SECTION GG INTENT

- Section GG includes items about functional abilities and goals focused on prior function, admission performance, discharge goals, and discharge performance.
- Residents in SNFs have self-care and mobility limitations and are at risk for further functional decline.
OVERVIEW

SECTION GG: SNF QUALITY REPORTING PROGRAM (QRP)

• SNF QRP added four new quality measures (QMs) that:
  – Meet the requirements of the IMPACT Act addressing the domain of functional status and cognitive function and changes in function and cognitive function.
  – Use data elements currently collected in Minimum Data Set (MDS) Section GG and add/modify data elements.
  – Include standardized data elements used across PAC settings.
  – Were adopted Functional Outcome measures previously endorsed by the National Quality Forum (NQF) for IRFs.

• Data collection for these measures began October 1, 2018.
SECTION GG: SNF QRP FUNCTION MEASURES

- Application of Percent of Long-Term Care Hospital Patients with an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function (#2631).
- SNF Functional Outcome Measure: Change in Self-Care for Skilled Nursing Facility Residents (NQF #2633).
- SNF Functional Outcome Measure: Change in Mobility Score for Skilled Nursing Facility Residents (NQF #2634).
- SNF Functional Outcome Measure: Discharge Self-Care Score for Skilled Nursing Facility Residents (NQF #2635).
- SNF Functional Outcome Measure: Discharge Mobility Score for Skilled Nursing Facility Residents (NQF #2636).

PART A PROSPECTIVE PAYMENT SYSTEM (PPS) ADMISSION

- **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.
- This functional assessment must be completed within the first 3 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 2 days, ending at 11:59 p.m. on Day 3.
PART A PPS INTERIM PERFORMANCE

• The Interim Payment Assessment (IPA) is an optional PPS assessment that may be completed by providers in order to report a change in the resident’s Patient-Driven Payment Model (PDPM) classification.

• Section GG data from the IPA is not used for the SNF QRP.

• The Assessment Reference Date (ARD) for the IPA is determined by the provider, and the assessment period is the last 3 days (i.e., the ARD and the 2 calendar days prior).

NOTE

• The IPA changes payment beginning on the ARD and continues until the end of the Medicare Part A stay or until another IPA is completed.

• The IPA does not affect the variable per diem schedule.

PART A PPS INTERIM PERFORMANCE (CONT.)

• Providers will use the same six-point scale and activity not attempted codes to complete the Section GG “Interim Performance” column, which will capture the interim functional performance of the resident.

• There have been several additions of the word “Interim” to the RAI Manual to support this new assessment.
GG0130. PART A PPS SELF-CARE INTERIM PERFORMANCE

5. Interim Performance
Enter Codes in Boxes

A. Eating: The ability to use suitable utensils to bring food and/or liquid to the mouth and swallow food and/or liquid once the meal is placed before the resident.

B. Oral hygiene: The ability to use suitable items to clean teeth. Dentures (if applicable): The ability to insert and remove dentures into and from the mouth, and manage denture soaking and rinsing with use of equipment.

C. Toileting hygiene: The ability to maintain perineal hygiene, adjust clothes before and after voiding or having a bowel movement. If managing an ostomy, include wiping the opening but not managing equipment.

GG0170. PART A PPS MOBILITY INTERIM PERFORMANCE

5. Interim 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 move from lying on the back to sitting on the side of the bed with feet flat on the floor, and with no back support.

D. Sit to stand: The ability to come to a standing position from sitting in a chair, wheelchair, or on the side of the bed.

E. Chair/bed-to-chair transfer: The ability to transfer to and from a bed to a chair (or wheelchair).

F. Toilet transfer: The ability to get on and off a toilet or commode.

I. Walk 10 feet: Once standing, the ability to walk at least 10 feet in a room, corridor, or similar space.
   If interim performance is coded 07, 09, 10, or 88 → Skip to H8010, Appliances

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.
**PART A PPS 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 Omnibus Budget Reconciliation Act of 1987 (OBRA) Discharge if the Medicare Part A stay ends on the day of, or 1 day before the resident's Discharge Date (A2000).

