Discharge Performance

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

Examples for GG0130A, Eating

1. **Eating:** Ms. S has multiple sclerosis, affecting her endurance and strength. Ms. S prefers to feed herself as much as she is capable. During all meals, after eating three-fourths of the meal by herself, Ms. S usually becomes extremely fatigued and requests assistance from the certified nursing assistant to feed her the remainder of the meal.

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

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

2. **Eating:** Mr. M has upper extremity weakness and fine motor impairments. The occupational therapist places an adaptive device onto Mr. M's hand that supports the eating utensil within his hand. At the start of each meal Mr. M can bring food and liquids to his mouth. Mr. M then tires and the certified nursing assistant feeds him more than half of each meal.

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

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

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

   Coding: GG0130A, Eating would be coded 06, Independent.

   Rationale: The resident can independently complete the activity without any assistance from a helper for this activity. In this scenario, the presence of a G-tube does not affect the eating score.

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

4. **Eating:** The dietary aide opens all of Mr. S's cartons and containers on his food tray before leaving the room. There are no safety concerns regarding Mr. S's ability to eat. Mr. S eats the food himself, bringing the food to his mouth using appropriate utensils and swallowing the food safely.

   Coding: GG0130A, Eating would be coded 05, Setup or clean-up assistance.
   Rationale: The helper provided setup assistance prior to the eating activity.

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

   Coding: GG0130A, Eating would be coded 04, Supervision or touching assistance.
   Rationale: Mrs. H swallows all types of food consistencies and requires verbal cueing (supervision) from the helper.

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

   Coding: GG0130A, Eating would be coded 04, Supervision or touching assistance.
   Rationale: The helper provides verbal cueing assistance during meals as Mrs. V completes the activity of eating. Supervision, such as reminders, may be provided throughout the activity or intermittently.

7. **Eating:** Mrs. N is impulsive. While she eats, the certified nursing assistant provides verbal and tactile cueing so that Mrs. N does not lift her fork to her mouth until she has swallowed the food in her mouth.

   Coding: GG0130A, Eating would be coded 04, Supervision or touching assistance.
   Rationale: The resident requires supervision and touching assistance in order to eat safely.

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

   Coding: GG0130A, Eating would be coded 88, Not attempted due to medical condition or safety concerns.
   Rationale: The resident does not eat or drink by mouth at this time due to his recent-onset stroke. This item includes eating and drinking by mouth only. Since eating and drinking did not occur due to his recent-onset medical condition, the activity is coded as 88, Not attempted due to medical condition and safety concerns. Assistance with G-tube feedings is not considered when coding this item.

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

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

   Coding: GG0130A, Eating would be coded 01, Dependent.
   Rationale: The helper does all of the effort for each meal. The resident does not contribute any effort to complete the eating activity.

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

    Coding: GG0130A, Eating would be coded 03, Partial/moderate assistance.
    Rationale: The certified nursing assistant provides less than half the effort for the resident to complete the activity of eating.

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

    Coding: GG0130A, Eating would be coded 02, Substantial/maximal assistance.
    Rationale: The helper provides more than half the effort for the resident to complete the activity of eating.

Examples for GG0130B, Oral hygiene

1. **Oral hygiene:** In the morning and at night, Mrs. F brushes her teeth while sitting on the side of the bed. Each time, the certified nursing assistant gathers her toothbrush, toothpaste, water, and an empty cup and puts them on the bedside table for her before leaving the room. Once Mrs. F is finished brushing her teeth, which she does without any help, the certified nursing assistant returns to gather her items and dispose of the waste.

   Coding: GG0130B, Oral hygiene would be coded 05, Setup or clean-up assistance.
   Rationale: The helper provides setup and clean-up assistance. The resident brushes her teeth without any help.

2. **Oral hygiene:** Before bedtime, the nurse provides steadying assistance to Mr. S as he walks to the bathroom. The nurse applies toothpaste onto Mr. S's toothbrush. Mr. S then brushes his teeth at the sink in the bathroom without physical assistance or supervision. Once Mr. S is done brushing his teeth and washing his hands and face, the nurse returns and provides steadying assistance as the resident walks back to his bed.

   Coding: GG0130B, Oral hygiene would be coded 05, Setup or clean-up assistance.
   Rationale: The helper provides setup assistance (putting toothpaste on the toothbrush) every evening before Mr. S brushes his teeth. *Do not consider assistance provided to get to or from the bathroom to score Oral hygiene.*

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

3. **Oral hygiene:** At night, the certified nursing assistant provides Mrs. K water and toothpaste to clean her dentures. Mrs. K cleans her upper denture plate. Mrs. K then cleans half of her lower denture plate, but states she is tired and unable to finish cleaning her lower denture plate. The certified nursing assistant finishes cleaning the lower denture plate and Mrs. K replaces the dentures in her mouth.

   Coding: GG0130B, Oral hygiene would be coded 03, Partial/moderate assistance.
   Rationale: The helper provided less than half the effort to complete oral hygiene.

4. **Oral hygiene:** Mr. W is edentulous (without teeth) and his dentures no longer fit his gums. In the morning and evening, Mr. W begins to brush his upper gums after the helper applies toothpaste onto his toothbrush. He brushes his upper gums, but cannot finish due to fatigue. The certified nursing assistant completes the activity of oral hygiene by brushing his back upper gums and his lower gums.

   Coding: GG0130B, Oral hygiene would be coded 02, Substantial/maximal assistance.
   Rationale: The resident begins the activity. The helper completes the activity by performing more than half the effort.

5. **Oral hygiene:** Mr. G has Parkinson's disease, resulting in tremors and incoordination. The certified nursing assistant retrieves all oral hygiene items for Mr. G and applies toothpaste to his toothbrush. Mr. G requires assistance to guide the toothbrush into his mouth and to steady his elbow while he brushes his teeth. Mr. G usually starts tooth brushing and the certified nursing assistant usually completes the activity by performing more than half of this activity.

   Coding: GG0130B, Oral hygiene would be coded 02, Substantial/maximal assistance.
   Rationale: The helper provided more than half the effort for the resident to complete the activity of oral hygiene.

