

MDS: Section G0110. and GG0130. and GG0170.- Coding Tips and Data Use

Presented for the DOH by
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Agenda

- Section G0110. Overview and Coding Tips
- Section G0110. – Data Use
 - RUGS based payment systems
 - MDS 3.0 QM
- Section GG0130./GG0170. Overview and Coding Tips
- Section GG0130./GG0170. – Data Use
 - PDPM
 - SNF-QRP QM's and APU determination

Section G

RUG III and IV
Reimbursement

MDS 3.0
Quality
Measures

G0110. ADLs

Activities of Daily Living (ADL) Assist

Section G Overview

Intent: Items in this section assess the need for assistance with activities of daily living (ADLs), altered gait and balance, and decreased range of motion. In addition, on admission, resident and staff opinions regarding functional rehabilitation potential are noted.

G0110. Items used to determine:

- RUGS III **and** RUGS IV reimbursement systems
Items Used- Late loss ADL's- Transfers, Toileting, Eating and Bed Mobility
- MDS 3.0 QMS
Items Used- Late Loss ADLs and Locomotion Items

G0110.: ADL Assistance

G0110: Activities of Daily Living (ADL) Assistance

G0110. Activities of Daily Living (ADL) Assistance																																					
Refer to the ADL flow chart in the RAI manual to facilitate accurate coding																																					
Instructions for Rule of 3																																					
<ul style="list-style-type: none"> When an activity occurs three times at any one given level, code that level. When an activity occurs three times at multiple levels, code the most dependent, exceptions are total dependence (4), activity must require full assist every time, and activity did not occur (8), activity must not have occurred at all. Example, three times extensive assistance (3) and three times limited assistance (2), code extensive assistance (3). When an activity occurs at various levels, but not three times at any given level, apply the following: <ul style="list-style-type: none"> When there is a combination of full staff performance, and extensive assistance, code extensive assistance. When there is a combination of full staff performance, weight bearing assistance and/or non-weight bearing assistance code limited assistance (2), if none of the above are met, code supervision. 																																					
1. ADL Self-Performance Code for resident's performance over all shifts - not including setup. If the ADL activity occurred 3 or more times at various levels of assistance, code the most dependent - except for total dependence, which requires full staff performance every time Coding: Activity Occurred 3 or More Times 0. Independent - no help or staff oversight at any time 1. Supervision - oversight, encouragement or cueing 2. Limited assistance - resident highly involved in activity, staff provide guided maneuvering of limbs or other non-weight-bearing assistance 3. Extensive assistance - resident involved in activity, staff provide weight-bearing support 4. Total dependence - full staff performance every time during entire 7-day period Activity Occurred 2 or Fewer Times 7. Activity occurred only once or twice - activity did occur but only once or twice 8. Activity did not occur - activity did not occur or family and/or non-facility staff provided care 100% of the time for that activity over the entire 7-day period	2. ADL Support Provided Code for most support provided over all shifts; code regardless of resident's self-performance classification Coding: 0. No setup or physical help from staff 1. Setup help only 2. One person physical assist 3. Two+ persons physical assist 8. ADL activity itself did not occur or family and/or non-facility staff provided care 100% of the time for that activity over the entire 7-day period																																				
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ADL SELF- PERFORMANCE

Measures what the resident actually did (not what he or she might be capable of doing) within each ADL category over the last 7 days according to a performance-based scale.

ADL SUPPORT PROVIDED

Measures the most support provided by staff over the last 7 days, even if that level of support only occurred once.

Coding G0110., Column 1, ADL Self-Performance

- **Code 0, independent:** if resident completed activity with no help or oversight **every time** during the 7-day look-back period and the activity occurred at least three times.
- **Code 1, supervision:** if oversight, encouragement, or cueing was provided **three or more times** during the last 7 days.
- **Code 2, limited assistance:** if resident was highly involved in activity and received physical help in guided maneuvering of limb(s) or other non-weight-bearing assistance on **three or more times** during the last 7 days.
- **Code 3, extensive assistance:** if resident performed part of the activity over the last 7 days and help of the following type(s) was provided **three or more times**:
 - Weight-bearing support provided **three or more times, OR**
 - Full staff performance of activity **three or more times** during part but not all of the last 7 days
- **Code 4, total dependence:** if there was **full staff performance** of an activity with no participation by resident for any aspect of the ADL activity and the activity occurred three or more times. The resident must be unwilling or unable to perform any part of the activity over the entire 7-day look-back period.
- **Code 7, activity occurred only once or twice:** if the activity occurred **fewer than three times**.
- **Code 8, activity did not occur:** if the activity did not occur or family and/or non-facility staff provided care 100% of the time for that activity over the entire 7-day look-back period.

Self-Performance Rule of 3

ADL Self-Performance Rule of 3 Algorithm

START HERE – Review these instructions for Rule of 3 before using the algorithm. Follow steps in sequence and stop at first level that applies.

Start by counting the number of episodes at each ADL Self-Performance Level.

