


New MDS Section GG--Post  
Acute QM Triggers

Carol Maher, RN-BC, RAC-CT, CPC



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Learning Objectives

- Participants will identify the new MDS/Oasis/IRF-PI functional ADL items.
- Participants will be able to list the proposed new Quality Measures that will be reported after the new functional ADL data has been collected.
- Participants will be able to explain strategies to successfully gather the needed data for the additional item set section.



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IMPACT ACT

- ▶ IMPACT—Improving Medicare Post-Acute Care Transformation Act—2014
- ▶ Requires CMS to make resident assessment items and Quality Measures data standardized across post-acute settings.



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## Section GG

- ▶ Items will be standardized between LTCH, SNF, HH and IRF.
- ▶ Not all items will appear on all 3 assessment tools.
- ▶ IRF-PAE will include more items than MDS or LTCH.



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## Section GG

- ▶ Admission to Medicare (first 3 days of new Medicare A stay)
- ▶ Discharge from Medicare (may be discharge date or end of Medicare Stay where A2400C = end of Medicare stay)



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## Section GG

- ▶ Required on **admission to SNF PPS stay** when A0310B = 1 SNF PPS 5-day MDS.
  - Admission/5-day MDS
  - 5-day PPS MDS (can be combined with OBRA)
- ▶ Only required for traditional Medicare SNF Part A stays.



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## Look-back

- ▶ **GG0130. Self-Care** (Assessment period is days 1 through 3 of the SNF PPS Stay starting with A2400B). **Complete only if A0310B = 01.**
- ▶ Although the 5-day MDS can have an ARD any day from days 1-8, the look-back for Section GG is days 1-3 of the Medicare A stay.



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## Discharge from Medicare

- ▶ Section GG is required on discharge from Medicare—End of Medicare stay (A2400C).
- ▶ Complete only if:
  - A0310G is not 2 (Unplanned discharge), AND
  - A0310H - 1 (End of Medicare Stay = Yes), AND
  - A2400C (Medicare stay end date) minus A2400B (Medicare A start date) is **greater than 2** and A2100 is not 03 (Hospital).



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## Discharge from Medicare

- ▶ Discharge from Medicare new item set.
- ▶ May be combined with planned discharge (assumption).
- ▶ MDS look-back is the last 3 days of Medicare stay.



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### Part A PPS Discharge Assessment (A0310H = 1):

- Must be completed when the resident's Medicare Part A stay ends, but the resident remains in the facility (i.e., is not physically discharged from the facility).
- For the Part A PPS Discharge assessment, the ARD (Item A2300) is not set prospectively as with other assessments.
- The ARD (A2300) for a **standalone** Part A PPS Discharge assessment is always equal to the End Date of the Most Recent Medicare Stay (A2400C) **and** is the same as the Discharge Date (A2000).
- The ARD may be coded on the assessment any time during the assessment completion period (i.e., End Date of Most Recent Medicare Stay (A2400C) + 14 calendar days).



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### Part A PPS Discharge Assessment (A0310H = 1):

- If the resident's Medicare Part A stay ends and the resident is physically discharged from the facility, an OBRA Discharge assessment is required.
- If the End Date of the Most Recent Medicare Stay (A2400C) occurs on the day of or one day before the Discharge Date (A2000) of a planned discharge (A0310G=1), the OBRA Discharge assessment and Part A PPS Discharge assessment are both required and may be combined. When the OBRA and Part A PPS Discharge assessments are combined, the ARD (A2300) must be equal to the Discharge Date (A2000).
- The Part A PPS Discharge assessment may be combined with most PPS and OBRA- required assessments when requirements for all assessments are met (please see Section



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### Part A PPS Discharge Assessment (A0310H = 1):

- Must be completed (Item Z0500B) within 14 days after the End Date of Most Recent Medicare Stay (A2400C + 14 calendar days).
- Must be submitted within 14 days after the MDS completion date (Z0500B + 14 calendar days).
- Consists of demographic, administrative, and clinical items.
- If the resident's Medicare Part A stay ends and the resident subsequently returns to a skilled level of care and Medicare Part A benefits resume, the Medicare schedule starts again with a 5-Day PPS assessment.



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### Why Section GG?

- ▶ Standardized functional assessment items are included in the new *Section GG* of the Minimum Data Set (MDS) 3.0 adopted for implementation starting October 1, 2016.
- ▶ These standardized items are used to collect data to calculate the adopted cross-setting quality measure intended to meet the IMPACT Act requirement for measure domain: functional status, cognitive function, and changes in function and cognitive function.



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### New Quality Measure

- ▶ The quality measure (an application of Percent of SNF Residents with an Admission and Discharge Functional Assessment and a Care Plan that Addresses Function (NQF #2631) relies on the collection of data using specific standardized items derived from the Continuity Assessment Record and Evaluation (CARE) Item Set.



