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3	GG0130	GG-2	**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 ~~3-day~~ assessment period~~,~~. For Section GG, the admission assessment period is the first three days of the Part A stay ~~which is days 1 through 3,~~ 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).
3	GG0130	GG-3	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~~Residents~~ should be ~~coded performing activities~~ based on the~~ir~~ resident's "usual performance~~,~~" ~~(or baseline performance on admission),~~ which is identified as the resident's usual activity/performance for any of the ~~s~~Self-~~c~~Care or ~~m~~Mobility activities, not the most independent or dependent performance over the assessment period. Therefore, if the resident's ~~s~~Self-~~c~~Care performance varies during the assessment period, report the resident's usual ~~status~~performance, **not** the resident's most independent performance and **not** the resident's most dependent ~~episode~~performance. A provider may need to use the entire 3-day assessment period to obtain the resident's usual performance.

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3	GG0130–GG0170	GG-3–GG-44	Page length changed due to revised content.
3	GG0130	GG-5	**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~~under~~ a SNF Part A stay. o For the 5-Day PPS~~Admission~~ assessment, code the resident's functional status based on a~~n~~ 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) ~~(days 1 through 3~~ of the Medicare Part A stay~~)~~, starting with the date in A2400B, Start of ~~m~~Most ~~r~~Recent Medicare ~~s~~Stay and the following two days, ending at 11:59 PM on day ~~3~~three. The assessment should occur, when possible, prior to the ~~start of~~resident benefitting from ~~therapeutic~~ treatment interventions in order to ~~capture~~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 ~~when the resident is discharged from the facility~~ on the day of, or one day ~~after~~before the resident's Discharge Date (A2000)~~Medicare Part A Stay ends. When this occurs, the OBRA Discharge assessment may be combined with the Part A PPS Discharge assessment.)~~. Please see Chapter 2 and Section A of the RAI Manual for additional details regarding the Part A PPS Discharge assessment.

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3	GG0130	GG-5	o 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~~n~~ 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. ~~The discharge function scores are to reflect the resident's discharge status and are to be based on an assessment.~~ The~~is~~ functional assessment must be completed within the last three~~3~~ 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.

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3	GG0130	GG-6	• At admission, when coding for the resident's ~~d~~Discharge ~~g~~Goal(s), use the same 6-point scale. Instructions about coding ~~d~~Discharge ~~g~~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. ~~• Record the resident's usual ability to perform each activity (e.g., eating). Do not record the resident's best performance and do not record the resident's worst performance, but rather record the resident's *usual performance* during the assessment period.~~
3	GG0130	GG-6	• 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, ~~c~~Code 07 if the resident refused to attempt the activity, ~~c~~Code 09 if the resident did not perform this activity prior to the current illness, exacerbation, or injury~~is not applicable for the resident~~, or ~~c~~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.

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3	GG0130	GG-6–GG-7	• 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 ~~2%~~ reduction in the annual payment update. If the reason the item was not assessed was that the resident refused (~~e~~Code 07), the item is not applicable because the resident did not perform this activity prior to the current illness, exacerbation or injury (~~e~~Code 09), or the activity was not attempted due to medical condition or safety concerns (~~e~~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. • 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.

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3	GG0130	GG-7	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.
3	GG0130	GG-7	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, t~~T~~he presence of a G-tube does not affect the eating score.
3	GG0130	GG-8	8. **Eating:** Mr. R is unable to eat by mouth ~~due to his medical condition~~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 th~~e~~is item ~~Eating~~.

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3	GG0130	GG-11	**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.
3	GG0130	GG-13	**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 ~~is~~ 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."