*** Exceptions to Rule of 3:**

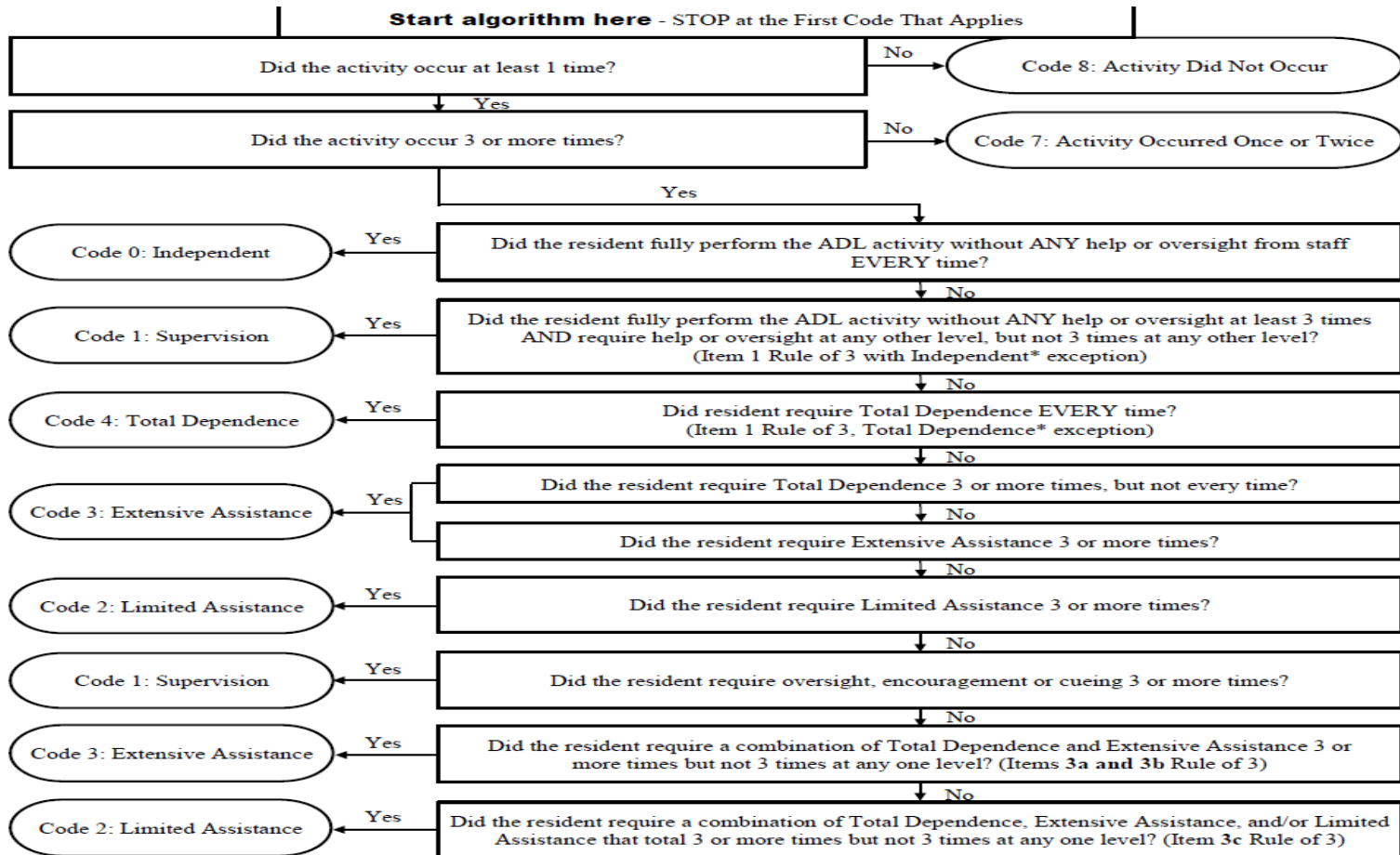
- The Rule of 3 does not apply when coding Independent (0), Total Dependence (4) or Activity Did Not Occur (8), since these levels must be EVERY time the ADL occurred during the look-back period.
- The Rule of 3 does not apply when Activity Occurred Only Once or Twice (7), since the activity did not occur at least 3 times.

Rule of 3:

1. When an activity occurs 3 or more times at any one level, code that level – *note exceptions for Independent (0) and Total Dependence (4).
2. When an activity occurs 3 or more times at multiple levels, code the most dependent level that occurs 3 or more times – *note exceptions for Independent (0) and Total Dependence (4).
3. When an activity occurs 3 or more times and at multiple levels, but NOT 3 times at any one level, apply the following in sequence as listed – stop at the first level that applies: (NOTE: This 3rd rule *only* applies if there are **NOT ANY LEVELS** that are 3 or more episodes at any one level. DO NOT proceed to 3a, 3b or 3c unless this criteria is met.)
 - a. Convert episodes of Total Dependence (4) to Extensive Assistance (3).
 - b. When there is a combination of Total Dependence (4) and Extensive Assist (3) that total 3 or more times – code Extensive Assistance (3).
 - c. When there is a combination of Total Dependence (4) and Extensive Assist (3) and/or Limited Assistance (2) that total 3 or more times, code Limited Assistance (2).

If none of the above are met, code Supervision (1).

Rule of 3 Algorithm



General Self-Performance Tips

- When an “8” is coded for ADL Self-Performance category, you must also code an “8” for ADL Support Provide in the same category.
- Residents may use an assistive device when assessing Self-Performance.
- Difference between guided maneuvering and weight bearing assistance

Key: Determine who is supporting the weight of the resident's extremity or body

– Limited Assistance (Guided Maneuvering) Example:

- The Resident can lift the utensil or cup but you need to guide the resident's hand to his or her mouth

– Extensive Assistance (Weight Bearing) Examples:

- Supporting some of the weight of the resident's hand while helping the resident to eat
- Performing part of the activity for the resident

Coding G0110. Column 2, Support Provided

- **Code 0, no setup or physical help from staff:** if resident completed activity with no help or oversight.
- **Code 1, setup help only:** if resident is provided with materials or devices necessary to perform the ADL independently. This can include giving or holding out an item that the resident takes from the caregiver.
- **Code 2, one person physical assist:** if the resident was assisted by one staff person.
- **Code 3, two+ person physical assist:** if the resident was assisted by two or more staff persons.
- **Code 8, ADL activity itself did not occur during the entire period:** if the activity did not occur or family and/or non-facility staff provided care 100% of the time for that activity over the entire 7-day period

Key: Remember you are coding **PHYSICAL ASSISTANCE** given.

Section G 0110. ADL Definitions and Item Coding Tips

- **G0110A. Bed mobility:** how resident moves to and from lying position, turns side or side, and positions body while in bed or alternate sleep furniture.
 - Consider assistance received in any alternative bed when coding bed mobility
 - Code Set-up when handing the resident a bar on a trapeze, staff raises the half rail for the resident's use and then provides no further help.
- **G0110B. Transfer:** how resident moves between surfaces including to or from: bed, chair, wheelchair, standing position (**excludes** to/from bath/toilet).
 - Some residents are transferred between surfaces, including to and from the bed, chair, and wheelchair, by staff, using a full-body mechanical lift. Whether or not the resident holds onto a bar, strap, or other device during the full-body mechanical lift transfer is not part of the transfer activity and should not be considered as resident participation in activity.
 - Giving the resident a transfer board or locking the wheelchair for safe transfer would be coded as set-up.

Definitions and Tips (Continued)

- **C. Walk in room:** how resident walks between locations in his/her room.
- **D. Walk in corridor:** how resident walks in corridor on unit.
- **E. Locomotion on unit:** how resident moves between locations in his/her room and adjacent corridor on same floor.
 - If in wheelchair, self-sufficiency once in chair.
 - There is no requirement that the resident must leave the room in order to code locomotion on the unit. The resident's room and bathroom are part of the unit. Locomotion in the resident's room would be included in the coding decision.