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### Application of Percent of SNF PPS Residents With an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function

(continued)

**Numerator**

The number of Medicare Part A covered resident stays with functional assessment data for each self-care and mobility activity and at least one self-care or mobility goal

**Denominator**

The number of Medicare Part A covered resident stays



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**% of PPS Residents With an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function**

- When a patient/resident has an incomplete stay, collection of discharge functional status data might not be feasible.
- For patients/residents with incomplete stays, admission functional status data and at least one treatment goal would be required, discharge functional status data would not be required to be reported.



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**New MDS Data Collection**

- ▶ The standardized items included within the MDS do not duplicate existing items on the MDS currently in use for data collection on functional assessment.
- ▶ While many of the standardized items have labels that are similar to existing items on the MDS, there are several key differences between the two sets that may result in variation in the resident assessment results.
- ▶ Key differences include:
  - (1) the data collection and associated data collection instructions;
  - (2) the rating scales used to score a resident's level of independence; and
  - (3) the item definitions.



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Data Collection and Data Collection Instructions for the Standardized Function Items:



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## Steps for Assessment

1. Assess the resident's self-care status based on direct observation, the resident's self-report, family reports, and direct care staff reports documented in the resident's medical record during the 3-day assessment period, which is days 1 through 3, starting with the date in A2400B, Start of most recent Medicare stay.

2. Residents should be allowed to perform activities as independently as possible, as long as they are safe.



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## Steps for Assessment

3. For the purposes of completing Section GG, a "helper" is defined as facility staff who are direct employees and facility-contracted employees (e.g., rehabilitation staff, nursing agency staff). Thus, does not include individuals hired, compensated or not, by individuals outside of the facility's management and administration such as hospice staff, nursing/certified nursing assistant students, etc. **Therefore, when helper assistance is required because a resident's performance is unsafe or of poor quality, only consider facility staff when scoring according to amount of assistance provided.**



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## Steps for Assessment

4. Activities may be completed with or without assistive device(s). **Use of assistive device(s) to complete an activity should not affect coding of the activity.**

5. Residents should be coded performing activities based on their "usual performance," or baseline performance, which is identified as the resident's usual activity/performance for any of the self-care or mobility activities, not the most independent or dependent performance over the assessment period. Therefore, if there's fluctuation in the performance of activities during the three-day assessment, the performance wouldn't be the worst, and it wouldn't be the best, but it would be what's "usual" for that individual.

6. Refer to facility, Federal, and State policies and procedures to determine which staff members may complete an assessment. Resident assessments are to be done in compliance with facility, Federal, and State requirements.



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## New Data Collection

- ▶ For the standardized items, the assessment period is **three (3) calendar days**.
- ▶ When resident functioning varies, the resident's **usual** performance would need to be reported on these standardized items.
- ▶ When resident functioning varies, the resident's **usual** performance **over a three day period** would need to be reported on these standardized items in contrast to the assessment and reporting of the resident's most dependent level of performance that occurs three or more times according to the "rule of 3" (and the definition and coding exceptions) during a seven day period as is required in the MDS 3.0 Section G.



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## Usual Performance

- ▶ Usual is defined as how the patient typically performs the activity during an assessment. The performance score is to be based on an assessment of the patient in which the patient is allowed to perform the activity as independently as possible, as long as he/she is safe. If the patient's self-care or mobility performance varies during the assessment period, **report the patient's usual status, *not the patient's most independent performance and not the patient's most dependent episode.***



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## Rating Scales Used to Assess Functional Activities:

- ▶ The standardized items include 3 self-care activities and 9 mobility activities that are rated on a 6-level rating scale ranging from "6" meaning "Independent" to "1" that refers to dependent (**Figure 1**).
  - A higher score on the rating scale means greater independence.



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## Examples of Setup-Clean up

1. Sit to Lying: The helper places the bedrail in the upright position and the patient uses the bedrail to move from a sitting position to a lying position.
2. Chair/Bed-to-Chair Transfer: The helper places the patient's wheelchair next to the patient's bed and moves the wheelchair footrests out of the way so that patient can transfer into the wheelchair safely without supervision, cueing or physical assistance.
3. Chair/Bed-to-Chair Transfer: The helper provides a slide board to the patient and the patient uses the slide board to transfer from his bed to his wheelchair. The helper does not provide any supervision, cueing or physical assistance.




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## GG0130 – (04) Supervision or Touching Assistance

**04. Supervision or touching assistance**

Code the resident's usual performance at the start of the SNF PPS stay, code the reason. Code the patient's end of SNF PPS stay goal(s) using the 6-point scale.