6. **Oral hygiene:** Ms. T has Lewy body dementia and multiple bone fractures. She does not understand how to use oral hygiene items nor does she understand the process of completing oral hygiene. The certified nursing assistant brushes her teeth and explains each step of the activity to engage cooperation from Ms. T; however, she requires full assistance for the activity of oral hygiene.

   Coding: GG0130B, Oral hygiene would be coded 01, Dependent.
   Rationale: The helper provides all the effort for the activity to be completed.

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

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

   Coding: GG0130B, Oral hygiene would be coded 04, Supervision or touching assistance.
   Rationale: The helper provides verbal cues to assist the resident in completing the activity of brushing his teeth.

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

   Coding: GG0130B, Oral hygiene would be coded 04, Supervision or touching assistance.
   Rationale: The helper provides verbal cues to assist the resident in completing the activity of brushing her teeth.

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

   Coding: GG0130B, Oral hygiene would be coded 03, Partial/moderate assistance.
   Rationale: The helper provided less than half the effort to complete oral hygiene.

Examples for GG0130C, Toileting hygiene

1. **Toileting hygiene:** Mrs. J uses a bedside commode. The certified nursing assistant provides steadying (touching) assistance as Mrs. J pulls down her pants and underwear before sitting down on the toilet. When Mrs. J is finished voiding or having a bowel movement, the certified nursing assistant provides steadying assistance as Mrs. J wipes her perineal area and pulls up her pants and underwear without assistance.

   Coding: GG0130C, Toileting hygiene would be coded 04, Supervision or touching assistance.
   Rationale: The helper provides steadying (touching) assistance to the resident to complete toileting hygiene.

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

2. **Toileting hygiene:** Mrs. L uses the toilet to void and have bowel movements. Mrs. L is unsteady, so the certified nursing assistant walks into the bathroom with her in case she needs help. During the assessment period, a staff member has been present in the bathroom, but has not needed to provide any physical assistance with managing clothes or cleansing.

   Coding: GG0130C, Toileting hygiene would be coded 04, Supervision or touching assistance.
   Rationale: The helper provides supervision as the resident performs the toilet hygiene activity. The resident is unsteady and the staff provide supervision for safety reasons.

3. **Toileting hygiene:** Mrs. P has urinary urgency. As soon as she gets in the bathroom, she asks the certified nursing assistant to lift her gown and pull down her underwear due to her balance problems. After voiding, Mrs. P wipes herself and pulls her underwear back up.

   Coding: GG0130C, Toileting hygiene would be coded 03, Partial/moderate assistance.
   Rationale: The helper provides more than touching assistance. The resident performs more than half the effort; the helper does less than half the effort. The resident completes two of the three toileting hygiene tasks.

4. **Toileting hygiene:** Mr. J is morbidly obese and has a diagnosis of debility. He requests the use of a bedpan when voiding or having bowel movements and requires two certified nursing assistants to pull down his pants and underwear and mobilize him onto and off the bedpan. Mr. J is unable to complete any of his perineal/perianal hygiene. Both certified nursing assistants help Mr. J pull up his underwear and pants.

   Coding: GG0130C, Toileting hygiene would be coded 01, Dependent.
   Rationale: The assistance of two helpers was needed to complete the activity of toileting hygiene.

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

   Coding: GG0130C, Toileting hygiene would be coded 03, Partial/moderate assistance.
   Rationale: The helper provides less than half the effort. The resident performs two of the three toileting hygiene tasks by himself. Walking to the bathroom is not considered when scoring toileting hygiene.

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

Examples of Probing Conversations with Staff

1. **Eating:** Example of a probing conversation between a nurse and a certified nursing assistant regarding the resident's eating abilities:

   Nurse: "Please describe to me how Mr. S eats his meals. Once the food and liquid are presented to him, does he use utensils to bring food to his mouth and swallow?"

   Certified nursing assistant: "No, I have to feed him."

   Nurse: "Do you always have to physically feed him or can he sometimes do some aspect of the eating activity with encouragement or cues to feed himself?"

   Certified nursing assistant: "No, he can't do anything by himself. I scoop up each portion of the food and bring the fork or spoon to his mouth. I try to encourage him to feed himself or to help guide the spoon to his mouth but he can't hold the fork. I even tried encouraging him to eat food he could pick up with his fingers, but he will not eat unless he is completely assisted for food and liquid."

   In this example, the nurse inquired specifically how Mr. S requires assistance to eat his meals. The nurse asked about instructions and physical assistance. If this nurse had not asked probing questions, he/she may not have received enough information to make an accurate assessment of the assistance Mr. S received. Accurate coding is important for reporting on the type and amount of care provided. Be sure to consider each activity definition fully.

   Coding: GG0130A, Eating would be coded 01, Dependent.
   Rationale: The resident requires complete assistance from the certified nursing assistant to eat his meals.

2. **Oral hygiene:** Example of a probing conversation between a nurse determining a resident's oral hygiene score and a certified nursing assistant regarding the resident's oral hygiene routine:

   Nurse: "Does Mrs. K help with brushing her teeth?"

   Certified nursing assistant: "She can help clean her teeth."

   Nurse: "How much help does she need to brush her teeth?"

   Certified nursing assistant: "She usually gets tired after starting to brush her upper teeth. I have to brush most of her teeth."

   In this example, the nurse inquired specifically how Mrs. K manages her oral hygiene. The nurse asked about physical assistance and how the resident performed the activity. If this nurse had not asked probing questions, he/she would not have received enough information to make an accurate assessment of the actual assistance Mrs. K received.

   Coding: GG0130B, Oral hygiene would be coded 02, Substantial/maximal assistance.
   Rationale: The certified nursing assistant provides more than half the effort to complete Mrs. K's oral hygiene.

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

Discharge Goal(s): Coding Tips

- Use the 6-point scale to code the resident's Discharge Goal(s). Do not use the "activity was not attempted" codes (07, 09, or 88) to code Discharge Goal(s). Use a dash (-) to indicate 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. Using the dash in this allowed instance does not affect APU determination.
- Licensed clinicians can establish a resident's Discharge Goal(s) at the time of admission based on the 5-Day PPS assessment, discussions with the resident and family, professional judgment, and the professional's standard of practice. 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.
- 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 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.