Definitions and Tips (Continued)

- **F. Locomotion off unit:** how resident moves to and returns from off-unit locations (e.g., areas set aside for dining, activities or treatments).
 - **If facility has only one floor,** how resident moves to and from distant areas on the floor. Consider off the unit when a resident has left the corridor adjacent to their room when facility has one floor/unit.
 - If in wheelchair, self-sufficiency once in chair
- **G. Dressing:** how resident puts on, fastens and takes off all items of clothing.
 - includes donning/removing a prosthesis or TED hose
 - includes putting on and changing pajamas and housedresses

Definition and Tips (Continued)

- **H. Eating:** how resident eats and drinks, regardless of skill. Do not include eating/drinking during medication pass. Includes intake of nourishment by other means (e.g., tube feeding, total parenteral nutrition, IV fluids administered for nutrition or hydration)
 - Extensive: If the resident with tube feeding, TPN, or IV fluids managed by staff **but did participate** in receiving food/fluids by oral nutrition.
 - Set-Up: Code set-up when Cutting of meat and Opening containers and/or giving one food at a time.
 - Supervision: Code supervision for residents seated together or in close proximity of one another during a meal who receive individual supervision with eating.
 - Dependent: Code only if the resident was assisted in eating all food items and liquids at all meals and snacks. (Including Tube feeding delivered totally by Staff)
 - Activity did not occur: Only code if resident received no nourishment by any route (by mouth, IV, TPN or Tube)

Definitions and Tips (Continued)

- **I. Toilet use:** how resident uses the toilet room, commode, bedpan, or urinal; transfers on/off toilet; cleanses self after elimination; changes pad; manages ostomy or catheter; and adjusts clothes. Do not include emptying of bedpan, urinal, bedside commode, catheter bag or ostomy bag.
 - Do **NOT** include the emptying of bedpan, urinal, bedside commode, catheter bag or ostomy bag
 - Code Set-up when handing the resident a bedpan or placing articles necessary for changing an ostomy appliance within reach.
- **J. Personal hygiene:** how resident maintains personal hygiene, including combing hair, brushing teeth, shaving, applying makeup, washing/drying face and hands.
 - Excludes baths and showers.

RUG-III Classification Instructions Using MDS 3.0

RUG-III version 5.12 44 Group

STEP ONE: CALCULATE THE RUG ADL SCORE

- A. To find the ADL scores for Bed mobility (G0110A), Transfer (G0110B), and Toilet use (G0110I), compare the MDS item responses to CHART A.

	<u>Self-perf.</u>	<u>Support</u>
Bed Mobility	G0110A1 _____	G0110A2 _____
Transfer	G0110B1 _____	G0110B2 _____
Toilet Use	G0110I1 _____	G0110I2 _____

CHART A

IF

AND

<u>Self-perf.</u> <u>(G0110-1) =</u>	<u>Support</u> <u>(G0110-2) =</u>	<u>ADL</u> <u>Score =</u>
'—', 0, 1 or 7	* (any number)	1
2	* (any number)	3
3 or 4	'—', 0, 1 or 2	4
3, 4 or 8	3 or 8	5

Enter the three ADL scores (one each for Bed mobility, Transfer, and Toilet use) on the RUG Element Worksheet.

- B. To find the Eating ADL score, check the MDS item response to Parenteral/IV (K0510A) and Feeding tube (K0510B).

Parenteral/IV feeding	K0510A1,2 _____
Feeding tube	K0510B1,2 _____*
* (K0710A3 must = 51% or more OR K0710A3 = 26 – 50% AND K0710B3 >= 501cc)	

If either K0510A1 or 2 is checked ('1'), or K0510B1 or 2 is checked and the supporting data is present for Feeding tube, the Eating ADL score is 3. If neither is checked or Feeding tube is not supported, note the number from Eating self-performance (G0110H1) and find the ADL score from CHART B.

Eating	G0110H1 _____
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CHART B

<u>IF</u> <u>G0110H1 =</u>	<u>ADL</u> <u>Score =</u>
'—', 0, 1 or 7	1
2	2
3, 4 or 8	3

RUGS III: Medicaid Reimbursement Section G Items

Late Loss ADLs

- Bed Mobility-Self-Performance and Support provided
- Transfer-Self-Performance and Support provided
- Toileting-Self-Performance and Support provided
- Eating-Self-Performance Only

These 4 ADL responses result in the total
ADL score.

MDS 3.0 QMs

MDS 3.0 Quality Measures that Utilize “Section G” Items as Data Elements:

- **Short-Term Measures-**

- Percent of Residents who made improvements in function

- Uses G0110B1/Transfer and G0110E1/Locomotion on the unit

- **Long-Term Measures-**

- Percent of Residents whose need for Help with Activities of Daily Living has Increased

- Uses late loss ADL's, the same items needed for current RUG III and RUG IV calculations. G0110A/Bed Mobility, G0010B/Transfers, G0010H/Eating and G0010I/Toileting.

- Percent High-Risk Residents with Pressure Ulcers-

- G0110A/Bed Mobility and G0110B Transfers
- This measure also uses the same late loss items above as covariates.

- Percent of Residents whose ability to move independently worsened-

- This measure uses G110E/Locomotion on the Unit

Section GG

PPS/PDPM
Reimbursement

SNF-QRP Measures
And APU
Determination

GG: 0130. and 0170. Overview

CMS 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).

PDPM reimbursement- Used in classification of PT, OT and Nursing case-mix categories.

SNF-QRP QMS- Used in the SNF-QRP Quality Measures and MDS completion requirements for the SNF-QRP Annual Payment Update(APU)

Section “GG” Rules for assessment

Qualified, Licensed clinicians assess the resident’s usual performance based on:

1. Direct Observation

2. Reports-From Resident, family clinicians, and care staff.

- 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.
- 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.

Coding Scale

GG0130. Self-Care and GG0170. Mobility

Coding:

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

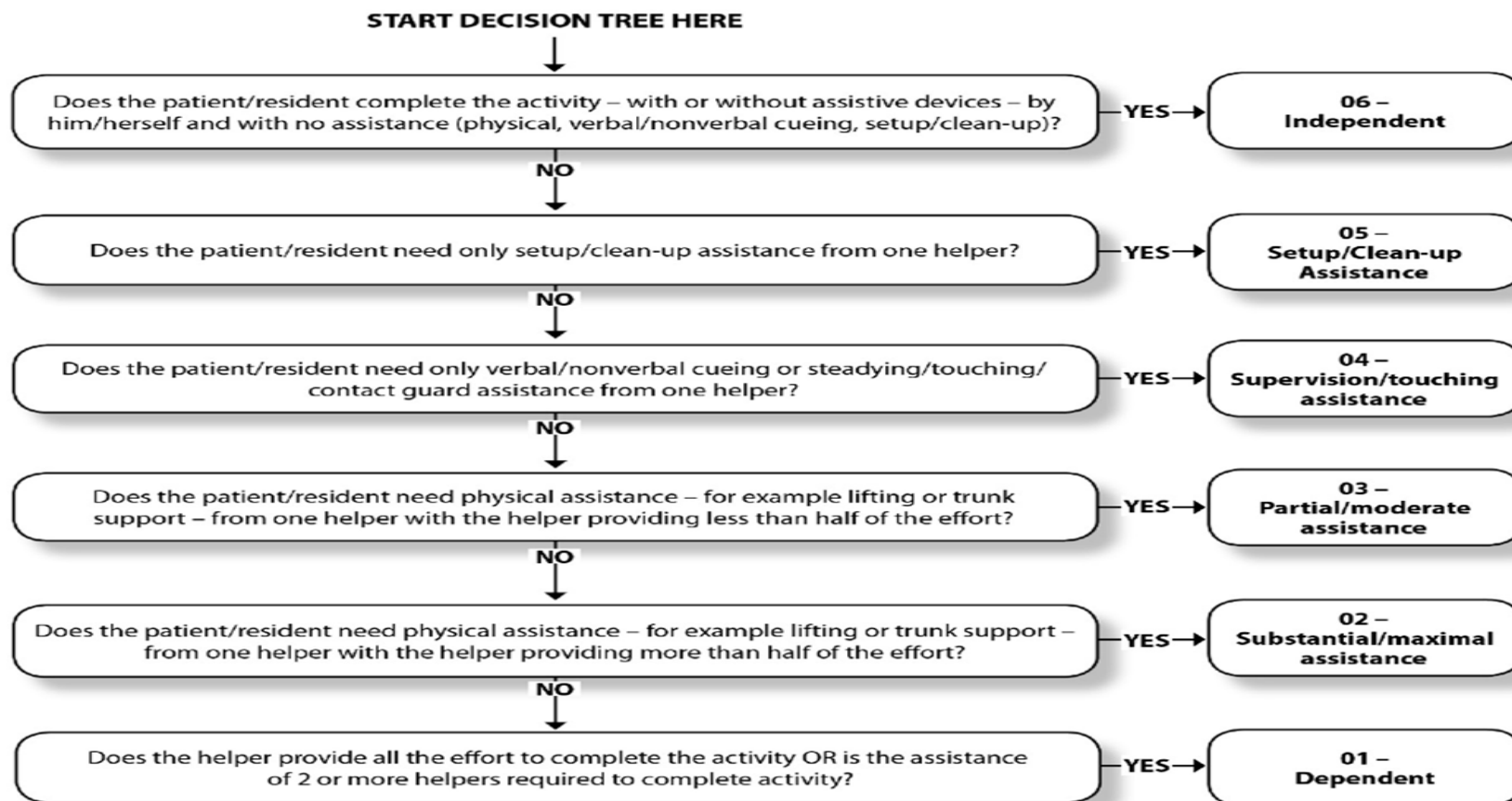
Activities may be completed with or without assistive devices.

06. **Independent** - Resident completes the activity by him/herself with no assistance from a helper.
05. **Setup or clean-up assistance** - Helper sets up or cleans up; resident completes activity. Helper assists only prior to or following the activity.
04. **Supervision or touching assistance** - Helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity. Assistance may be provided throughout the activity or intermittently.
03. **Partial/moderate assistance** - Helper does LESS THAN HALF the effort. Helper lifts, holds, or supports trunk or limbs, but provides less than half the effort.
02. **Substantial/maximal assistance** - Helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs and provides more than half the effort.
01. **Dependent** - Helper does ALL of the effort. Resident does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the resident to complete the activity.

If activity was not attempted, code reason:

07. **Resident refused**
09. **Not applicable** - Not attempted and the resident did not perform this activity prior to the current illness, exacerbation, or injury.
10. **Not attempted due to environmental limitations** (e.g., lack of equipment, weather constraints)
88. **Not attempted due to medical condition or safety concerns**

Decision Tree



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

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.

GG0130. and GG0170.

Use of Dash

- 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).

Usual Status

- 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.
- Residents should be allowed to perform activity as independently as possible as long as they are safe.

GG0130./GG0170. Admission

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

1. Admission Performance	2. Discharge Goal	
↓ Enter Codes in Boxes ↓		
<input type="checkbox"/>	<input type="checkbox"/>	A. Eating: The ability to use suitable utensils to bring food and/or liquid to the mouth and swallow food and/or liquid once the meal is placed before the resident.
<input type="checkbox"/>	<input type="checkbox"/>	B. Oral hygiene: The ability to use suitable items to clean teeth. Dentures (if applicable); The ability to insert and remove dentures into and from the mouth, and manage denture soaking and rinsing with use of equipment.
<input type="checkbox"/>	<input type="checkbox"/>	C. Toileting hygiene: The ability to maintain perineal hygiene, adjust clothes before and after voiding or having a bowel movement. If managing an ostomy, include wiping the opening but not managing equipment.
<input type="checkbox"/>	<input type="checkbox"/>	E. Shower/bathe self: The ability to bathe self, including washing, rinsing, and drying self (excludes washing of back and hair). Does not include transferring in/out of tub/shower.
<input type="checkbox"/>	<input type="checkbox"/>	F. Upper body dressing: The ability to dress and undress above the waist; including fasteners, if applicable.
<input type="checkbox"/>	<input type="checkbox"/>	G. Lower body dressing: The ability to dress and undress below the waist, including fasteners; does not include footwear.
<input type="checkbox"/>	<input type="checkbox"/>	H. Putting on/taking off footwear: The ability to put on and take off socks and shoes or other footwear that is appropriate for safe mobility; including fasteners, if applicable.