**Coding:**

<p><b>Safety and Quality of Performance:</b> 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 assistance provided.</p> <p>06. <b>Independent:</b> Resident completes the activity by him/herself with no assistance from a helper.</p> <p>05. <b>Setup or clean up assistance:</b> Helper SETS UP or CLEANS UP; resident completes activity. Helper assists only prior to or following the activity.</p> <p>04. <b>Supervision or touching assistance:</b> Helper provides VERBAL CUES or TOUCHING/STEADYING assistance as resident completes activity. Assistance may be provided throughout the activity or intermittently.</p> <p>03. <b>Partial/moderate assistance:</b> Helper does LESS THAN HALF the effort. Helper lifts, holds, or supports trunk or limbs, but provides less than half the effort.</p>	<p><b>If activity was not attempted, code reason:</b></p> <p>07. Resident refused.</p> <p>08. Not applicable.</p> <p>09. Not attempted due to medical condition or safety concerns.</p>
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**Code 04, Supervision or touching assistance:** if the helper provides VERBAL CUES or TOUCHING/STEADYING assistance as resident completes activity. Assistance may be provided throughout the activity or intermittently. No lifting assistance provided.




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## GG0130 –(03) Partial/Moderate Assistance

**03. Partial/moderate assistance**

Code the resident's usual performance at the start of the SNF PPS stay, code the reason. Code the patient's end of SNF PPS stay goal(s) using the 6-point scale.

**Coding:**

<p><b>Safety and Quality of Performance:</b> 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 assistance provided.</p> <p>06. <b>Independent:</b> Resident completes the activity by him/herself with no assistance from a helper.</p> <p>05. <b>Setup or clean up assistance:</b> Helper SETS UP or CLEANS UP; resident completes activity. Helper assists only prior to or following the activity.</p> <p>04. <b>Supervision or touching assistance:</b> Helper provides VERBAL CUES or TOUCHING/STEADYING assistance as resident completes activity. Assistance may be provided throughout the activity or intermittently.</p> <p>03. <b>Partial/moderate assistance:</b> Helper does LESS THAN HALF the effort. Helper lifts, holds, or supports trunk or limbs, but provides less than half the effort.</p> <p>02. <b>Substantial/total assistance:</b> Helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs and provides more than half the effort.</p>	<p><b>If activity was not attempted, code reason:</b></p> <p>07. Resident refused.</p> <p>08. Not applicable.</p> <p>09. Not attempted due to medical condition or safety concerns.</p>
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**Code 03, Partial/moderate assistance:** if the helper does LESS THAN HALF the effort. Helper lifts, holds, or supports trunk or limbs, but provides less than half the effort.




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## GG0130 – (02) Substantial/Maximal Assistance

Code the resident's usual performance at the start of the SNF PPS stay, code the reason. Code the patient's end of SNF PPS stay goal(s) using the 6-point scale. not attempted at

**02. Substantial/maximal assistance**

**Calling:**

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

As helper may be completed with or without assistive devices.

04. **Independent:** Resident completes the activity by themselves 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.

06. **Supervision or teaching assistance:** Helper provides VERBAL CUES or TOUCHING/TEACHING assistance as resident completes activity. Assistance may be provided throughout the activity or intermittently.

07. **Partial/maximal assistance:** Helper does LESS THAN HALF the effort. Helper lifts, holds, or supports trunk or limbs, but provides less than half the effort.

08. **Substantial/maximal assistance:** Helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs and provides more than half the effort.

**If activity was not attempted, code reason:**

09. Resident refused.

10. Not applicable.

11. Not attempted due to medical condition or safety concerns.

**Code 02, Substantial/maximal assistance:** if the helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs and provides more than half the effort.




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## GG0130 – (01) Dependent

Code the resident's usual performance at the start of the SNF PPS stay for each activity. not attempted at

**01. Dependent**

**Calling:**

**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.

As helper may be completed with or without assistive devices.

04. **Independent:** Resident completes the activity by themselves 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.

06. **Supervision or teaching assistance:** Helper provides VERBAL CUES or TOUCHING/TEACHING assistance as resident completes activity. Assistance may be provided throughout the activity or intermittently.

07. **Partial/maximal assistance:** Helper does LESS THAN HALF the effort. Helper lifts, holds, or supports trunk or limbs, but provides less than half the effort.

08. **Substantial/maximal assistance:** Helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs and provides more than half the effort.

09. **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:**

10. Resident refused.

11. Not applicable.

12. Not attempted due to medical condition or safety concerns.

**Code 01, Dependent:** if the helper does ALL of the effort. Resident does none of the effort to complete the activity, or the assistance of two or more helpers is required for the resident to complete the activity.




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If activity was not attempted, code reason:




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## GG0130 – Coding Algorithm

- Does the resident need assistance (physical, verbal/non-verbal cueing, setup/clean-up) to complete the self-care activity?
  - If no, **Code 06, Independent**
  - If yes...
- Does the resident need only setup or clean-up assistance?
  - If yes, **Code 05, Setup or clean-up**
  - If no...



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## GG0130 – Coding Algorithm

- Does the resident need only verbal/non-verbal cueing, or steadying/touching assistance?
  - If yes, **Code 04, Supervision or touching assistance**
  - If no...
- Does the resident need lifting assistance or trunk support with the helper providing **less** than half of the effort?
  - If yes, **Code 03, Partial/moderate assistance**
  - If no...