**GENERAL CODING TIPS**

- Admission Performance and Discharge Goals are coded on **every** Admission Assessment (Start of Part A PPS Stay) regardless of length of stay and planned or unplanned discharge.
- If the resident has an incomplete stay: Complete admission performance and discharge goals.
- Discharge self-care and mobility **performance** items are not required.
**INCOMPLETE STAY**

- Unplanned discharge indicated by Type of Discharge (A0310G = [2]) that has a Discharge Date (A2000) that is on the same day or the day after the End Date of Most Recent Medicare Stay (A2400C) OR
- Discharge to an acute care, psychiatric, or long-term care hospital (indicated by A2100 = 03, 04, 09) on an MDS Discharge (A0310F = [10, 11]) that has a Discharge Date (A2000) that is on the same day or the day after the End Date of Most Recent Medicare Stay (A2400C) OR
- The resident’s death (A2100 = 08) as indicated on an MDS tracking record (A0310F = 12) (Death in Facility) that has a Discharge Date (A2000) that is on the same day or the day after the End Date of Most Recent Medicare Stay (A2400C) OR
- Medicare Part A Stay is less than 3 days as indicated by End Date of Most Recent Medicare Stay (A2400C) minus Start Date of Most Recent Medicare Stay (A2400B) < 3 days.

**GG0110C. MECHANICAL LIFT**

- **Coding Tip** revised:
GG0130. SELF - CARE AND GG0170. MOBILITY, STEPS FOR ASSESSMENT

• Steps for Assessment clarified:
• Step #1: Self-care performance revised to include “incorporating” resident self report.
• Added statement: “For the Interim Payment Assessment (A0310B=08), the assessment period for Section GG is the last 3 days (i.e., the ARD and two days prior).”
• Step #5: The admission functional assessment…should be conducted prior to resident benefiting from treatment interventions in order to reflect the resident’s true admission baseline functional status.

GG0130. PERFORMANCE CODING

• Performance Coding :
• “Contact guard” added to definition of code 04, Supervision or touching assistance in the Resident Assessment Instrument (RAI) Manual.
  – Addition of a “Decision Tree” – This tool guides the provider in coding the resident’s performance on the assessment instrument. If helper assistance is required because the resident’s performance is unsafe or of poor quality, score the assessment according to the amount of assistance provided.
  – Only use the ‘activity not attempted codes’ if the activity did not occur; that is, the resident did not perform the activity and a helper did not perform that activity for the resident.”
**DECISION TREE**

**START DECISION TREE HERE**

1. Does the patient/resident complete the activity - with or without assistive devices - by him/herself and with no assistance (physical, verbal/nonverbal cueing, setup/clean-up)?
   - **YES** → 06 - Independent
   - **NO** →
     2. Does the patient/resident need only setup/clean-up assistance from one helper?
        - **YES** → 05 - Setup/Clean-up Assistance
        - **NO** →
          3. Does the patient/resident need only verbal/nonverbal cueing or steadying/touching/contact guard assistance from one helper?
             - **YES** → 04 - Supervision/touching assistance
             - **NO** →
               4. Does the patient/resident need physical assistance - for example lifting or trunk support - from one helper with the helper providing less than half of the effort?
                  - **YES** → 03 - Partial/moderate assistance
                  - **NO** →
                    5. Does the patient/resident need physical assistance - for example lifting or trunk support - from one helper with the helper providing more than half of the effort?
                       - **YES** → 02 - Substantial/maximal assistance
                       - **NO** →
                         6. Does the helper provide all the effort to complete the activity OR is the assistance of 2 or more helpers required to complete activity?
                            - **YES** → 01 - Dependent