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

Example 2: Discharge Goal Code Is the *Same* as 5-Day PPS Assessment Admission Performance Code

The 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 clinician determines that the resident would be able to maintain her admission functional performance level. The 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 clinician anticipates that the resident will have the same level of function for oral hygiene at admission and discharge. The resident's 5-Day PPS admission performance code is coded and the Discharge Goal is coded at the same level. Mrs. E has stated her preference for participation twice daily in her oral hygiene activity. Mrs. E has severe arthritis, Parkinson's disease, diabetic neuropathy, and renal failure. These conditions result in multiple impairments (e.g., limited endurance, weak grasp, slow movements, and tremors). The clinician observes Mrs. E's 5-Day PPS admission performance and discusses her usual performance with clinicians, caregivers, and family to determine the necessary interventions for skilled therapy (e.g., positioning of an adaptive toothbrush cuff, verbal cues, lifting, and supporting Mrs. E's limb). The clinician codes Mrs. E's 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 clinician anticipates Mrs. E's discharge performance will remain 02, Substantial/maximal assistance. Due to Mrs. E's progressive and degenerative condition, the 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 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.

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

Toileting Hygiene 5-Day PPS Assessment Admission Performance: Mrs. T has a progressive neurological illness that affects her strength, coordination, and endurance. Mrs. T prefers to use a bedside commode rather than incontinence undergarments for as long as possible. The certified nursing assistant currently supports Mrs. T while she is standing so that Mrs. T can release her hand from the grab bar (next to her bedside commode) and pull down her underwear before sitting onto the bedside commode. When Mrs. T has finished voiding, she wipes her perineal area. Mrs. T then requires the helper to support her trunk while Mrs. T pulls up her underwear. The 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 clinician codes her Discharge Goal as 02, Substantial/maximal assistance.

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

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

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

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 or TOUCHING/STEADYING 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.**
88. Not attempted due to **medical condition or safety concerns.**

1. Admission Performance	2. Discharge Goal	
↓ Enter Codes in Boxes ↓		
☐☐	☐☐	**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 safely 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 safely come to a standing position from sitting in a chair or on the side of the bed.
☐☐	☐☐	**E. Chair/bed-to-chair transfer:** The ability to safely transfer to and from a bed to a chair (or wheelchair).
☐☐	☐☐	**F. Toilet transfer:** The ability to safely get on and off a toilet or commode.
		☐ **H1. Does the resident walk?** 0. **No**, and walking goal is not clinically indicated → Skip to GG0170Q1, Does the resident use a wheelchair/scooter? 1. **No**, and walking goal is clinically indicated → Code the resident's discharge goal(s) for items GG0170J and GG0170K 2. **Yes** → Continue to GG0170J, Walk 50 feet with two turns
☐☐	☐☐	**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.
		☐ **Q1. Does the resident use a wheelchair/scooter?** 0. **No** → Skip to GG0130, Self Care (Discharge) 1. **Yes** → Continue to GG0170R, Wheel 50 feet with two turns
☐☐	☐☐	**R. Wheel 50 feet with two turns:** Once seated in wheelchair/scooter, can wheel at least 50 feet and make two turns.
		☐ **RR1. Indicate the type of wheelchair/scooter used.** 1. **Manual** 2. **Motorized**
☐☐	☐☐	**S. Wheel 150 feet:** Once seated in wheelchair/scooter, can wheel at least 150 feet in a corridor or similar space.
		☐ **SS1. Indicate the type of wheelchair/scooter used.** 1. **Manual** 2. **Motorized**

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 or TOUCHING/STEADYING 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.**
88. Not attempted due to **medical condition or safety concerns.**

3. Discharge Performance Enter Codes in Boxes	
☐☐	**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 safely 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 safely come to a standing position from sitting in a chair or on the side of the bed.
☐☐	**E. Chair/bed-to-chair transfer:** The ability to safely transfer to and from a bed to a chair (or wheelchair).
☐☐	**F. Toilet transfer:** The ability to safely get on and off a toilet or commode.
	☐ **H3. Does the resident walk?** 0. **No** → Skip to GG0170Q3, Does the resident use a wheelchair/scooter? 2. **Yes** → Continue to GG0170J, Walk 50 feet with two turns
☐☐	**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.
	☐ **Q3. Does the resident use a wheelchair/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, can wheel at least 50 feet and make two turns.
	☐ **RR3. Indicate the type of wheelchair/scooter used.** 1. **Manual** 2. **Motorized**
☐☐	**S. Wheel 150 feet:** Once seated in wheelchair/scooter, can wheel at least 150 feet in a corridor or similar space.
	☐ **SS3. Indicate the type of wheelchair/scooter used.** 1. **Manual** 2. **Motorized**

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

Item Rationale

- Residents in Medicare Part A SNF stays 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 based on direct observation, the resident's self-report, family reports, and direct care staff reports documented in the resident's medical record during the 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 start of most recent Medicare stay. 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.

DEFINITION

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

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.

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

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 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. 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.

Admission or Discharge Performance Coding Instructions

- Code 06, Independent: if the resident completes the activity by him/herself with no assistance from a helper.
- Code 05, Setup or clean-up assistance: if the helper SETS UP or CLEANS UP; resident completes activity. Helper assists only prior to or following the activity, but not during the activity. For example, the resident requires placement of a bed rail to facilitate rolling, or requires setup of a leg lifter or other assistive devices.
- Code 04, Supervision or touching assistance: if the helper provides VERBAL CUES or TOUCHING/STEADYING assistance as resident completes activity. Assistance may be provided throughout the activity or intermittently. For example, the resident requires verbal cueing, coaxing, or general supervision for safety to complete the activity; or resident may require only incidental help such as contact guard or steadying assistance during the activity.
- Code 03, Partial/moderate assistance: if the helper does LESS THAN HALF the effort. Helper lifts, holds, or supports trunk or limbs, but provides less than half the effort. For example, the resident requires assistance such as partial weight-bearing assistance, but HELPER does LESS THAN HALF the effort.
- Code 02, Substantial/maximal assistance: if the helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs and provides more than half the effort.
- Code 01, Dependent: if the helper does ALL of the effort. Resident does none of the effort to complete the activity. Or the assistance of two or more helpers is required for the resident to complete the activity.
- Code 07, Resident refused: if the resident refused to complete the activity.
- Code 09, Not applicable: if the resident did not perform this activity prior to the current illness, exacerbation, or injury.