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## GG0130 – Coding Algorithm

- Does the resident need lifting assistance or trunk support with the helper providing **more** than half of the effort?
  - If yes, **Code 02, Substantial/maximal assistance**
  - If no...
- Does the helper provide **all** of the effort to complete the activity **OR** is the assistance of two or more helpers required?
  - If yes, **Code 01, Dependent**



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## GG0130 - Coding Algorithm

- Was the activity not attempted? Indicate why.
  - **Code 07, Resident refused**, if the resident refused to complete the activity.
  - **Code 09, Not applicable**, if the resident did not perform this activity prior to the current illness, exacerbation, or injury.
  - **Code 88, Not attempted due to medical condition or safety concerns**, if the activity was not attempted due to medical condition or safety concerns.



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## Use of a Dash (-)

- Coding a dash ("-") in these items indicates "No information." CMS expects dash use for SNF QRP items to be a rare occurrence. **Use of dashes for these items may result in a 2% reduction in the annual payment update.**
- If the reason the item was not assessed was that the resident refused (code 07), the item is not applicable (code 09), or the activity was not attempted due to medical condition or safety concerns (code 88), use these codes instead of a dash ("-").



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## Assessment Items: 3-day Look-Back

**Self-Care Items (Reported on both the Admit to Medicare and Discharge from Medicare Assessments.**

**Discharge goal also coded on admit to Medicare MDS.**

**Presently, these items are only required for traditional Medicare A residents.**



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## GG0130A. Eating

1. Admission Performance	2. Discharge Goal	
<input type="checkbox"/>	<input type="checkbox"/>	<b>A. Eating</b> The ability to use suitable utensils to bring food to the mouth and swallow food once the meal is presented on a table/tray. Includes modified food consistency.
<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/>	<input type="checkbox"/>	

**GG0130A. Eating:** The ability to use suitable utensils to bring food to the mouth and swallow food once the meal is presented on a table/tray. Includes modified food consistency. **(Does not include IVs or Tube Feeding!)**




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## GG0130A. Eating Polling Scenario

▶ Mr. R is unable to eat by mouth due to his medical condition. He receives nutrition through a gastrostomy tube (G-tube), which is administered by nurses.




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How would you code GG0130A. Eating for Mr. R?

- A. Code 88, Not attempted due to medical condition or safety concerns
- B. Code 02, Substantial/maximal assistance
- C. Code 03, Partial/moderate assistance
- D. Code 09, Not applicable




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## GG0130B. Oral Hygiene

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

**GG0130B. Oral hygiene:** The ability to use suitable items to clean teeth. [Dentures (if applicable): The ability to remove and replace dentures from and to the mouth, and manage equipment for soaking and rinsing them.]




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## GG0130B. Oral Hygiene Coding Scenario

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

- How would you code GG0130B?
- What is your rationale?




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## GG0130B. Oral Hygiene Coding Scenario (continued)

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




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## GG0130C. Toileting Hygiene

1. Admission Performance	2. Discharge Goal	
Enter Codes in Boxes		
<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/>	<input type="checkbox"/>	

**C. Toileting hygiene**

**A. Eating:** The ability to use suitable utensils to bring food to the mouth and swallow food once the meal is presented on a table-top. Includes modified food consistency.

**B. Oral hygiene:** The ability to use suitable items to clean teeth. (Dentures (if applicable), the ability to remove and replace dentures from and to the mouth, and manage equipment for soaking and rinsing them.)

**C. Toileting hygiene:** The ability to maintain perineal hygiene, adjust clothes before and after using the toilet, commode, bedpan, or urinal. If managing an ostomy, include wiping the opening but not managing equipment.

**GG0130C. Toileting hygiene:** The ability to maintain perineal hygiene, adjust clothes before and after using the toilet, commode, bedpan, or urinal. If managing an ostomy, include wiping the opening but not managing equipment.




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## GG0130C. Toileting Hygiene Polling Scenario

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




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### Polling Question:

How would you code GG0130C. Toileting Hygiene for Mr. C?

- ▶ A. 02. Substantial/Maximal Assistance
- ▶ B. 03. Partial/Minimal Assistance
- ▶ C. 04. Supervision/Touching Assistance
- ▶ D. Setup/Clean Up Assistance




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## GG0130. Self-Care – Discharge Goal

**GG0130. Self-Care** (Assessment period is days 1 through 3 of the SNF PPS Stay starting with A24008)  
(Complete only if AG3108 = 01)  
Code the resident's usual performance at the start of the SNF PPS stay for each activity using the 6-point scale. If activity was not attempted at the start of the SNF PPS stay, code the reason. Code the patient's end of SNF PPS stay goal(s) using the 6-point scale.

Coding:

1. Admission Performance	2. Discharge Goal
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>

**A. Eating:** The ability to use suitable utensils to bring food to the mouth and swallow food once the meal is presented on a table/tray. Includes modified food consistency.

**B. Oral hygiene:** The ability to use suitable items to clean teeth. (Dentures (if applicable): The ability to remove and replace dentures from and to the mouth, and manage equipment for soaking and rinsing them.)