---

**GG0130. CODING TIPS**

- **Eating (item GG0130A):**
  - Statement added to address coding of eating when a resident receives tube feedings or parenteral nutrition: "**Eating involves bringing food and liquids to the mouth and swallowing food. The administration of tube feedings and parenteral nutrition is not considered when coding this activity. The following is guidance for some situations in which a resident receives tube feedings or parenteral nutrition...**"
  - References to "**parenteral nutrition**" were added throughout Coding Tips for this item.
GG0170. CODING TIPS

• **Car Transfers (item GG0170G)** – added:
  
  – For item GG0170G, Car transfer, use of an indoor car can be used to simulate outdoor car transfers. These half or full cars would need to have similar physical features of a real car for the purpose of simulating a car transfer, that is, a car seat within a car cabin.
  
  – The Car transfer item does not include transfers into the driver’s seat, opening/closing the car door, fastening/unfastening the seat belt. The Car transfer item includes the resident’s ability to transfer in and out of the passenger seat of a car or car simulator.

GG0170. CODING TIPS (CONT.)

• *In the event of inclement weather or if an indoor car simulator or outdoor car is not available during the entire 3-day assessment period then use of code 10, Not attempted due to environmental limitations.*

• Examples had several edits made to clarify. Please read through the RAI Manual to see these changes.
GG0100. PRIOR FUNCTIONING: EVERYDAY ACTIVITIES

- **Item Rationale**
  - Knowledge of the resident’s functioning prior to the current illness, exacerbation, or injury may inform treatment goals

Complete only at Admission/Entry/Reentry at the Start of the SNF PPS Stay (5-Day PPS)
### GG0100A. SELF CARE

**A. Self Care:** Code the patient’s need for assistance with bathing, dressing, using the toilet, or eating prior to the current illness, exacerbation, or injury.

<table>
<thead>
<tr>
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<tbody>
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<td>Indicate the patient’s usual ability with everyday activities prior to the current illness, exacerbation, or injury.</td>
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</table>

**Coding:**

3. Independent – Patient completed the activities by him/herself, with or without an assistive device, with no assistance from a helper.
2. Needed Some Help – Patient needed partial assistance from another person to complete activities.
1. Dependent – A helper completed the activities for the patient.
8. Unknown
9. Not Applicable

### GG0100B. INDOOR MOBILITY (AMBULATION)

**B. Indoor Mobility (Ambulation):** Code the patient’s need for assistance with walking from room to room (with or without a device such as cane, crutch or walker) prior to the current illness, exacerbation, or injury.

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**Coding:**

3. Independent – Patient completed the activities by him/herself, with or without an assistive device, with no assistance from a helper.
2. Needed Some Help – Patient needed partial assistance from another person to complete activities.
1. Dependent – A helper completed the activities for the patient.
8. Unknown
9. Not Applicable
### GG0100C. STAIRS

**C. Stairs:** Code the patient's need for assistance with internal or external stairs (with or without a device such as cane, crutch, or walker) prior to the current illness, exacerbation, or injury.

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<tr>
<td>4. Unknown</td>
<td></td>
</tr>
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<td>5. Not Applicable</td>
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#### Enter Codes in Boxes

- **A. Self Care:** Code the patient's need for assistance with bathing, dressing, using the toilet, or eating prior to the current illness, exacerbation, or injury.
- **B. Indoor Mobility (Ambulation):** Code the patient's need for assistance with walking from room to room (with or without a device such as cane, crutch or walker) prior to the current illness, exacerbation, or injury.
- **C. Stairs:** Code the patient's need for assistance with internal or external stairs (with or without a device such as cane, crutch, or walker) prior to the current illness, exacerbation, or injury.
- **D. Functional Cognition:** Code the patient's need for assistance with planning regular tasks, such as shopping or remembering to take medication prior to the current illness, exacerbation, or injury.

### GG0100D. FUNCTIONAL COGNITION

**D. Functional Cognition:** Code the patient's need for assistance with planning regular tasks, such as shopping or remembering to take medication prior to the current illness, exacerbation, or injury.