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

- Code 88, Not attempted due to medical condition or safety concerns: if the activity was not attempted due to medical condition or safety concerns.

Admission or Discharge Performance Coding Tips

- **Admission:** The 5-Day PPS assessment (A0310B = 01) is the first Medicare-required assessment to be completed when the resident is admitted for a SNF Part A stay.
    - For the 5-Day PPS assessment, code the resident's functional status based on a clinical assessment of the resident's performance that occurs soon after the resident's admission. This functional assessment must be completed within the first three days (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 three. 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.
- **Discharge:** The Part A PPS Discharge assessment is required to be completed when the resident's Medicare Part A stay ends as documented in A2400C, End of Most Recent Medicare Stay, either as a standalone assessment when the resident's Medicare Part A stay ends, but the resident remains in the facility; or may be combined with an OBRA Discharge if the Medicare Part A stay ends on the day of or one day before the resident's Discharge Date (A2000). Please see Chapter 2 and Section A of the RAI Manual for additional details regarding the Part A PPS Discharge assessment.
    - For the Discharge assessment, (i.e., standalone Part A PPS or combined OBRA/Part A PPS), code the resident's discharge functional status, based on a clinical assessment of the resident's performance that occurs as close to the time of the resident's discharge from Medicare Part A as possible. This functional assessment must be completed within the last three calendar days of the resident's Medicare Part A stay, which includes the day of discharge from Medicare Part A and the two days prior to the day of discharge from Medicare Part A.
- When reviewing the medical record, interviewing staff, and observing the resident, be familiar with the definition of each activity. For example, when assessing Walk 50 feet with 2 turns (item GG0170J), determine the level of assistance required to walk 50 feet while making 2 turns.
- 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.
- 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.

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

- 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)**.
- 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.
- Do not record the staff's assessment of the resident's potential capability to perform the activity.
- If the resident does not attempt the activity and a helper does not complete the activity for the resident, code the reason the activity was not attempted. For example, Code 07 if the resident refused to attempt the activity, Code 09 if the activity is not applicable for the resident because the resident did not perform this activity prior to the current illness, exacerbation, or injury, or Code 88 if the resident was not able to attempt the activity due to medical condition or safety concerns.
- If two or more helpers are required to assist the resident to complete the activity, code as 01, Dependent.
- To clarify your own understanding and observations about a resident's performance of an activity, ask probing questions, beginning with the general and proceeding to the more specific. See examples of using probes when talking with staff at the end of this section.
- 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).
- 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 annual payment update. 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), 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.

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

- 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.
- 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.
- Completion of the Mobility 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.

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 GG0170B, Sit to lying

1. **Sit to lying:** Mrs. H requires assistance from a nurse to transfer from sitting at the edge of the bed to lying flat on the bed because of paralysis on her right side. The helper lifts and positions Mrs. H's right leg. Mrs. H uses her arms to position her upper body. Overall, Mrs. H performs more than half of the effort.

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

   Rationale: A helper lifts Mrs. H's right leg and helps her position it as she moves from a seated to a lying position; the helper performs less than half of the effort.

2. **Sit to lying:** Mrs. F requires assistance from a certified nursing assistant to get from a sitting position to lying flat on the bed because of postsurgical open reduction internal fixation healing fractures of her right hip and left and right wrists. The certified nursing assistant cradles and supports her trunk and right leg to transition Mrs. F from sitting at the side of the bed to lying flat on the bed. Mrs. F assists herself a small amount by bending her elbows and left leg while pushing her elbows and left foot into the mattress only to straighten her trunk while transitioning into a lying position.

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

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

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

3. **Sit to lying:** Mrs. H requires assistance from two certified nursing assistants to transfer from sitting at the edge of the bed to lying flat on the bed due to paralysis on her right side, obesity, and cognitive limitations. One of the certified nursing assistants explains to Mrs. H each step of the sitting to lying activity. Mrs. H is then fully assisted to get from sitting to a lying position on the bed. Mrs. H makes no attempt to assist when asked to perform the incremental steps of the activity.

   Coding: GG0170B, Sit to lying would be coded 01, Dependent.
   Rationale: The assistance of two certified nursing assistants was needed to complete the activity of sit to lying. If two or more helpers are required to assist the resident to complete an activity, code as 01, Dependent.

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

   Coding: GG0170B, Sit to lying 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, Sit to lying 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.

   Coding: GG0170B, Sit to lying would be coded 03, Partial/moderate assistance.
   Rationale: A helper lifts Mrs. E's left leg and helps her position it as Mrs. E transitions from a seated to a lying position; the helper does less than half of the effort.

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

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

   Coding: GG0170B, Sit to lying 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.

Examples for GG0170C, Lying to sitting on side of bed

1. **Lying to sitting on side of bed:** Mr. B pushes up from the bed to get himself from a lying to a seated position. The certified nursing assistant provides steadying (touching) assistance as Mr. B scoots himself to the edge of the bed and lowers his feet onto the floor.

   Coding: GG0170C, Lying to sitting on side of bed would be coded 04, Supervision or touching assistance.
   Rationale: The helper provides touching assistance as the resident moves from a lying to sitting position.

2. **Lying to sitting on side of bed:** Mr. B pushes up on the bed to attempt to get himself from a lying to a seated position as the occupational therapist provides much of the lifting assistance necessary for him to sit upright. The occupational therapist provides assistance as Mr. B scoots himself to the edge of the bed and lowers his feet to the floor. Overall, the occupational therapist performs more than half of the effort.

   Coding: GG0170C, Lying to sitting on side of bed would be coded 02, Substantial/maximal assistance.
   Rationale: The helper provides lifting assistance (more than half the effort) as the resident moves from a lying to sitting position.

3. **Lying to sitting on side of bed:** Ms. P is being treated for sepsis and has multiple infected wounds on her lower extremities. Full assistance from the certified nursing assistant is needed to move Ms. P from a lying position to sitting on the side of her bed because she usually has pain in her lower extremities upon movement.

   Coding: GG0170C, Lying to sitting on side of bed would be coded 01, Dependent.
   Rationale: The helper fully completed the activity of lying to sitting on the side of bed for the resident.

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

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

   Coding: GG0170C, Lying to sitting on side of bed would be coded 04, Supervision or touching assistance.