**C. Toileting hygiene:** The ability to maintain perineal hygiene, adjust clothes before and after using the toilet, commode, bedpan, or urinal. If managing an ostomy, include wiping the opening but not managing equipment.



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## Discharge Goal: Coding Tips

- Use the 6-point scale to code the resident's discharge goal(s). Do not use codes 07, 09, or 88 to code discharge goal(s).
- Licensed clinicians can establish a resident's discharge goal(s) at the time of admission based on discussions with the resident and family, professional judgment, and the professional's standard of practice. Goals should be established as part of the resident's care plan.



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## Discharge Goal: Coding Tips

- A minimum of one self-care or mobility goal must be coded per resident stay on the 5-day PPS assessment.
- Clinicians may code one goal for each self-care and mobility item included in Section GG at the time of the 5-day PPS assessment.



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## GG0130. Discharge Goal

▶ **Discharge Goal Code Is Higher than 5-Day PPS Assessment Admission Performance Code**

- ▶ If the clinician determines that the resident is expected to make gains in function by discharge, the code reported for discharge goal will be higher than the admission performance code.



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## GG0130. Discharge Goal

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

The clinician determines that a medically complex resident is not expected to progress to a higher level of functioning during the SNF Medicare Part A stay; however, the clinician determines that the resident would be able to maintain her admission functional performance level. The clinician discusses functional status goals with the resident and her family and they agree that maintaining function is a reasonable goal. In this scenario, the discharge goal is coded at the same level as the resident's admission performance code.



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## GG0130. Discharge Goal

**Discharge Goal Code Is Lower than 5-Day PPS Assessment Admission Performance Code**

The clinician determines that a resident is expected to rapidly decline and that skilled therapy services may slow, but not prevent, the decline of function. In this scenario, the discharge goal code is lower than the resident's 5-day PPS assessment admission performance code.



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## GG0170B. Sit to Lying

1. Admission Performance	2. Discharge Goal	
Enter Codes in Boxes	Enter Codes in Boxes	
<input type="checkbox"/>	<input type="checkbox"/>	<b>B. Sit to lying:</b> The ability to move from sitting on side of bed to lying flat on the bed.
<input type="checkbox"/>	<input type="checkbox"/>	<b>C. Lying to sitting on side of bed:</b> The ability to safely move from lying on the back to sitting on the side of the bed with feet flat on the floor, and with no back support.
<input type="checkbox"/>	<input type="checkbox"/>	<b>D. Sit to stand:</b> The ability to safely come to a standing position from sitting in a chair or on the side of the bed.
<input type="checkbox"/>	<input type="checkbox"/>	<b>E. Chair/bed-to-chair transfer:</b> The ability to safely transfer to and from a bed to a chair (or wheelchair).
<input type="checkbox"/>	<input type="checkbox"/>	<b>F. Toilet transfer:</b> The ability to safely get on and off a toilet or commode.

**GG0170B. Sit to lying:** The ability to move from sitting on side of bed to lying flat on the bed.




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## GG0170C. Lying to Sitting on Side of Bed

1. Admission Performance	2. Discharge Goal	
Enter Codes in Boxes	Enter Codes in Boxes	
<input type="checkbox"/>	<input type="checkbox"/>	<b>B. Sit to lying:</b> The ability to move from sitting on side of bed to lying flat on the bed.
<input type="checkbox"/>	<input type="checkbox"/>	<b>C. Lying to sitting on side of bed:</b> The ability to safely move from lying on the back to sitting on the side of the bed with feet flat on the floor, and with no back support.
<input type="checkbox"/>	<input type="checkbox"/>	<b>D. Sit to stand:</b> The ability to safely come to a standing position from sitting in a chair or on the side of the bed.
<input type="checkbox"/>	<input type="checkbox"/>	<b>E. Chair/bed-to-chair transfer:</b> The ability to safely transfer to and from a bed to a chair (or wheelchair).
<input type="checkbox"/>	<input type="checkbox"/>	<b>F. Toilet transfer:</b> The ability to safely get on and off a toilet or commode.

**GG0170C. Lying to sitting on side of bed:** The ability to safely move from lying on the back to sitting on the side of the bed with feet flat on the floor, and with no back support.




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## GG0170D. Sit to Stand

1. Admission Performance	2. Discharge Goal	
Enter Codes in Boxes	Enter Codes in Boxes	
<input type="checkbox"/>	<input type="checkbox"/>	<b>B. Sit to lying:</b> The ability to move from sitting on side of bed to lying flat on the bed.
<input type="checkbox"/>	<input type="checkbox"/>	<b>C. Lying to sitting on side of bed:</b> The ability to safely move from lying on the back to sitting on the side of the bed with feet flat on the floor, and with no back support.
<input type="checkbox"/>	<input type="checkbox"/>	<b>D. Sit to stand:</b> The ability to safely come to a standing position from sitting in a chair or on the side of the bed.
<input type="checkbox"/>	<input type="checkbox"/>	<b>E. Chair/bed-to-chair transfer:</b> The ability to safely transfer to and from a bed to a chair (or wheelchair).
<input type="checkbox"/>	<input type="checkbox"/>	<b>F. Toilet transfer:</b> The ability to safely get on and off a toilet or commode.

**GG0170D. Sit to stand:** The ability to safely come to a standing position from sitting in a chair or on the side of the bed.




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## GG0170E. Chair/Bed-to-Chair Transfer

1. Admission Performance	2. Discharge Goal	
Enter Codes in Boxes		
<input type="checkbox"/>	<input type="checkbox"/>	<b>E. Chair/bed-to-chair transfer:</b> The ability to safely transfer to and from a bed to a chair (or wheelchair).
<input type="checkbox"/>	<input type="checkbox"/>	<b>F. Toilet transfer:</b> The ability to safely get on and off a toilet or commode.

**GG0170E. Chair/bed-to-chair transfer:** The ability to safely transfer to and from a bed to a chair (or wheelchair).




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## GG0170F. Toilet Transfer

1. Admission Performance	2. Discharge Goal	
Enter Codes in Boxes		
<input type="checkbox"/>	<input type="checkbox"/>	<b>F. Toilet transfer:</b> The ability to safely get on and off a toilet or commode.

**GG0170F. Toilet transfer:** The ability to safely get on and off a toilet or commode.




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## GG0170F. Toilet Transfer Polling Scenario

- ▶ The CNA provides steadying (touching) assistance as Mrs. Z transfers onto the toilet and lowers her underwear. After voiding, Mrs. Z cleanses herself.
- ▶ She then stand up as the helper steadies her and Mrs. Z pulls up her underwear as the helper steadies her to ensure Mrs. Z does not lose her balance.




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**Polling Question:**  
How would you code GG0170F Toilet transfer for Mrs. Z?

- A. Code 04, Supervision or touching assistance
- B. Code 02, Substantial/maximal assistance
- C. Code 03, Partial/moderate assistance
- D. Code 01, Dependent

**HH**  
HARRIS HOSPITAL & CLINICAL CENTER  
Certified PPS Assessor

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**GG0170H1 /H3. Does the Resident Walk?**

1. Admission Performance	2. Discharge Goal
Enter Codes in Boxes 1	Enter Codes in Boxes 2
[ ] [ ]	[ ] [ ]

**H1. Does the resident walk?**

0. No, and walking goal is not clinically indicated → Skip to GG0170Q1, Does the resident use a wheelchair/scooter?

1. No, and walking goal is clinically indicated → Code the resident's discharge goal(s) for items GG0170J and GG0170K

2. Yes → Continue to GG0170J, Walk 50 feet with two turns

**J. Walk 50 feet with two turns:** Once standing, the ability to walk at least 50 feet and make two turns.

**K. Walk 150 feet:** Once standing, the ability to walk at least 150 feet in a corridor or similar space.

**Q1. Does the resident use a wheelchair/scooter?**

0. No → Skip to GG0170L Self Care

1. Yes → Continue to GG0170L, Wheel 50 feet with two turns.

**GG0170H1. Does the resident walk?**

0. No, and walking goal is not clinically indicated → Skip to GG0170Q1, Does the resident use a wheelchair/scooter?

1. No, and walking goal is clinically indicated → Code the resident's discharge goal(s) for items GG0170J and GG0170K

2. Yes → Continue to GG0170J, Walk 50 feet with two turns

*GG0170H1 is done with Admission (Start of SNF PPS Stay)*  
*GG0170H3 is done with Discharge from PPS Assessments*

**HH**  
HARRIS HOSPITAL & CLINICAL CENTER  
Certified PPS Assessor

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**GG0170J.**  
**Walk 50 Feet With Two Turns**

1. Admission Performance	2. Discharge Goal
Enter Codes in Boxes 1	Enter Codes in Boxes 2
[ ] [ ]	[ ] [ ]

**J. Walk 50 feet with two turns**

**J. Walk 50 feet with two turns:** Once standing, the ability to walk at least 50 feet and make two turns.

**K. Walk 150 feet:** Once standing, the ability to walk at least 150 feet in a corridor or similar space.

**Q1. Does the resident use a wheelchair/scooter?**

0. No → Skip to GG0170L Self Care

1. Yes → Continue to GG0170L, Wheel 50 feet with two turns.

**GG0170J. Walk 50 feet with two turns:**  
Once standing, the ability to walk at least 50 feet and make two turns.

**HH**  
HARRIS HOSPITAL & CLINICAL CENTER  
Certified PPS Assessor

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## GG0170J. Walk 50 Feet With Two Turns Polling Scenario

▶ Mrs. L is unable to bear her full weight on her left leg. As she walks 60 feet down the hall with her crutches and makes two turns, the CNA supports her trunk and provides less than half the effort.