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3	GG0130	GG-14	**Discharge Goal(s): Coding Tips** • Use the 6-point scale to code the resident's ~~d~~Discharge ~~g~~Goal(s). Do not use the "activity was not attempted" codes (07, 09, or 88) to code ~~d~~Discharge ~~g~~Goal(s). Use a dash (-) to indicate that a specific activity is not a Discharge ~~g~~Goal. Of note, at least one Discharge ~~g~~Goal must be indicated for either ~~s~~Self-~~c~~Care or ~~m~~Mobility. Using the dash in this allowed instance does not affect APU determination. • Licensed clinicians can establish a resident's ~~d~~Discharge ~~g~~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 ~~s~~Self-~~c~~Care or ~~m~~Mobility Discharge ~~g~~Goal must be coded per resident stay on the 5-Day PPS assessment. Even though only one ~~d~~Discharge ~~g~~Goal is required, the facility may choose to code more than one ~~d~~Discharge ~~g~~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 ~~d~~Discharge ~~g~~Goal may be entered using the 6-point scale if the resident is expected to be able to perform the activity by discharge.

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3	GG0170	GG-19	**Steps for Assessment** 1. Assess the resident's mobility statusabilities based on direct observation, the resident's self-report, family and reports, and from the clinician,direct care staff reports, or family as documented in the resident's medical record during the 3-day assessment period,. For Section GG on admission, the assessment period is the first which is three days 1 through 3, of the Part A stay, starting with the date in A2400B, which is the Sstart 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. If helper assistance is required because the resident's performance is unsafe or of poor quality, score according to amount of assistance provided.
3	GG0170	GG-19	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.

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3	GG0170	GG-19–GG-20	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 ~~Residents~~ should be ~~coded performing activities~~ based on the~~ir~~ resident's "usual performance," ~~(baseline performance on admission),~~ which is identified as the resident's usual activity/performance for any of the ~~s~~Self-~~c~~Care or ~~m~~Mobility activities, not the most independent or dependent performance over the assessment period. Therefore, if the resident's ~~m~~Mobility performance varies during the assessment period, report the resident's usual performance~~status~~, **not** the resident's most independent performance and **not** the resident's most dependent performance~~episode~~. 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.

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3	GG0170	GG-21	**Admission or Discharge Performance Coding Tips** • **Admission:** The 5-Day PPS assessment (A0310B = 01) is the first Medicare-required assessment to be completed when the resident is admitted for a SNF Part A stay. o For the 5-Day PPS~~Admission~~ assessment, code the resident's functional status based on a~~n~~ 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~~3~~ days (calendar days) ~~(days 1 through 3~~ of the Medicare Part A stay~~)~~, starting with the date in A2400B, Start of ~~m~~Most ~~r~~Recent Medicare ~~s~~Stay and the following two days, ending at 11:59 PM on day ~~3~~three. The assessment should occur, when possible, prior to the resident benefitting from ~~start of therapeutic~~treatment interventions in order to determine~~capture~~ 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 ~~S~~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.

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3	GG0170	GG-21	o 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~~n~~ 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. ~~The discharge function scores are to reflect the resident's discharge status and are to be based on assessment.~~ The~~is~~ functional assessment must be completed within the last ~~3~~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 ~~health~~medical record~~s~~, 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.

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3	GG0170	GG-22	• At admission, when coding ~~On the 5-Day PPS assessment, code the resident's "usual performance," or baseline performance, using the 6-point scale or code the reason an activity was not attempted, as well as~~ the resident's ~~d~~Discharge ~~g~~Goal(s), use~~ing~~ the same 6-point scale. **Instructions above related to coding Discharge Goals for the ~~m~~Mobility items (GG0170) are the same as those for coding Discharge Goals for the ~~s~~Self-~~c~~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.
3	GG0170	GG-22	~~• 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).~~ ~~• On the Part A PPS Discharge assessment, code the resident's usual performance using the 6-point scale or one of the 3 "activity was not attempted" codes to specify the reason why an activity was not attempted.~~ • ~~Record the resident's usual ability to perform each activity (e.g., sit to lying). Do not record the resident's best performance and do not record the resident's worst performance, but rather record the resident's *usual performance* during the assessment period.~~ • 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, ~~c~~Code 07 if the resident refused to attempt the activity, ~~c~~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 ~~c~~Code 88 if the resident was not able to attempt the activity due to medical condition or safety concerns.