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#### Enter Codes in Boxes

- **A. Self Care:** Code the patient's need for assistance with bathing, dressing, using the toilet, or eating prior to the current illness, exacerbation, or injury.
- **B. Indoor Mobility (Ambulation):** Code the patient's need for assistance with walking from room to room (with or without a device such as cane, crutch or walker) prior to the current illness, exacerbation, or injury.
- **C. Stairs:** Code the patient's need for assistance with internal or external stairs (with or without a device such as cane, crutch, or walker) prior to the current illness, exacerbation, or injury.
- **D. Functional Cognition:** Code the patient's need for assistance with planning regular tasks, such as shopping or remembering to take medication prior to the current illness, exacerbation, or injury.
GG0100. STEPS FOR ASSESSMENT

Ask the resident or family about prior functioning with ADLs.

GG0100. CODING INSTRUCTIONS

• Code 3, Independent: If the resident completed the activities by himself or herself, with or without an assistive device, with no assistance from a helper.

• Code 2, Needed Some Help: If the resident needed partial assistance from another person to complete the activities.

• Code 1, Dependent: If the helper completed the activities for the resident, or the assistance of two or more helpers was required for the resident to complete the activity.

• Code 8, Unknown: If the resident’s usual ability prior to the current illness, exacerbation or injury is unknown.
  - If no information about the resident’s ability is available after attempts to interview the resident or his or her family, and after reviewing the resident’s medical record, code as 8, Unknown.

• Code 9, Not Applicable: If the activity was not applicable to the resident prior to the current illness, exacerbation, or injury.

• A dash is a valid response for this item. CMS expects dash use to be a rare occurrence.
GG0110. PRIOR DEVICE USE

- Rationale: Knowledge of the resident's routine use of devices and aids immediately prior to the current illness, exacerbation, or injury may inform treatment goals.
- Complete only at Admission/Entry/Reentry at the Start of the SNF PPS Stay (5-Day PPS)

GG0110. STEPS FOR ASSESSMENT

- Ask the resident or family about the resident's prior device or aid use.
- Review the resident's medical records describing the resident's use of prior devices and aids.
GG0110. CODING INSTRUCTIONS

• Check all devices that apply:
  – Manual Wheelchair
  – Motorized wheelchair and/or scooter.
  – Mechanical Lift.
  – Walker.
  – Orthotics/Prosthetics.
• Check Z. None of the above, if the resident did not use any of the listed devices or aids immediately prior to the current illness, exacerbation, or injury.

GG0110C. MECHANICAL LIFT

• Any device a resident or caregiver requires for lifting or supporting the resident’s bodyweight.
• Examples include, but are not limited to:
  – Stair lift.
  – Hoyer lift.
  – Bathtub lift.
**GG0110D. WALKER**

- Include all walker types.
- Examples include, but are not limited to:
  - Pick-up walkers.
  - Hemi-walkers.
  - Rolling walkers.
  - Platform walkers.
  - Four-wheel walker.
  - Rollator walker.
  - Knee walker.
  - Walkers for mobilizing while seated in walker.

**GG0130. AND GG0170. INTENT**

- **GG0130** identifies the resident’s ability to perform the listed self-care activities and discharge goal(s).
- **GG0170** identifies the resident’s ability to perform the listed mobility activities and discharge goal(s).
Qualified, licensed clinicians assess the resident’s performance based on:

- Residents should be allowed to perform activities as independently as possible, as long as they are safe. 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 device(s). Use of assistive device(s) to complete an activity should not affect coding of the activity.
**GG0130. AND GG0170. STEPS FOR ASSESSMENT (CONT. 2)**

- 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 - DAY ASSESSMENT PERIOD:**

- **Admission Assessment Period** First 3 days of the Part A stay starting with the date in A2400B, Start of the Most Recent Medicare Stay, and the following 2 days, ending at 11:59 p.m. on day 3.
- **Discharge Assessment Period:** Last 3 days of the Part A stay starting with the date in A2400C, End of the Most Recent Medicare Stay, and the 2 calendar days prior.
USUAL STATUS

- **Admission (Start of SNF PPS Stay):**
  - The resident's functional status should be based on a clinical assessment of the resident's performance that occurs soon after the resident's admission.
  - The resident's functional assessment, when possible, should be conducted prior to the resident benefiting from treatment interventions in order to reflect the resident's true admission baseline functional status.