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

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

   Coding: GG0170C, Lying to sitting on side of bed would be coded 03, Partial/moderate assistance.

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

Coding 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.
- 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.

Examples for GG0170D, Sit to stand

1. **Sit to stand:** Mr. M has osteoarthritis and is recovering from sepsis. Mr. M transitions from a sitting to a standing position with the steadying (touching) assistance of the nurse's hand on Mr. M's trunk.

   Coding: GG0170D, Sit to stand would be coded 04, Supervision or touching assistance.

   Rationale: The helper provides touching assistance only.

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

2. **Sit to stand:** Mrs. L has multiple healing fractures and multiple sclerosis, requiring two certified nursing assistants to assist her to stand up from sitting in a chair.

   Coding: GG0170D, Sit to stand would be coded 01, Dependent.
   Rationale: Mrs. L requires the assistance of two helpers to complete the activity.

3. **Sit to stand:** Mr. B has complete tetraplegia and is currently unable to stand when getting out of bed. He transfers from his bed into a wheelchair with assistance. The activity of sit to stand is not attempted due to his medical condition.

   Coding: GG0170D, Sit to stand would be coded 88, Not attempted due to medical condition or safety concerns.
   Rationale: The activity is not attempted due to the resident's diagnosis of complete tetraplegia.

4. **Sit to stand:** Ms. Z has amyotrophic lateral sclerosis with moderate weakness in her lower and upper extremities. Ms. Z has prominent foot drop in her left foot, requiring the use of an ankle foot orthosis (AFO) for standing and walking. The certified nursing assistant applies Ms. Z's AFO and places the platform walker in front of her; Ms. Z uses the walker to steady herself once standing. The certified nursing assistant provides lifting assistance to get Ms. Z to a standing position and must also provide assistance to steady Ms. Z's balance to complete the activity.

   Coding: GG0170D, Sit to stand would be coded 02, Substantial/maximal assistance.
   Rationale: The helper provided lifting assistance and more than half of the effort for the resident to complete the activity of sit to stand.

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

   Coding: GG0170D, Sit to stand would be coded 03, Partial/moderate assistance.
   Rationale: The helper provided lifting assistance and less than half the effort for the resident to complete the activity of sit to stand.

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

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

1. **Chair/bed-to-chair transfer:** Mr. L had a stroke and currently is not able to walk. He uses a wheelchair for mobility. When Mr. L gets out of bed, the certified nursing assistant moves the wheelchair into the correct position and locks the brakes so that Mr. L can transfer into the wheelchair safely. Mr. L had been observed several other times to determine any safety concerns, and it was documented that he transfers safely without the need for supervision. Mr. L transfers into the wheelchair by himself (no helper) after the certified nursing assistant leaves the room.

   Coding: GG0170E, Chair/bed-to-chair transfer would be coded 05, Setup or clean-up assistance.
   Rationale: Mr. L is not able to walk, so he transfers from his bed to a wheelchair when getting out of bed. The helper provides setup assistance only. Mr. L transfers safely and does not need supervision or physical assistance during the transfer.

2. **Chair/bed-to-chair transfer:** Mr. C is sitting on the side of the bed. He stands and pivots into the chair as the nurse provides contact guard (touching) assistance. The nurse reports that one time Mr. C only required verbal cues for safety, but usually Mr. C requires touching assistance.

   Coding: GG0170E, Chair/bed-to-chair transfer would be coded 04, Supervision or touching assistance.
   Rationale: The helper provides touching assistance during the transfers.

3. **Chair/bed-to-chair transfer:** Mr. F's medical conditions include morbid obesity, diabetes mellitus, and sepsis, and he recently underwent bilateral above-the-knee amputations. Mr. F requires full assistance with transfers from the bed to the wheelchair using a lift device. Two certified nursing assistants are required for safety when using the device to transfer Mr. F from the bed to a wheelchair. Mr. F is unable to assist in the transfer from his bed to the wheelchair.

   Coding: GG0170E, Chair/bed-to-chair transfer would be coded 01, Dependent.
   Rationale: The two helpers completed all the effort for the activity of chair/bed-to-chair transfer. If two or more helpers are required to assist the resident to complete an activity, code as 01, Dependent.

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

4. **Chair/bed-to-chair transfer:** Ms. P has metastatic bone cancer, severely affecting her ability to use her lower and upper extremities during daily activities. Ms. P is motivated to assist with her transfers from the side of her bed to the wheelchair. Ms. P pushes herself up from the bed to begin the transfer while the therapist provides trunk support with weight-bearing assistance. Once standing, Ms. P shuffles her feet, turns, and slowly sits down into the wheelchair with the therapist providing trunk support with weight-bearing assistance. Overall, the therapist provides less than half of the effort.

   Coding: GG0170E, Chair/bed-to-chair transfer would be coded 03, Partial/moderate assistance.
   Rationale: The helper provided less than half of the effort for the resident to complete the activity of chair/bed-to-chair transfer.

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

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 the side of the 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 a mechanical lift transfer, then Code 01, Dependent, even if the resident assists with any part of the chair/bed-to-chair transfer.

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

Examples for GG0170F, Toilet transfer

1. **Toilet transfer:** The certified nursing assistant moves the wheelchair footrests up so that Mrs. T can transfer from the wheelchair onto the toilet by herself safely. The certified nursing assistant is not present during the transfer, because supervision is not required. Once Mrs. T completes the transfer from the toilet back to the wheelchair, she flips the footrests back down herself.

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

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

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

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

   Rationale: The helper provides supervision as the resident transfers onto and off the toilet. The resident may use an assistive device.

3. **Toilet transfer:** Mrs. Y is anxious about getting up to use the bathroom. She asks the certified nursing assistant to stay with her in the bathroom as she gets on and off the toilet. The certified nursing assistant stays with her, as requested, and provides verbal encouragement and instructions (cues) to Mrs. Y.

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

   Rationale: The helper provides supervision/verbal cues as Mrs. Y transfers onto and off the toilet.

4. **Toilet transfer:** The certified nursing assistant provides steadying (touching) assistance as Mrs. Z lowers her underwear and then transfers onto the toilet. After voiding, Mrs. Z cleanses herself. She then stands up as the helper steadies her and Mrs. Z pulls up her underwear as the helper steadies her to ensure Mrs. Z does not lose her balance.