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

1. Admission Performance	2. Discharge Goal	
↓ Enter Codes in Boxes ↓		
<input type="checkbox"/>	<input type="checkbox"/>	A. Roll left and right: The ability to roll from lying on back to left and right side, and return to lying on back on the bed.
<input type="checkbox"/>	<input type="checkbox"/>	B. Sit to lying: The ability to move from sitting on side of bed to lying flat on the bed.
<input type="checkbox"/>	<input type="checkbox"/>	C. Lying to sitting on side of bed: The ability to move from lying on the back to sitting on the side of the bed with feet flat on the floor, and with no back support.
<input type="checkbox"/>	<input type="checkbox"/>	D. Sit to stand: The ability to come to a standing position from sitting in a chair, wheelchair, or on the side of the bed.
<input type="checkbox"/>	<input type="checkbox"/>	E. Chair/bed-to-chair transfer: The ability to transfer to and from a bed to a chair (or wheelchair).
<input type="checkbox"/>	<input type="checkbox"/>	F. Toilet transfer: The ability to get on and off a toilet or commode.
<input type="checkbox"/>	<input type="checkbox"/>	G. Car transfer: The ability to transfer in and out of a car or van on the passenger side. Does not include the ability to open/close door or fasten seat belt.
<input type="checkbox"/>	<input type="checkbox"/>	I. Walk 10 feet: Once standing, the ability to walk at least 10 feet in a room, corridor, or similar space. If admission performance is coded 07, 09, 10, or 88 → Skip to GG0170M, 1 step (curb)
<input type="checkbox"/>	<input type="checkbox"/>	J. Walk 50 feet with two turns: Once standing, the ability to walk at least 50 feet and make two turns.
<input type="checkbox"/>	<input type="checkbox"/>	K. Walk 150 feet: Once standing, the ability to walk at least 150 feet in a corridor or similar space.
<input type="checkbox"/>	<input type="checkbox"/>	L. Walking 10 feet on uneven surfaces: The ability to walk 10 feet on uneven or sloping surfaces (indoor or outdoor), such as turf or gravel.
<input type="checkbox"/>	<input type="checkbox"/>	M. 1 step (curb): The ability to go up and down a curb and/or up and down one step. If admission performance is coded 07, 09, 10, or 88 → Skip to GG0170P, Picking up object
<input type="checkbox"/>	<input type="checkbox"/>	N. 4 steps: The ability to go up and down four steps with or without a rail. If admission performance is coded 07, 09, 10, or 88 → Skip to GG0170M, Picking up object
<input type="checkbox"/>	<input type="checkbox"/>	O. 12 steps: The ability to go up and down 12 steps with or without a rail.
<input type="checkbox"/>	<input type="checkbox"/>	P. Picking up object: The ability to bend/stoop from a standing position to pick up a small object, such as a spoon, from the floor.
<input type="checkbox"/>	<input type="checkbox"/>	Q1. Does the resident use a wheelchair and/or scooter? 0. No → Skip to GG0130, Self Care (Discharge) 1. Yes → Continue to GG0170R, Wheel 50 feet with two turns
<input type="checkbox"/>	<input type="checkbox"/>	R. Wheel 50 feet with two turns: Once seated in wheelchair/scooter, the ability to wheel at least 50 feet and make two turns.
<input type="checkbox"/>	<input type="checkbox"/>	RR1. Indicate the type of wheelchair or scooter used. 1. Manual 2. Motorized
<input type="checkbox"/>	<input type="checkbox"/>	S. Wheel 150 feet: Once seated in wheelchair/scooter, the ability to wheel at least 150 feet in a corridor or similar space.
<input type="checkbox"/>	<input type="checkbox"/>	SS1. Indicate the type of wheelchair or scooter used. 1. Manual 2. Motorized

Admission Tips

- GG0130 and GG0170:

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.

Admission Assessment Period		
Mon	Tues	Wed
1	2	3
8	9	10
15	16	17

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

GG0130./GG0170. Interim Performance

GG0130: Self-Care (3-Day Assessment Period)
Interim Performance-
(Interim Payment Assessment-Optional)

GG0170: Mobility (3-Day Assessment Period)
Interim Performance
(Interim Payment Assessment-Optional)

5. Interim Performance Enter Codes in Boxes ↓	
<input type="checkbox"/>	A. Eating: The ability to use suitable utensils to bring food and/or liquid to the mouth and swallow food and/or liquid once the meal is placed before the resident.
<input type="checkbox"/>	B. Oral hygiene: The ability to use suitable items to clean teeth. Dentures (if applicable): The ability to insert and remove dentures into and from the mouth, and manage denture soaking and rinsing with use of equipment.
<input type="checkbox"/>	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.

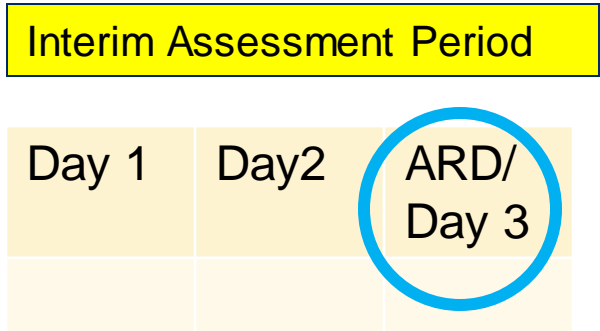
5. Interim Performance Enter Codes in Boxes ↓	
<input type="checkbox"/>	B. Sit to lying: The ability to move from sitting on side of bed to lying flat on the bed.
<input type="checkbox"/>	C. Lying to sitting on side of bed: The ability to move from lying on the back to sitting on the side of the bed with feet flat on the floor, and with no back support.
<input type="checkbox"/>	D. Sit to stand: The ability to come to a standing position from sitting in a chair, wheelchair, or on the side of the bed.
<input type="checkbox"/>	E. Chair/bed-to-chair transfer: The ability to transfer to and from a bed to a chair (or wheelchair).
<input type="checkbox"/>	F. Toilet transfer: The ability to get on and off a toilet or commode.
<input type="checkbox"/>	I. Walk 10 feet: Once standing, the ability to walk at least 10 feet in a room, corridor, or similar space. If interim performance is coded 07, 09, 10, or 88 → Skip to H0100C, Appliances
<input type="checkbox"/>	J. Walk 50 feet with two turns: Once standing, the ability to walk at least 50 feet and make two turns.
<input type="checkbox"/>	K. Walk 150 feet: Once standing, the ability to walk at least 150 feet in a corridor or similar space.

Interim Tips

- **GG0130 and GG0170:**

Interim Assessment Period:

The Assessment reference date (ARD) is determined by the provider, and the assessment period is the last 3 days. (i.e., the ARD and the 2 calendar days prior).



- Code usual performance using 6-point scale. If activity is not attempted, code the reason.
- The Interim Payment Assessment (IPA) is an optional assessment that may be completed by providers in order to report a change in the resident's Payment Driven Payment Model classification.
- Section GG data from the IPA is not used for the SNF-QRP

GG0130./GG0170. End of PPS

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

3. Discharge Performance	
Enter Codes in Boxes	
<input type="text"/>	A. Eating: The ability to use suitable utensils to bring food and/or liquid to the mouth and swallow food and/or liquid once the meal is placed before the resident.
<input type="text"/>	B. Oral hygiene: The ability to use suitable items to clean teeth. Dentures (if applicable); The ability to insert and remove dentures into and from the mouth, and manage denture soaking and rinsing with use of equipment.
<input type="text"/>	C. Toileting hygiene: The ability to maintain perineal hygiene, adjust clothes before and after voiding or having a bowel movement. If managing an ostomy, include wiping the opening but not managing equipment.
<input type="text"/>	E. Shower/bathe self: The ability to bathe self, including washing, rinsing, and drying self (excludes washing of back and hair). Does not include transferring in/out of tub/shower.
<input type="text"/>	F. Upper body dressing: The ability to dress and undress above the waist; including fasteners, if applicable.
<input type="text"/>	G. Lower body dressing: The ability to dress and undress below the waist, including fasteners; does not include footwear.
<input type="text"/>	H. Putting on/taking off footwear: The ability to put on and take off socks and shoes or other footwear that is appropriate for safe mobility; including fasteners, if applicable.