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3	GG0170	GG-22	• 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 ~~2%~~ reduction in annual payment update. If the reason the item was not assessed~~that the activity was not attempted is~~was that the resident refused (~~e~~Code 07), the item is not applicable because the resident did not perform this activity prior to the current illness, exacerbation, or injury (~~e~~Code 09), or the activity was not attempted due to medical condition or safety concerns (~~e~~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.

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3	GG0170	GG-23	• 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 ~~s~~Self-~~c~~Care or ~~m~~Mobility goal must be coded per resident stay on the 5-Day PPS assessment. Even though only one ~~d~~Discharge gGoal is required, the facility may choose to code more than one ~~d~~Discharge ~~g~~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.
3	GG0170	GG-23	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 ~~Mrs. H does more~~ than half of the effort.

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3	GG0170	GG-24	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~~Mrs. E~~ does less~~more~~ than half of the effort.
3	GG0170	GG-29	**Coding Tips for GG0170E, Chair/bed-to-chair transfer** • Item GG0170E, Chair/bed-to-chair transfer, begins with the resident sitting in a chair or wheelchair or sitting upright at the edge of the bed and returning to sitting in a chair or wheelchair or sitting upright at the edge of the bed. The activities of GG0170B~~.~~, Sit to lying and GG0170C~~.~~, Lying to sitting on 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.
3	GG0170	GG-30	4. **Toilet transfer:** The certified nursing assistant provides steadying (touching) assistance as Mrs. Z lowers her underwear and then transfers onto the toilet~~ and lowers her underwear~~. 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.

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3	GG0170	GG-32	**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, ~~so no~~ the admission performance ~~code is entered for the~~ walking items are skipped. However, a walking goal is clinically indicated and walking goals may be coded.
3	GG0170	GG-34	**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.

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3	GG0170	GG-35	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. ~~The resident provided more than half the effort.~~
3	GG0170	GG-36	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.
3	GG0170	GG-36	~~**Coding Tip for GG0170R, Wheel 50 feet with two turns**~~ • ~~Admission assessment for wheelchair items should be coded for residents who used a wheelchair prior to admission or are anticipated to use a wheelchair by discharge, even if the resident is anticipated to ambulate during the stay or by discharge.~~

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Chapter	Section	Page	Change
3	GG0170	GG-37	6. **Indicate the type of wheelchair/scooter used:** ~~In the above example~~ 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.
3	GG0170	GG-38	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.

Chapter	Section	Page	Change
3	GG0170	GG-38	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.
3	GG0170	GG-38–GG-39	**Coding Tips for GG0170R and GG0170S, Wheelchair Items** • The intention of the wheelchair items is to assess the resident's use of a wheelchair for self-mobilization at admission and discharge when appropriate. The clinician uses clinical judgment to determine if the resident's use of a wheelchair is appropriate for self-mobilization due to the resident's medical condition or safety. • Do not code wheelchair mobility if the resident only uses a wheelchair when transported between locations within the facility. Only code wheelchair mobility based on an assessment of the resident's ability to mobilize in the wheelchair. • If the resident walks and is not learning how to mobilize in a wheelchair, and only uses a wheelchair for transport between locations within the facility, code the wheelchair gateway items at admission and/or discharge items—GG0170Q1 and/or GG0170Q3, Does the resident use a wheelchair/scooter—as 0, No. Answering the question in this way invokes a skip pattern which will skip all remaining wheelchair questions. • Admission assessment for wheelchair items should be coded for residents who used a wheelchair prior to admission or are anticipated to use a wheelchair during the stay, even if the resident is anticipated to ambulate during the stay or by discharge. o The responses for gateway admission and discharge walking items (GG0170H1 and GG0170H3) and the gateway admission and discharge wheelchair items (GG0170Q1 and GG0170Q3) do not have to be the same on the admission and discharge assessments.