- **Discharge (End of SNF PPS Stay):**
  - 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.

USUAL STATUS (CONT.)

- 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 status varies, record the resident's usual ability to perform each activity. Do not record the resident's best performance and worst performance; instead, record the resident's usual performance.
GG0130. & GG0170. CODING INSTRUCTIONS: SIX-POINT SCALE

<table>
<thead>
<tr>
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<tr>
<td>CODE 05</td>
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<td>Substantial/maximal assistance</td>
</tr>
<tr>
<td>CODE 01</td>
<td>Dependent</td>
</tr>
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GG0130. & GG0170. ACTIVITY WAS NOT ATTEMPTED CODES

Code 07, Resident refused
- Resident refused to complete the activity.

Code 09, Not applicable
- Not attempted and the resident did not perform this activity prior to the current illness, exacerbation or injury.

Code 10, Not attempted due to environmental limitations
- For example, lack of equipment, weather constraints.

Code 88, Not attempted due to medical conditions or safety concerns
- Activity was not attempted due to medical condition or safety concerns.
PROVIDER Q&A: CODE 10, NOT ATTEMPTED DUE TO ENVIRONMENTAL LIMITATIONS

• We do not expect code 10, Not attempted due to environmental limitations, to be used often.
  – If a resident is unable to go outside due to inclement weather (such as snow or cold temperatures) and no indoor option for uneven surfaces is available, code the activity GG0170L, Walk 10 feet on uneven surfaces as 10, Not attempted due to environmental limitations.
  – For GG0170R, Wheel 50 feet with two turns if the resident is obese and you do not have a wheelchair that is the appropriate size for the resident, you would code 10, not attempted due to environmental limitations, due to the lack of equipment.

GG0130. AND GG0170. GENERAL CODING TIPS

• When observing the resident, reviewing the resident’s medical record, and interviewing staff, be familiar with the definition for each activity.
• Do not record the staff’s assessment of the resident’s potential capability to perform the activity.
• 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.
GG0130. AND GG0170. GENERAL CODING TIPS

- 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.
- If the resident does not attempt the activity and a helper does not complete the activity for the resident during the entire assessment period, code the reason the activity was not attempted.
- You will be using the same six-point scale for recording usual performance and the resident’s discharge goals, or one of the four “activity not attempted” codes to specify the reason why an activity was not attempted, on both admission and discharge.

GG0130. AND GG0170. GENERAL CODING TIPS

- 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.
GG0130. AND GG0170. GENERAL CODING TIPS

- Use of assistive device(s) to complete an activity should not affect coding of the activity. If the resident uses adaptive equipment and uses the device independently when performing an activity, enter code **06, Independent.**
- If the only help a resident needs to complete an activity is for a helper to retrieve an assistive device or adaptive equipment, such as a cane for walking, then enter code **05, Setup or clean-up assistance.**
- If two or more helpers are required to assist the resident in completing the activity, code as **01, Dependent.**

GG0130. AND GG0170. GENERAL CODING TIPS

- A dash (” – ”) indicates “No information.”
- CMS expects dash use to be a rare occurrence.
- Do not use a dash (” – ”) if the reason the activity was not observed was because:
  - The resident refused (code 07).
  - The item is not applicable (code 09).
  - The activity was not attempted due to environmental limitations (code 10), or
  - The activity was not attempted due to a medical condition or safety concerns (code 88).
GG0130. AND GG0170. DISCHARGE GOALS USE OF THE DASH