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

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

Discharge Tips

- GG0130. and GG0170.

Discharge Assessment Period:

Assessment period is the last 3 days of the SNF PPS Stay ending on A2400C.
End of the most recent Medicare A stay and the 2 prior calendar days.

Discharge Assessment Period		
Mon	Tues	Wed
1	2	3
8	9	10
Day 1	Day 2	Day 3: Discharge
15	16	17

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

Admission and Discharge Coding

- **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 benefitting 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.

Section GG: General Tips

If a resident cannot complete an activity because they state they are tired, fatigued or exhausted, 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, Resident refused.
- If the resident completed the activity once during the assessment period, code based on the amount of assistance provided.

GG0130. Self-Care

Functional Abilities and Goals

GG0130A. Eating Coding Tips

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 in front of them.

- Assess eating and drinking by mouth only
 - 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 finger foods with his or her hands, code based upon the amount of assistance provided.
- Resident receives tube feedings or parenteral nutrition (PN):
 - Assistance with tube feedings or PN is **not considered** when coding 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**.
 - 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.

GG0103B. Oral Hygiene

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 the use of equipment.

- If a resident does not perform oral hygiene during therapy, determine the resident's abilities based on performance on the nursing care unit.

See Slide # for video for Oral Hygiene



GG0130C. Toileting Hygiene Coding Tips

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.

- 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 need by the resident when moving his or her bowels.

GG0130E. Shower/Bathe Self Coding Tips

Shower/Bathe Self:

Shower/bathe self includes the ability to wash, rinse, and dry the face, upper and lower body, perineal area, and feet. Do not include washing, rinsing, and drying the resident's back or hair. Shower/bathe self does not include transferring in/out of a tub/shower.

- Assessment 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-H:Upper and Lower Body Dressing and Footwear Coding Tips

Dressing and Footwear:

The ability to dress and undress; including fasteners, if applicable. Do not include footwear in lower-body dressing.

Examples of Upper Body Dressing Items

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

Examples of Lower Body Dressing Items

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

Examples of Footwear Dressing Items

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

- For upper body dressing, lower body dressing, and putting on/taking off footwear, if the resident dresses himself or herself and a helper retrieves or puts away the resident's clothing, then code 05, Setup or clean-up assistance.
- When coding upper body dressing and lower body dressing, helper assistance with buttons and/or fasteners is considered touching assistance.

GG0170. Mobility

Functional Abilities and Goals

GG0170: A-C Coding Tips

- 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.



See Slide for Video Link

GG0170E: Chair/Bed to Chair Transfer Coding Tip

Bed/Chair-to-Chair transfer:

The ability to transfer to and from a bed to a chair (or wheelchair)

- The activities of Sit-to-Lying to sitting on the side of the bed are two separate activities that are not assessed as a 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 need 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.
- Also consider transfer from an alternate sleeping arrangement (i.e. recliner)when coding this item.

GG0170F: Toilet Transfer Coding Tip

Toilet Transfer:

The ability to get on and off a toilet or commode

- Do not consider or include GG0130C. Toileting Hygiene item tasks (managing clothing, perineal hygiene) when assessing the Toilet Transfer item.
- Transferring on and off of a bedpan is not include in Toilet transfer.

GG0170G: Car Transfers

Car Transfers:

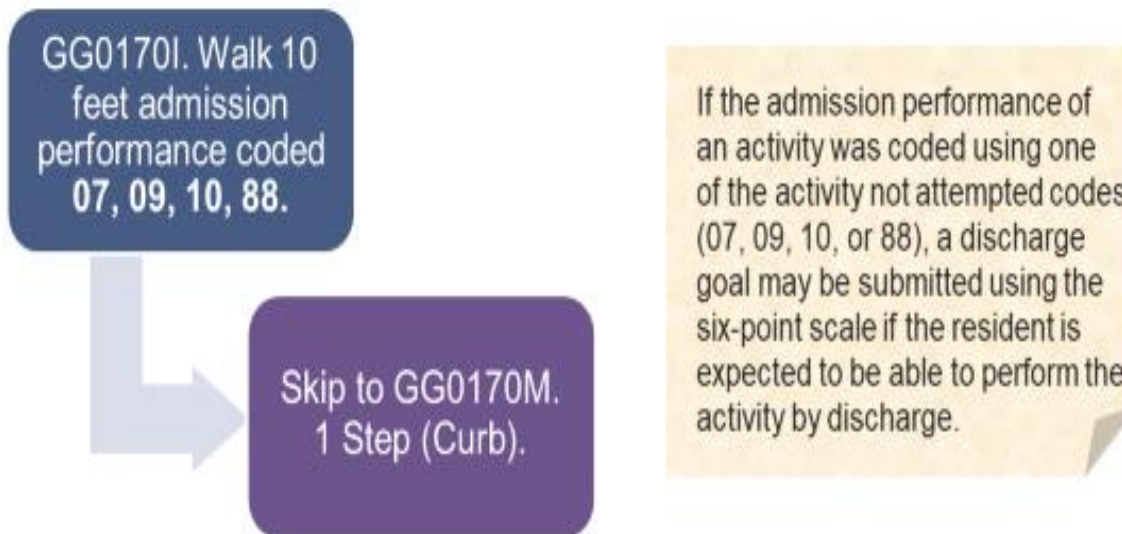
The ability to transfer in and out of a car or van on the passenger side.

- 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.**

GG0170I-L: Walking Items

- Use of assistive devices and adaptive equipment required to complete the walking activity should not affect coding of the activity.
- A resident who needs a second helper to provide supervision and follow with a walker when ambulating would be coded “0” dependent.
- 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: Walking Skip Pattern



GG0170M. and GG0170N. Stairs Skip Pattern

GG0170M. 1 step
(curb) admission
performance coded
07, 09, 10, 88.

Skip to GG0170P.
Picking up object.

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 6-point scale if the resident is expected to be able to perform the activity by discharge.

GG0170N. 4 steps
admission
performance coded
07, 09, 10, 88.

Skip to GG0170P.
Picking up object.

In a scenario where the facility does not have access to 12 stairs to assess the resident's ability, a simulation of the activity may be used. The combination of climbing and descending 4 stairs consecutively, in this case, is an acceptable alternative.

Section GG 0170Q.

Wheelchair/Scooter Use

- 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.

GG0130. and GG0170. More 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.**
- 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.
- If two or more helpers are required to assist the resident in completing the activity, code as 01, Dependent



See Section GG-Decision Tree for further guidance

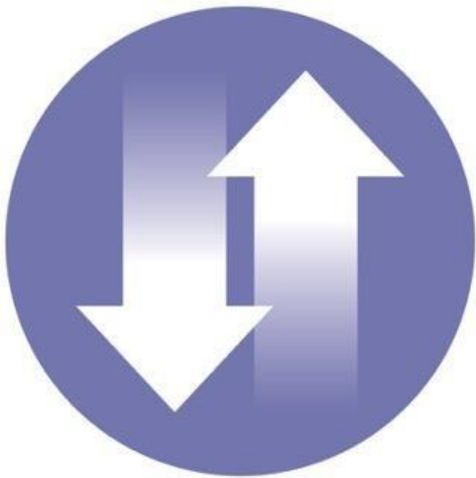
GG1030 and
GG0170

Goal Setting

GG0130./0170. 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./0170. Discharge Goal Coding Tips



- 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.

Discharge Goals should be established as part of the resident's care plan.

More Goal 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.

GG0130. and GG0170. Use of Dash with Discharge Goals

- 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.

Incomplete Stay

Section GG

Can you clarify how Section GG Discharge Performance items should be completed if a resident is in the facility for less than 3 days?

A SNF Part A stay of less than 3 days is one of the criteria that define an incomplete stay.

Medicare Part A SNF Stay incomplete stays are defined as:

- a) Length of stay is less than 3 days; based on A2400C (End date of most recent Medicare stay) – A2400B (Start date of most recent Medicare stay) is less than three days;
- b) Discharged against medical advice coded as an Unplanned Discharge (A0310G = [2])
- c) Died while in SNF (A2100 = [08]); or A0310F = [12];
- d) Discharged unexpectedly (short-stay acute hospital: A0310G = [2] or A2100 = [03]; inpatient psychiatric facility: A0310G = [2] or A2100 = [04]; long-term care hospital: A0310G = [2] or A2100 = [09]).

For residents who have an incomplete stay, Section GG – Discharge Performance on the Medicare Part A PPS Discharge Assessment will be greyed-out and cannot be completed for residents with an incomplete stay. Discharge self-care and mobility performance data are not required if the resident has an incomplete stay.



SNF-QRP FAQ's are posted quarterly on the SNF-QRP website

Medicare A- PPS Reimbursement

- Patient Driven Payment Model (PDPM)
 - Uses Section GG elements to determine PT, OT and Nursing Functional Scores.
 - These scores are then used in the determination of an appropriate Case-mix group for the PT, OT and Nursing, PDPM Categories.

Section GG items used in PDPM

- Section GG items included in the Nursing Functional Score:

Section GG Item	Functional Score Range
GG0130A1 – Self-care: Eating	0 – 4
GG0130C1 – Self-care: Toileting Hygiene	0 – 4
GG0170B1 – Mobility: Sit to Lying	0 – 4
GG0170C1 – Mobility: Lying to Sitting on side of bed	(average of 2 items)
GG0170D1 – Mobility: Sit to Stand	0 – 4
GG0170E1 – Mobility: Chair/bed-to-chair transfer	(average of 3 items)
GG0170F1 – Mobility: Toilet Transfer	

- Section GG items included in the PT & OT Functional Score:

Section GG Item	Functional Score Range
GG0130A1 – Self-care: Eating	0 – 4
GG0130B1 – Self-care: Oral Hygiene	0 – 4
GG0130C1 – Self-care: Toileting Hygiene	0 – 4
GG0170B1 – Mobility: Sit to Lying	0 – 4
GG0170C1 – Mobility: Lying to Sitting on side of bed	(average of 2 items)
GG0170D1 – Mobility: Sit to Stand	0 – 4
GG0170E1 – Mobility: Chair/bed-to-chair transfer	(average of 3 items)
GG0170F1 – Mobility: Toilet Transfer	
GG0170J1 – Mobility: Walk 50 feet with 2 turns	0 – 4
GG0170K1 – Mobility: Walk 150 feet	(average of 2 items)

Section GG: 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).

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

SNF-QRP Section GG: Data Elements Affecting APU

Skilled Nursing Facility Quality Reporting Program (SNF QRP)

Overview of Data Elements Used for Reporting Assessment-Based Quality Measures Affecting FY 2021 Annual Payment Update (APU) Determination

Page 2 of 5

MDS Data Elements Used for FY 2021 SNF QRP APU Determination		MDS 3.0 Assessment Type		Data Collection Periods (CY 2019)	
MDS Section & Number	Data Element Label/Description	PPS 5-Day A0310B=[01]	Part A PPS Discharge A0310H=[1]	Q1, Q2, Q3 2019 MDS 3.0 Version 1.16.1	Q4 2019 MDS 3.0 Version 1.17.0
GG0130A1	Eating (Admission Performance)	X		X	X
GG0130A2	Eating (Discharge Goal)	X		X	X
GG0130A3	Eating (Discharge Performance)		X	X	X
GG0130B1	Oral hygiene (Admission Performance)	X		X	X
GG0130B2	Oral hygiene (Discharge Goal)	X		X	X
GG0130B3	Oral hygiene (Discharge Performance)		X	X	X
GG0130C1	Toileting hygiene (Admission Performance)	X		X	X
GG0130C2	Toileting hygiene (Discharge Goal)	X		X	X
GG0130C3	Toileting hygiene (Discharge Performance)		X	X	X
GG0130E1	Shower/bathe self (Admission Performance)	X		X	X
GG0130E2	Shower/bathe self (Discharge Goal)	X		X	X
GG0130E3	Shower/bathe self (Discharge Performance)		X	X	X
GG0130F1	Upper body dressing (Admission Performance)	X		X	X
GG0130F2	Upper body dressing (Discharge Goal)	X		X	X
GG0130F3	Upper body dressing (Discharge Performance)		X	X	X
GG0130G1	Lower body dressing (Admission Performance)	X		X	X
GG0130G2	Lower body dressing (Discharge Goal)	X		X	X
GG0130G3	Lower body dressing (Discharge Performance)		X	X	X
GG0130H1	Putting on/taking off footwear (Admission Performance)	X		X	X
GG0130H2	Putting on/taking off footwear (Discharge Goal)	X		X	X
GG0130H3	Putting on/taking off footwear (Discharge Performance)		X	X	X
GG0170A1	Roll left and right (Admission Performance)	X		X	X
GG0170A2	Roll left and right (Discharge Goal)	X		X	X
GG0170A3	Roll left and right (Discharge Performance)		X	X	X
GG0170B1	Sit to lying (Admission Performance)	X		X	X
GG0170B2	Sit to lying (Discharge Goal)	X		X	X
GG0170B3	Sit to lying (Discharge Performance)		X	X	X
GG0170C1	Lying to sitting on side of bed (Admission Performance)	X		X	X
GG0170C2	Lying to sitting on side of bed (Discharge Goal)	X		X	X