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

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

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

5. **Toilet transfer:** The therapist supports Mrs. M's trunk with a gait belt as Mrs. M pivots and lowers herself onto the toilet. The therapist provides less than half the effort during the toilet transfer.

   Coding: GG0170F, Toilet transfer would be coded 03, Partial/moderate assistance.
   Rationale: The helper provides less than half the effort to complete the activity. The helper provided weight-bearing assistance as the resident transferred on and off the toilet.

6. **Toilet transfer:** Ms. W has peripheral vascular disease and sepsis, resulting in lower extremity pain and severe weakness. Ms. W uses a bedside commode when having a bowel movement. The certified nursing assistant raises the bed to a height that facilitates the transfer activity. Ms. W initiates lifting her buttocks from the bed and in addition requires some of her weight to be lifted by the certified nursing assistant to stand upright. Ms. W then reaches and grabs onto the armrest of the bedside commode to steady herself. The certified nursing assistant slowly lowers Ms. W onto the bedside commode. Ms. W contributes less than half of the effort to transfer onto the toilet.

   Coding: GG0170F, Toilet transfer would be coded 02, Substantial/maximal assistance.
   Rationale: The helper provided more than half of the effort for the resident to complete the activity of toilet transfer.

7. **Toilet transfer:** Mr. H has paraplegia incomplete, pneumonia, and a chronic respiratory condition. Mr. H prefers to use the bedside commode when moving his bowels. Due to his severe weakness, history of falls, and dependent transfer status, two certified nursing assistants assist during the toilet transfer.

   Coding: GG0170F, Toilet transfer would be coded 01, Dependent.
   Rationale: The activity required the assistance of two or more helpers for the resident to complete the activity.

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

   Coding: GG0170F, Toilet transfer would be coded 88, Not attempted due to medical condition or safety concerns.
   Rationale: The resident does not transfer onto or off a toilet due to being on bedrest because of a medical condition.

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

Examples for GG0170H1, Does the resident walk?

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.

2. **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.

Examples for GG0170J, Walk 50 feet with two turns

1. **Walk 50 feet with two turns:** A therapist provides steadying assistance as Mrs. W gets up from a sitting position to a standing position. After the therapist places Mrs. W's walker within reach, Mrs. W walks 60 feet down the hall with two turns without any assistance from the therapist. No supervision is required while she walks.

   Coding: GG0170J, Walk 50 feet with two turns would be coded 05, Setup or clean-up assistance.
   Rationale: Mrs. W walks more than 50 feet and makes two turns once the helper places the walker within reach. Assistance with getting from a sitting to a standing position is coded separately under the item GG0170D, Sit to stand (04, Supervision or touching assistance).

2. **Walk 50 feet with two turns:** Mrs. P walks 70 feet with a quad cane, completing two turns during the walk. The therapist provides steadying assistance only when Mrs. P turns.

   Coding: GG0170J, Walk 50 feet with two turns would be coded 04, Supervision or touching assistance.
   Rationale: The helper provides touching assistance as the resident walks more than 50 feet and makes two turns. The resident may use an assistive device.

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

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 and provides less than half the effort.

   Coding: GG0170J, Walk 50 feet with two turns would be coded 03, Partial/moderate assistance.
   Rationale: The helper provides trunk support as the 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, Walk 50 feet with two turns 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.

   Coding: GG0170J, Walk 50 feet with two turns would be coded 02, Substantial/ maximal assistance.
   Rationale: The helper provided more than half of the effort for the resident to complete the activity of walk 50 feet with two turns.

Examples for GG0170K, Walk 150 feet

1. **Walk 150 feet:** Mrs. D walks down the hall using her walker and the certified nursing assistant usually needs to provide touching assistance to Mrs. D, who intermittently loses her balance while she uses the walker.

   Coding: GG0170K, Walk 150 feet would be coded 04, Supervision or touching assistance.
   Rationale: The helper provides touching assistance intermittently throughout the activity.

2. **Walk 150 feet:** Mr. R has endurance limitations due to heart failure and has only walked about 30 feet during the 3-day assessment period. He has not walked 150 feet or more during the assessment period, including with the physical therapist who has been working with Mr. R. The therapist speculates that Mr. R could walk this distance in the future with additional assistance.

   Coding: GG0170K, Walk 150 feet would be coded 88, Activity not attempted due to medical or safety concerns.
   Rationale: The activity was not attempted.

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

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, Walk 150 feet would be coded 03, Partial/moderate assistance.
   Rationale: The helper provides less than half of the effort for the resident to complete the activity of walking at least 150 feet.

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

   Coding: GG0170K, Walk 150 feet would be coded 02, Substantial/maximal assistance.
   Rationale: The helper provides more than half the effort for the resident to complete the activity of walk 150 feet.

Example for 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 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 and coding the type of wheelchair (manual) is indicated. Wheeling goal(s) if clinically indicated may be coded.

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

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

1. **Wheel 50 feet with two turns:** Mrs. M is unable to bear any weight on her right leg due to a recent fracture. The certified nursing assistant provides steadying assistance when transferring Mrs. M from the bed into the wheelchair. Once in her wheelchair, Mrs. M propels herself about 60 feet down the hall using her left leg and makes two turns without any physical assistance or supervision.

   Coding: GG0170R, Wheel 50 feet with two turns would be coded 06, Independent.
   Rationale: The resident wheels herself more than 50 feet. Assistance provided with the transfer is not considered when scoring Wheel 50 feet with two turns. There is a separate item for scoring bed-to-chair transfers.

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

   Coding: GG0170RR, Indicate the type of wheelchair/scooter used would be coded 1, Manual.
   Rationale: Mrs. M used a manual wheelchair during the 3-day assessment period.

3. **Wheel 50 feet with two turns:** Mr. R is very motivated to use his motorized wheelchair with an adaptive throttle for speed and steering. Mr. R has amyotrophic lateral sclerosis, and moving his upper and lower extremities is very difficult. The 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, Wheel 50 feet with two turns 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, Indicate the type of wheelchair/scooter used would be coded 2, Motorized.
   Rationale: Mr. R used a motorized wheelchair during the 3-day assessment period.

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

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, Wheel 50 feet with two turns would be coded 04, Supervision or touching assistance.
   Rationale: The helper provided verbal cues for the resident to complete the activity, Wheel 50 feet with two turns.

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

   Coding: GG0170RR, Indicate the type of wheelchair/scooter used 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, then asks the certified nursing assistant to push the wheelchair an additional 40 feet into her room and her bathroom.

   Coding: GG0170R, Wheel 50 feet with two turns would be coded 02, Substantial/maximal assistance.
   Rationale: The helper provides more than half the effort to assist the resident to complete the activity.

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

   Coding: GG0170RR, Indicate the type of wheelchair/scooter used would be coded 1, Manual.
   Rationale: Ms. R used a manual wheelchair during the 3-day assessment period.

Examples for GG0170S, Wheel 150 feet and GG0170SS3, Indicate the type of wheelchair/scooter used

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

   Coding: GG0170S, Wheel 150 feet would be coded 04, Supervision or touching assistance.
   Rationale: The helper provides verbal cues to complete the activity.

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

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

   Coding: GG0170SS, Indicate the type of wheelchair/scooter used would be coded 2, Motorized.
   Rationale: Mr. G used a motorized scooter during the 3-day assessment period.

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

   Coding: GG0170S, Wheel 150 feet would be coded 04, Supervision or touching assistance.
   Rationale: Mr. N requires the helper to provide verbal cues for his safety when using a wheelchair for 150 feet.

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

   Coding: GG0170SS, Indicate the type of wheelchair/scooter used would be coded 1, Manual.
   Rationale: Mr. N used a manual wheelchair during the 3-day assessment period.

5. **Wheel 150 feet:** Mr. L has multiple sclerosis, resulting in extreme muscle weakness and minimal vision impairment. Mr. L uses a motorized wheelchair with an adaptive joystick to control both the speed and steering of the motorized wheelchair. He occasionally needs reminders to slow down around the turns and requires assistance from the nurse for backing up the scooter when barriers are present.

   Coding: GG0170S, Wheel 150 feet would be coded 03, Partial/moderate assistance.
   Rationale: The helper provides less than half of the effort to complete the activity of wheel 150 feet.

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

   Coding: GG0170SS, Indicate the type of wheelchair/scooter used would be coded 2, Motorized.
   Rationale: Mr. L used a motorized wheelchair during the 3-day assessment period.

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

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

   Coding: GG0170S, Wheel 150 feet would be coded 02, Substantial/Maximal assistance.
   Rationale: The helper provides more than half of the effort to complete the activity of wheel 150 feet.

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

   Coding: GG0170SS, Indicate the type of wheelchair/scooter used would be coded 1, Manual.
   Rationale: Mr. M used a manual wheelchair during the 3-day assessment period.

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

   Coding: GG0170S, Wheel 150 feet would be coded 01, Dependent.
   Rationale: The helper provides all the effort and the resident does none of the effort to complete the activity of wheel 150 feet.

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

    Coding: GG0170SS, Indicate the type of wheelchair/scooter used would be coded 1, Manual.
    Rationale: Mr. A is assisted using a manual wheelchair during the 3-day assessment period.

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.

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

- 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 stay, even if the resident is anticipated to ambulate during the stay or by discharge.
    - 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.

Examples of Probing Conversations with Staff

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

    Nurse: "Please describe how Mrs. H moves herself from sitting on the side of the bed to lying flat on the bed. When she is sitting on the side of the bed, how does she move to lying on her back?"

    Certified nursing assistant: "She can lie down with some help."

    Nurse: "Please describe how much help she needs and exactly how you help her."

    Certified nursing assistant: "I have to lift and position her right leg, but once I do that, she can use her arms to position her upper body."

    In this example, the nurse inquired specifically about how Mrs. H moves from a sitting position to a lying position. The nurse asked about physical assistance.

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

    Rationale: The certified nursing assistant lifts Mrs. H's right leg and helps her position it as she moves from a sitting position to a lying position. The helper does less than half the effort.

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

2. **Lying to sitting on side of bed:** Example of a probing conversation between a nurse determining a resident's score for lying to sitting on side of bed and a certified nursing assistant regarding the resident's bed mobility:

   Nurse: "Please describe how Mrs. L moves herself in bed. When she is in bed, how does she move from lying on her back to sitting up on the side of the bed?"

   Certified nursing assistant: "She can sit up by herself."

   Nurse: "She sits up without any instructions or physical help?"

   Certified nursing assistant: "No, I have to remind her to check on the position of her arm that has limited movement and sensation as she moves in the bed, but once I remind her to check her arm, she can do it herself."

   In this example, the nurse inquired specifically about how Mrs. L moves from a lying position to a sitting position. The nurse asked about instructions and physical assistance.

   Coding: GG0170C, Lying to sitting on side of bed would be coded 04, Supervision or touching assistance.
   Rationale: The certified nursing assistant provides verbal instructions as the resident moves from a lying to sitting position.

3. **Sit to stand:** Example of a probing conversation between a nurse determining a resident's sit to stand score and a certified nursing assistant regarding the resident's sit to stand ability:

   Nurse: "Please describe how Mrs. L usually moves from sitting on the side of the bed or chair to a standing position. Once she is sitting, how does she get to a standing position?"

   Certified nursing assistant: "She needs help to get to sitting up and then standing."

   Nurse: "I'd like to know how much help she needs for safely rising up from sitting in a chair or sitting on the bed to get to a standing position."

   Certified nursing assistant: "She needs two people to assist her to stand up from sitting on the side of the bed or when she is sitting in a chair."

   In this example, the nurse inquired specifically about how Mrs. L moves from a sitting position to a standing position and clarified that this did not include any other positioning to be included in the answer. The nurse specifically asked about physical assistance.

   Coding: GG0170D, Sit to stand would be coded 01, Dependent.
   Rationale: Mrs. L requires the assistance of two helpers to complete the activity.

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

4. **Chair/bed-to-chair transfer:** Example of a probing conversation between a nurse determining a resident's score for chair/bed-to-chair transfer and a certified nursing assistant regarding the resident's chair/bed-to-chair transfer ability:

   Nurse: "Please describe how Mr. C moves into the chair from the bed. When he is sitting at the side of the bed, how much help does he need to move from the bed to the chair?"