- Use the 6-point scale or “activity not attempted codes” to code the resident’s discharge goal(s); use of codes 07, 09, 10, or 88 is permissible to code discharge goal(s).
- For the SNF (QRP), completion of at least one discharge goal is required for one of the self-care or mobility items for each resident.
- The use of a dash is permissible for any remaining self-care or mobility goals that were not coded; using the dash in this allowed instance does not affect Annual Payment Update (APU) determination.
- Licensed, qualified clinicians can establish a resident’s discharge goal(s) at the time of admission.

GG0130A. EATING CODING TIPS

- GG0130A. Eating: Assess eating and drinking by mouth only.
- Resident receives tube feedings or parenteral nutrition (PN):
  - Assistance with tube feedings or PN is not considered when coding the item Eating.
  - If the resident does not eat or drink by mouth and relies solely on nutrition and liquids through tube feedings or PN because of a new (recent - onset) medical condition, code GG0130A as 88, Not attempted due to medical conditions or safety concerns.
GG0130A. EATING CODING TIPS (CONT.)

• If the resident does not eat or drink by mouth at the time of the assessment, and the resident did not eat or drink by mouth prior to the current illness, injury or exacerbation, code GG0130A as 09, Not applicable.
• If the resident eats and drinks by mouth, and relies partially on obtaining nutrition and liquids via tube feedings or PN, code eating based on the amount of assistance the resident requires to eat and drink by mouth.
• If the resident eats finger foods with his or her hands, code based upon the amount of assistance provided.

GG0130C. TOILETING HYGIENE CODING TIPS

• Toileting hygiene:
  – Includes managing undergarments, clothing, and incontinence products, and performing perineal cleansing before and after voiding or having a bowel movement. Toileting hygiene can take place before and after use of the toilet, commode, bedpan, or urinal.
  – If the resident completes a bowel toileting program in bed, code Toileting hygiene based on the resident’s need for assistance in managing clothing and perineal cleansing.
  – If the resident does not usually use undergarments, then assess the resident’s need for assistance to manage lower - body clothing and perineal hygiene.
  – If the resident has an indwelling urinary catheter and has bowel movements, code the Toileting hygiene item based on the amount of assistance needed by the resident when moving his or her bowels.
GG0130E. SHOWER/BATHE SELF

- Assessment can take place in a shower or bath, at a sink, or at the bedside (i.e., sponge bath).
- If the resident bathes himself or herself and a helper sets up materials for bathing/showering, then code as 05, Setup or clean - up assistance.
- If the resident cannot bathe his or her entire body because of a medical condition, then code shower/bathe self based on the amount of assistance needed to complete the activity.

GG0130F. UPPER BODY DRESSING
EXAMPLES OF UPPER BODY DRESSING ITEMS

- Bra
- Undershirt
- T-shirt
- Button-down shirt
- Pullover shirt
- Sweatshirt
- Sweater
- Pajama top
- Thoracic-lumbar-sacrum orthosis (TLSO)
- Abdominal binder
- Back brace
- Stump sock / shrinker
- Upper body support device
- Neck support
- Hand or arm prosthetic/orthotic
LOWER BODY DRESSING EXAMPLES

- Underwear
- Incontinence brief
- Slacks
- Shorts
- Capri pants
- Pajama bottoms
- Skirts
- Knee brace
- Elastic bandage
- Stump sock/shrinker
- Lower-limb prosthesis

QUESTION

- **Question:** If a resident does not have clothing on the day of admission, do you code 10, Not attempted due to environmental limitations (i.e., lack of equipment) for Dressing?
- **Answer:** The intent for this item is to assess the resident clothing that would be worn in the community.
  - If clothing is available by day 3, code based on the assessment conducted on that day.
  - If clothing is not available by day 3, paper scrubs could be used to assess the activities of upper and lower body dressing,
  - If a resident does not have upper body clothing other than a hospital gown during the entire 3 - day assessment period, you would use code 10, Not attempted due to environmental limitations for GG0130F, Upper body dressing.
FOOTWEAR EXAMPLES