SNF-QRP Section GG: Data Elements Affecting APU

Skilled Nursing Facility Quality Reporting Program (SNF QRP)

Overview of Data Elements Used for Reporting Assessment-Based Quality Measures Affecting FY 2021 Annual Payment Update (APU) Determination

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MDS Data Elements Used for FY 2021 SNF QRP APU Determination		MDS 3.0 Assessment Type		Data Collection Periods (CY 2019)	
MDS Section & Number	Data Element Label/Description	PPS 5-Day A0310B=[01]	Part A PPS Discharge A0310H=[1]	Q1, Q2, Q3 2019 MDS 3.0 Version 1.16.1	Q4 2019 MDS 3.0 Version 1.17.0
GG0170C3	Lying to sitting on side of bed (Discharge Performance)		X	X	X
GG0170D1	Sit to stand (Admission Performance)	X		X	X
GG0170D2	Sit to stand (Discharge Goal)	X		X	X
GG0170D3	Sit to stand (Discharge Performance)		X	X	X
GG0170E1	Chair/bed-to-chair transfer (Admission Performance)	X		X	X
GG0170E2	Chair/bed-to-chair transfer (Discharge Goal)	X		X	X
GG0170E3	Chair/bed-to-chair transfer (Discharge Performance)		X	X	X
GG0170F1	Toilet transfer (Admission Performance)	X		X	X
GG0170F2	Toilet transfer (Discharge Goal)	X		X	X
GG0170F3	Toilet transfer (Discharge Performance)		X	X	X
GG0170G1	Car transfer (Admission Performance)	X		X	X
GG0170G2	Car transfer (Discharge Goal)	X		X	X
GG0170G3	Car transfer (Discharge Performance)		X	X	X
GG0170I1	Walk 10 feet (Admission Performance)	X		X	X
GG0170I2	Walk 10 feet (Discharge Goal)	X		X	X
GG0170I3	Walk 10 feet (Discharge Performance)		X	X	X
GG0170J1	Walk 50 feet with two turns (Admission Performance)	X		X	X
GG0170J2	Walk 50 feet with two turns (Discharge Goal)	X		X	X
GG0170J3	Walk 50 feet with two turns (Discharge Performance)		X	X	X
GG0170K1	Walk 150 feet (Admission Performance)	X		X	X
GG0170K2	Walk 150 feet (Discharge Goal)	X		X	X
GG0170K3	Walk 150 feet (Discharge Performance)		X	X	X
GG0170L1	Walk 10 feet on uneven surfaces (Admission Performance)	X		X	X
GG0170L2	Walk 10 feet on uneven surfaces (Discharge Goal)	X		X	X
GG0170L3	Walk 10 feet on uneven surfaces (Discharge Performance)		X	X	X
GG0170M1	1 step (curb) (Admission Performance)	X		X	X
GG0170M2	1 step (curb) (Discharge Goal)	X		X	X
GG0170M3	1 step (curb) (Discharge Performance)		X	X	X
GG0170N1	4 steps (Admission Performance)	X		X	X

SNF-QRP Section GG: Data Elements Affecting APU

Skilled Nursing Facility Quality Reporting Program (SNF QRP)

Overview of Data Elements Used for Reporting Assessment-Based Quality Measures Affecting FY 2021 Annual Payment Update (APU) Determination

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MDS Data Elements Used for FY 2021 SNF QRP APU Determination		MDS 3.0 Assessment Type		Data Collection Periods (CY 2019)	
MDS Section & Number	Data Element Label/Description	PPS 5-Day A0310B=[01]	Part A PPS Discharge A0310H=[1]	Q1, Q2, Q3 2019 MDS 3.0 Version 1.16.1	Q4 2019 MDS 3.0 Version 1.17.0
GG0170N2	4 steps (Discharge Goal)	X		X	X
GG0170N3	4 steps (Discharge Performance)		X	X	X
GG0170O1	12 steps (Admission Performance)	X		X	X
GG0170O2	12 steps (Discharge Goal)	X		X	X
GG0170O3	12 steps (Discharge Performance)		X	X	X
GG0170P1	Picking up object (Admission Performance)	X		X	X
GG0170P2	Picking up object (Discharge Goal)	X		X	X
GG0170P3	Picking up object (Discharge Performance)		X	X	X
GG0170Q1	Does the resident use a wheelchair and/or scooter? (Admission)	X		X	X
GG0170Q3	Does the resident use a wheelchair and/or scooter? (Discharge)		X	X	X
GG0170R1	Wheel 50 feet with two turns (Admission Performance)	X		X	X
GG0170R2	Wheel 50 feet with two turns (Discharge Goal)	X		X	X
GG0170R3	Wheel 50 feet with two turns (Discharge Performance)		X	X	X
GG0170RR1	Indicate the type of wheelchair or scooter used (Admission)	X		X	X
GG0170RR3	Indicate the type of wheelchair or scooter used (Discharge)		X	X	X
GG0170S1	Wheel 150 feet (Admission Performance)	X		X	X
GG0170S2	Wheel 150 feet (Discharge Goal)	X		X	X
GG0170S3	Wheel 150 feet (Discharge Performance)		X	X	X
GG0170SS1	Indicate the type of wheelchair or scooter used (Admission)	X		X	X
GG0170SS3	Indicate the type of wheelchair or scooter used (Discharge)		X	X	X

Section GG Video Links

- CMS released a series of short videos to assist providers with coding select Section GG data elements. items.
- 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:
 - [Coding GG0110. Prior Device Use with Information From Multiple Sources \(3:58\).](#)
 - [Decision Tree for Coding Section GG0130. Self-Care and GG0170. Mobility \(11:56\).](#)
 - [Coding GG0130B. Oral Hygiene \(4:25\).](#)
 - [Coding GG0170C. Lying to Sitting on side of bed \(4:33\).](#)

Section GG Web Based Training

- 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

Resources

- Resident Assessment Instrument (RAI) Manual v1.17.1 <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/MDS30RAIManual.html>
- Resident Data Reporting Manual <http://www.dhs.pa.gov/provider/longtermcarecasemixinformation/index.htm>
- MDS 3.0 Quality Measure Manual <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/NHQIQualityMeasures.html>
- SNF-QRP Manual <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/Skilled-Nursing-Facility-Quality-Reporting-Program/SNF-Quality-Reporting-Program-Measures-and-Technical-Information.html>

Questions



- Questions can be submitted to qa-mds@pa.gov and will be answered in the next RAI Spotlight.
- The next teleconference will be held January 9, 2020.