   Certified nursing assistant: "He needs me to help him move from the bed to the chair."

   Nurse: "Does he help with these transfers when you give him any instructions, setup, or physical help?"

   Certified nursing assistant: "Yes, he will follow some of my instructions to get ready to transfer, such as moving his feet from being spread out to placing them under his knees. I have to place the chair close to the bed and then I lift him because he is very weak. I then tell him to reach for the armrest of the chair. Mr. C follows these directions and that helps a little in transferring him from the bed to the chair. He does help with the transfer."

   In this example, the nurse inquired specifically about how Mr. C moves from sitting on the side of the bed to sitting in a chair. The nurse asked about instructions, physical assistance, and cueing instructions. If this nurse had not asked probing questions, he/she would not have received enough information to make an accurate assessment of the actual assistance Mr. C received.

   Coding: GG0170E, Chair/bed-to-chair transfer would be coded 02, Substantial/maximal assistance.
   Rationale: The helper provides more than half of the effort to complete the activity of Chair/bed-to-chair transfer.

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

5. **Toilet transfer:** Example of a probing conversation between a nurse determining the resident's score and a certified nursing assistant regarding a resident's toilet transfer assessment:

   Nurse: "I understand that Mrs. M usually uses a wheelchair to get to her toilet. Please describe how Mrs. M moves from her wheelchair to the toilet. How does she move from sitting in a wheelchair to sitting on the toilet?"

   Certified nursing assistant: "It is hard for her, but she does it with my help."

   Nurse: "Can you describe the amount of help in more detail?"

   Certified nursing assistant: "I have to give her a bit of a lift using a gait belt to get her to stand and then remind her to reach for the toilet grab bar while she pivots to the toilet. Sometimes, I have to remind her to take a step while she pivots to or from the toilet, but she does most of the effort herself."

   In this example, the nurse inquired specifically about how Mrs. M moves from sitting in a wheelchair to sitting on the toilet. The nurse specifically asked about instructions and physical assistance. If this nurse had not asked probing questions, he/she would not have received enough information to make an accurate assessment of the actual assistance Mrs. M received.

   Coding: GG0170F, Toilet transfer would be coded 03, Partial/moderate assistance.
   Rationale: The certified nursing assistant provides less than half the effort to complete this activity.

6. **Walk 50 feet with two turns:** Example of a probing conversation between a nurse determining a resident's score for walking 50 feet with two turns and a certified nursing assistant regarding the resident's walking ability:

   Nurse: "How much help does Mr. T need to walk 50 feet and make two turns once he is standing?"

   Certified nursing assistant: "He needs help to do that."

   Nurse: "How much help does he need?"

   Certified nursing assistant: "He walks about 50 feet with one of us holding onto the gait belt and another person following closely with a wheelchair in case he needs to sit down."

   In this example, the nurse inquired specifically about how Mr. T walks 50 feet and makes two turns. The nurse asked about physical assistance. If this nurse had not asked probing questions, he/she would not have received enough information to make an accurate assessment of the actual assistance Mr. T received.

   Coding: GG0170J, Walk 50 feet with two turns would be coded 01, Dependent.
   Rationale: Mr. T requires two helpers to complete this activity.

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

7. **Walk 150 feet:** Example of a probing conversation between a nurse determining a resident's score for walking 150 feet and a certified nursing assistant regarding the resident's walking ability:

   Nurse: "Please describe how Mrs. D walks 150 feet in the corridor once she is standing."

   Certified nursing assistant: "She uses a walker and some help."

   Nurse: "She uses a walker and how much instructions or physical help does she need?"

   Certified nursing assistant: "I have to support her by holding onto the gait belt that is around her waist so that she doesn't fall. She does push the walker forward most of the time."

   Nurse: "Do you help with more than or less than half the effort?"

   Certified nursing assistant: "I have to hold onto her belt firmly when she walks because she frequently loses her balance when taking steps. Her balance gets worse the further she walks, but she is very motivated to keep walking. I would say I help her with more than half the effort."

   In this example, the nurse inquired specifically about how Mrs. D walks 150 feet. The nurse asked about instructions and physical assistance. If this nurse had not asked probing questions, he/she would not have received enough information to make an accurate assessment of the actual assistance Mrs. D received.

   Coding: GG0170K, Walk 150 feet would be coded 02, Substantial/maximal assistance**.**
   Rationale: The certified nursing assistant provides trunk support that is more than half the effort as Mrs. D walks 150 feet.

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

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

   Nurse: "I understand that Ms. R uses a manual wheelchair. Describe to me how Ms. R wheels herself 50 feet and makes two turns once she is seated in the wheelchair."

   Certified nursing assistant: "She wheels herself."

   Nurse: "She wheels herself without any instructions or physical help?"

   Certified nursing assistant: "Well yes, she needs help to get around turns, so I have to help her and set her on a straight path, but once I do, she wheels herself."

   In this example, the nurse inquired specifically about how Ms. R wheels 50 feet with two turns. The nurse asked about instructions and physical assistance. If this nurse had not asked probing questions, he/she would not have received enough information to make an accurate assessment of the actual assistance Ms. R received.

   Coding: GG0170R, Wheel 50 feet with two turns would be coded 03, Partial/Moderate assistance.
   Rationale: The certified nursing assistant must physically push the wheelchair at some points of the activity; however, the helper does less than half of the activity for the resident.

9. **Wheel 150 feet:** Example of a probing conversation between a nurse determining a resident's score for wheel 150 feet and a certified nursing assistant regarding the resident's mobility:

   Nurse: "I understand that Mr. G usually uses an electric scooter for longer distances. Once he is seated in the scooter, does he need any help to mobilize himself at least 150 feet?"

   Certified nursing assistant: "He drives the scooter himself … he's very slow."

   Nurse: "He uses the scooter himself without any instructions or physical help?"

   Certified nursing assistant: "That is correct."

   In this example, the nurse inquired specifically about how Mr. G uses an electric scooter to mobilize himself 150 feet. If this nurse had not asked probing questions, he/she would not have received enough information to make an accurate assessment of the actual assistance Mr. G received.

   Coding: GG0170S, Wheel 150 feet would be coded 06, Independent.
   Rationale: The resident navigates in the corridor for at least 150 feet without assistance.