- Socks
- Shoes
- Boots
- Running shoes
- Ankle foot orthosis (AFO)
- Elastic bandages
- Foot orthotic
- Orthopedic walking boots
- Compression stockings

GG0130. DISCHARGE GOAL CODING TIPS

- Code the resident’s discharge goal(s) at the Start of the SNF PPS Stay (5 - Day PPS) using:
  - The 6 - point scale, or
  - One of the “activity not attempted codes” (07, 09, 10, or 88)

- For the SNF QRP, a minimum of one self - care or mobility goal must be coded. However, facilities can choose to complete more than one.
  - Enter a dash ( – ) for any remaining self - care or mobility goals that were not coded.
  - Using the dash in this allowed instance does not affect APU determination.
GG0130. DISCHARGE GOAL CODING TIPS (CONT. 1)

- Licensed, qualified clinicians can establish a resident's discharge goal(s) at the time of admission based on:
  - Resident's prior medical condition(s).
  - Discussions with resident and family.
  - Expected treatments.
  - Anticipated length of stay.
  - Prior and current self-care and mobility status.
  - Professional judgment and standards of practice.
  - Resident's motivation to improve.
  - Discharge setting/home.
- Goals should be established as part of the resident's care plan.

GG0130. DISCHARGE GOAL CODING TIPS (CONT. 2)

- Discharge goal(s) may be coded the same as 5 - Day PPS admission performance, higher than the admission performance, or lower than the admission performance and reflect maintenance, improvement or decline in function, respectively.
- If the admission performance of an activity was coded using one of the activity not attempted codes (07, 09, 10, or 88), a discharge goal may be coded using the six-point scale if the resident is expected to be able to perform the activity by discharge.
GG0170A.–C. CODING TIPS
BED MOBILITY

• If the clinician determines that bed mobility cannot be assessed because of the degree to which the head of the bed must be elevated because of a recent onset medical condition, then code the activities GG0170A, Roll left and right, GG0170B, Sit to lying, and GG0170C, Lying to sitting on side of bed, as 88, Not attempted due to medical condition or safety concern.
• For GG0170A–C, clinical judgment should be used to determine what is considered a “lying” position for the resident.
  – For example, a clinician could determine that a resident’s slightly elevated resting position is “lying” for that resident.

GG0170E. CHAIR/BED-TO-CHAIR TRANSFER CODING TIPS

• The activities of Sit to lying and Lying to sitting on side of bed are two separate activities that are not assessed as part of GG0170E.
• If a mechanical lift is used to assist in transferring a resident for a chair/bed - to – chair transfer and two helpers are needed to assist with the mechanical lift transfer, then code 01, Dependent, even if the resident assists with any part of the chair/bed - to - chair transfer.
GG0170F. TOILET TRANSFER CODING TIP

• Do not consider or include GG0130C. Toileting hygiene item tasks (managing clothing, perineal hygiene) when assessing the Toilet transfer item.

• Transferring on and off a bedpan is not included in Toilet transfer

GG0170G. CAR TRANSFER CODING TIPS

• Use of an indoor car can be used to simulate outdoor car transfers. These half or full cars would need to have similar physical features of a real car (a car seat within a car cabin).

• Car transfer does not include transfers into the driver’s seat, opening/closing the car door, fastening/unfastening the seat belt.