▶ Code:

- ▶ A. 02. Substantial/Maximal Assistance
- ▶ B. 03. Partial/Minimal Assistance
- ▶ C. 04. Supervision/Touching
- ▶ D. 05. Setup/Cleanup




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## GG0170K. Walk 150 Feet

1. Admission Performance	2. Discharge Goal
Enter Codes in Boxes	
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>

**K. Walk 150 feet**

**J. Walk 50 feet with two turns:** Once standing, the ability to walk at least 50 feet and make two turns.

**K. Walk 150 feet:** Once standing, the ability to walk at least 150 feet in a corridor or similar space.

**Q1. Does the resident use a wheelchair/scooter?**

0. No → Skip to GG0170L Self Care

1. Yes → Continue to GG0170L Wheel 50 feet with two turns

**GG0170K. Walk 150 feet:** Once standing, the ability to walk at least 150 feet in a corridor or similar space.




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## GG0170K. Walk 150 Feet Coding Scenario

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

- How would you code GG0170K?
- What is your rationale?




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## GG0170K. Walk 150 Feet Coding Scenario

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



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## GG0170Q1. Does the Resident Use a Wheelchair/Scooter?

1. Admission Performance	2. Discharge Goal
Enter Codes in Boxes	Enter Codes in Boxes
[ ] [ ]	[ ] [ ]

**Q1. Does the resident use a wheelchair/scooter?**

**J. Walk 50 feet with two turns:** Once standing, the ability to walk at least 50 feet and make two turns.

**K. Walk 150 feet:** Once standing, the ability to walk at least 150 feet in a corridor or similar space.

**Q1. Does the resident use a wheelchair/scooter?**

No → Skip to GG0130, Self Care


Yes → Continue to GG0170R, Wheel 50 feet with two turns

**GG0170Q1. Does the resident use a wheelchair/scooter?**

1. No → Skip to GG0130, Self Care
2. Yes → Continue to GG0170R, Wheel 50 feet with two turns

*GG0170Q1 is done with Admission (Start of SNF PPS Stay)*

*GG0170Q3 is done with a Discharge from PPS MDS*



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## GG0170R. Wheel 50 Feet With Two Turns

1. Admission Performance	2. Discharge Goal
Enter Codes in Boxes	Enter Codes in Boxes
[ ] [ ]	[ ] [ ]

**R. Wheel 50 feet with two turns:** Once seated in wheelchair/scooter, can wheel at least 50 feet and make two turns.


**RR1. Indicate the type of wheelchair/scooter used.**

Manual

Motorized

**GG0170R. Wheel 50 feet with two turns:** Once seated in wheelchair/scooter, can wheel at least 50 feet and make two turns.

Per the CMS Train-the-Trainer Instructions—a turn is a 90 degree turn to left or right.



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## GG0170R. Wheel 50 Feet With Two Turns Coding Scenario

Once seated in the manual wheelchair, Ms. R wheels about 10 feet, then asks the therapist to push the wheelchair an additional 40 feet into her room and her bathroom.

- How would you code GG0170R?
- What is your rationale?




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## GG0170R. Wheel 50 Feet With Two Turns Coding Scenario

(continued)

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




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## GG0170RR1 /RR3. Indicate the Type of Wheelchair/Scooter Used

1. Admission Performance	2. Discharge Goal	<b>RR1. Indicate the type of wheelchair/scooter used.</b> B. Wheel 50 feet with two turns: Once seated in wheelchair/scooter, can wheel at least 50 feet and make two turns. <input type="checkbox"/> <b>RR1. Indicate the type of wheelchair/scooter used.</b> 1. Manual 2. Motorized
Enter Codes in Boxes	Enter Codes in Boxes	

5. Wheel 150 feet: Once seated in wheelchair/scooter, can wheel at least 150 feet in a corridor or similar space

**GG0170RR1/RR3. Indicate the type of wheelchair/scooter used.**

1. Manual
2. Motorized

GG0170RR1 is done with Admission (Start of SNF PPS Stay)  
 GG0170RR3 is done with PPS Discharge MDS




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## GG0170S. Wheel 150 Feet

3. Discharge Performance		<b>S. Wheel 150 feet</b>	
Enter Codes in Boxes		<b>R. Wheel 50 feet with two turns:</b> Once seated in wheelchair/scooter, can wheel at least 50 feet and make two turns.	
		<b>RR3. Indicate the type of wheelchair/scooter used.</b> 1. Manual 2. Motorized	
		<b>S. Wheel 150 feet:</b> Once seated in wheelchair/scooter, can wheel at least 150 feet in a corridor or similar space.	

**GG0170S. Wheel 150 feet:** Once seated in wheelchair/scooter, can wheel at least 150 feet in a corridor or similar space.




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## GG0170SS1/SS3. Indicate the Type of Wheelchair/Scooter Used

1. Admission Performance	2. Discharge Goal	<b>SS1. Indicate the type of wheelchair/scooter used.</b>	
Enter Codes in Boxes		<b>S. Wheel 150 feet:</b> Once seated in wheelchair/scooter, can wheel at least 150 feet in a corridor or similar space.	
		<b>SS1. Indicate the type of wheelchair/scooter used.</b> 1. Manual 2. Motorized	

**GG0170SS1/SS3. Indicate the type of wheelchair/ scooter used.**

1. Manual
2. Motorized

*GG0170SS1 is done with Admission (Start of SNF PPS Stay)*

*GG0170SS3 is done with PPS Discharge MDS*




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## Questions?



cmaher@hnc-cpa.com

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## Section GG Q & A, March 2016

Thank you for attending one of the SNF Section GG webinars. Here is a compilation of Q&As received from participants. There were several questions related to very specific clinical scenarios that we did not address, at this time, until CMS releases the actual MDS 3.0 Section GG coding instructions.

The answers provided are based on information known at this time and will need to be verified when the Section GG coding guidance is released by CMS.

**1. Does this assessment need to be done on the skilled 5-day PPS assess if it is dual coded as an Admission assessment?**

A: Yes, Section GG will be required on the 5-day assessment regardless if it is dually coded with the Admission assessment.

**2. Has it been determined the department that will be responsible for completing section GG?**

A: CMS is relatively silent on who should complete which section(s) of the MDS. Each organization should take the time to determine who is best suited to complete this section. Regardless of who completes this section, input from multiple disciplines may be needed to determine the resident's "usual" performance.

**3. Will we be able to combine a significant change assessment with an end of stay assessment? If a resident is going to stay long term care at the facility can we dual code the last assessment and complete Section G?**

A: CMS will provide further guidance related to the End of Medicare Assessment and combining in future instruction.

**4. If the patient is an unplanned discharge will the end of Medicare stay still be required or just a discharge return anticipated?**

A: An End of Stay would still be required since other information, besides Section GG needs to be collected to calculate the other QMs. It may be able to be combined with the discharge assessment (awaiting further guidance on combining from CMS).

**5. If the resident should go to the hospital unplanned on day 99, would that be an incomplete stay?**

A: Yes, any unplanned discharge to an acute hospital is considered an "incomplete" stay.

**6. Is it required that the prior level of function be entered in Section GG?**

A: There are no questions on the SNF version of Section GG related to a resident's prior level of functioning. (Note: There are questions related to prior level of function on the LTCH and IRF versions of Section GG).

**7. Is the first day considered the entry date, no matter what time they arrived at the SNF?**

A: Yes

**8. So all admission/5-day assessments will need to be separated?**

A: No, you will still be able to combine the two assessments.

**9. What about Medicare Advantage plans?**

A: Section GG is only required for traditional Medicare beneficiaries under a Medicare SNF Part A stay. Section GG does not apply to Medicare Advantage plans (or other payers) since PPS assessments completed for Medicare Advantage plans and other non-Medicare payers are not submitted to the QIES ASAP system.

**10. Could a resident be counted in the measure more than once...for those who go in and out of the hospital?**

A: Yes, the QM is based on Medicare stays. Residents can have more than one stay in the SNF. Each resident stay would need to meet the QM criteria in order to be included in the numerator.

**11. Are the patients that we take with the knowledge that they are going back to acute care for surgery considered planned or unplanned since they are an acute care admission?**

A: These are considered planned discharges.

**12. If resident is not picked up for therapy but is admitted for IV medication or wounds what happens if no functional goals are anticipated?**

A: To qualify for the QM there has to be at least one discharge goal identified. Keep in mind that maintaining the same level of function can be a discharge goal.

**13. So the data for Section GG will be from a different date than the actual ARD?**

A: Yes, Section GG is based on information collected during the first 3 calendar days of their Medicare stay and last 3 days of their Medicare stay.

**14. What if we need to re-code a discharge goal based on functional turn around that is unexpected?**

A: The discharge goal is established within the first 3 days. Based on information read thus far there is no need to modify an assessment if the goal should change later.

**15. Will Section G and GG be done on 5-day and End of Medicare stay assessments or just GG?**

A: The requirements for Section G are not changing. Section GG is not replacing Section G. Section G is still required on all OBRA and PPS assessments. Section GG will be required on the 5-day assessment and End of Medicare Stay assessment.

**16. Where do we get the sample GG form?**

A: See the "downloads" section of this web page:

<https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/SNF-Quality-Reporting-Program-Measures-and-Technical-Information.html>

**17. Is Section GG required on all unplanned discharges?**

A. Section GG will be required upon admission but will not be required upon discharge if the discharge is coded as “unplanned” in A0310G.

**18. On the penalty slide, the 80% of the MDSs submitted is just for Medicare A residents?**

A. Correct. Only Medicare PPS assessments for traditional Medicare Part A residents should be submitted to the QIES ASAP. Medicare PPS Assessments submitted for other payer sources, such as Medicare Advantage, should not be submitted as per current CMS guidance.

**19. What is the possibility that this will be postponed until 2017?**

A: Slim to none. Have not heard or seen anything that would lead me to believe that this will be postponed.