• In the event of inclement weather or if an indoor car simulator or outdoor car is not available during the entire 3-day assessment period, use code 10, Not attempted due to environmental limitations.
CODING TIPS FOR WALKING ITEMS

- Walking activities do not need to occur during one session.
- A resident may take a brief standing break (“breather”) while walking. Clinicians should use clinical judgment to define a “breather.”
- When coding GG0170 walking items, do not consider the resident’s mobility performance when using parallel bars.
- Parallel bars are not a portable assistive device. If safe, assess and code walking using a portable walking device.
- If the resident cannot walk without the use of parallel bars due to his/her recent-onset medical condition or safety concerns, use code 88, Activity not attempted due to medical condition or safety concern.

GG0170I. SKIP PATTERN

- If the admission performance of an activity was coded using one of the activity not attempted codes (07, 09, 10, or 88), a discharge goal may be submitted using the six-point scale if the resident is expected to be able to perform the activity by discharge.
GG0170I. WALK 10 FEET CODING TIPS

• Use of assistive device(s) and adaptive equipment (for instance a cane) required to complete the walking activity should not affect coding of the activity.

GG0170J. WALK 50 FEET WITH TWO TURNS CODING TIPS

• The turns are 90 - degree turns and may be:
  – In the same direction (two 90 - degree turns to the right or two 90 - degree turns to the left).
  – In different directions (one 90 - degree turn to the right and one 90 - degree turn to the left).

• The 90 - degree turn should occur at the person's ability level and can include the use of an assistive device (for example, cane) without affecting coding of the activity.
Question: If a resident cannot complete an activity because they state they are simply tired, fatigued or exhausted, should we code this as a refusal or as 88 for safety concerns? For example, a resident completes 8 out of the 12 stairs and then say they are done.

Answer: Please use your clinical judgement based on the resident’s circumstances:
- If you or the resident believe there is a safety concern and the activity did not occur as a result of that concern, code 88, Not attempted due to medical condition or safety concerns.
- If you determine that the resident is refusing to perform the activity and there is no medical issue or safety concern associated with the refusal, code 07, Patient/resident refused.
- If the resident completes the activity once during the assessment period, code based on the amount of assistance provided.
GG0170R. WHEEL 50 FEET WITH TWO TURNS CODING TIPS

- The turns are 90-degree turns and may be:
  - In the same direction (two 90-degree turns to the right or two 90-degree turns to the left).
  - In different directions (one 90-degree turn to the right and one 90-degree turn to the left).
- The 90-degree turns should occur at the person’s ability level.

SECTION GG WEB-BASED TRAINING (E-LEARNING)

- CMS is also offering a newly released, updated web-based training course on how to accurately properly code Section GG data elements.
- This 45-minute course is designed to be used on demand, and can be used on any device with anywhere you can access a browser.
- The course is divided into four lessons and includes interactive scenarios exercises that allow you to test your knowledge in real-life scenarios: Lesson 1: Importance of Section GG for Post-Acute Care.
- Lesson 2: Section GG Assessment and Coding Principles.
- Lesson 3: Coding GG0130. Self-Care Items.
- Lesson 4: Coding GG0170. Mobility Items.
- To access the training, click on the link below: [https://pac.training/courses/section_gg_2019/story_html5.html](https://pac.training/courses/section_gg_2019/story_html5.html)
GG0170Q. DOES THE RESIDENT USE A WHEELCHAIR/SCOOTER? CODING TIPS

- The intent of the wheelchair mobility items is to assess the ability of residents who are learning how to self-mobilize using a wheelchair or who used a wheelchair prior to admission.
- Use clinical judgment to determine whether a resident's use of a wheelchair is for self-mobilization as a result of the resident's medical condition or safety, or used for staff convenience.
- If the resident walks and is not learning how to mobilize in a wheelchair, and only uses a wheelchair for transport between locations within the facility or for staff convenience, code the wheelchair gateway items at admission and/or discharge as 0, No, and skip all remaining wheelchair questions.

SECTION GG RESOURCES

- CMS released a series of short videos to assist providers with coding select Section GG data elements.
- These videos, ranging from 4 to 12 minutes, are designed to provide targeted guidance using simulated patient scenarios.
- To access the videos, click on the links below: