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Functional Outcome Assessment, Compliance For SNF Therapists.

Focus on the MDS : Section GG

Kathleen Dwyer OTR/L, CHT, RAC-CT, CHC, R-RAM™
JMD Healthcare Solutions, LLC

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- **Presenter Disclosure:** Financial: Kathleen Dwyer has received an honorarium for presenting this course. Non-financial: Kathleen Dwyer has no relevant non-financial relationships to disclose.
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Learning Outcomes

After this course, participants will be able to:

- Define the required functional outcome measurement reporting per the IMPACT Act and PDPM
- List RAI rules for assessing for functional outcomes for Section GG
- Describe a plan of care supporting the assessment of Section GG function items

3

Skilled – Medicare Guidelines

4

Skilled Nursing Facility (SNF) Payment

- 1998 Medicare began paying SNFs under PPS
- Prospective Payment System (PPS)
  - Per diem rates based on patient's condition
  - Clinical Assessment used is the Minimum Data Set (MDS)
    - Required to be performed periodically
    - Represents the patient's clinical status based on an Assessment Reference Date (ARD)

5

RAI Manual

- Long-Term Care Facility Resident Assessment Instrument 3.0 version 1.17.1 Oct 2019
- Published by Centers for Medicare & Medicaid Services (CMS)
- 6 Chapters, 8 Appendices, 1,309 pages
- RAI consists of three basic components
  - The Minimum Data Set (MDS)
  - The Care Area Assessment (CAA) process
  - The RAI Utilization Guidelines

6

RAI Manual – Chapter 3: MDS

Today's Focus:

- Chapter 3: Overview to the Item-by-Item Guide to the MDS 3.0
- Minimum data set (MDS)
  - Core set of screening, clinical and functional status
  - Standard communication about resident problems and conditions
  - Health professional certifies that the information entered is complete to the best of their knowledge and accurately reflects the resident's status.

Q1 7

Section	Title	Intent
A	Identification Information	Obtain key information to uniquely identify each resident, nursing home, type of record, and reasons for assessment.
B	Hearing, Speech, and Vision	Document the resident's ability to hear, understand, and communicate with others and whether the resident experiences visual, hearing or speech limitations and/or difficulties.
C	Cognitive Patterns	Determine the resident's attention, orientation, and ability to register and recall information.
D	Mood	Identify signs and symptoms of mood distress.
E	Behavior	Identify behavioral symptoms that may cause distress or are potentially harmful to the resident, or may be distressing or disruptive to facility residents, staff members or the environment.
F	Preferences for Customary Routine and Activities	Obtain information regarding the resident's preferences for his or her daily routine and activities.
G	Functional Status	Assess the need for assistance with activities of daily living (ADLs), altered gait and balance, and decreased range of motion.
GG	Functional Abilities and Goals	Assess the need for assistance with self-care and mobility activities.

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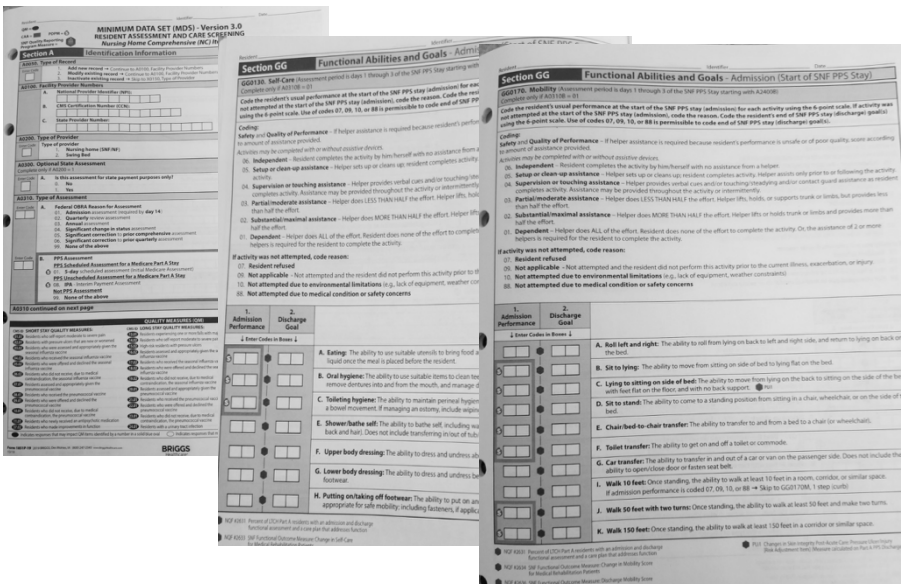
H	Bladder and Bowel	Gather information on the use of bowel and bladder appliances, the use of and response to urinary toileting programs, urinary and bowel continence, bowel training programs, and bowel patterns.
I	Active Diagnoses	Code diseases that have a relationship to the resident's current functional, cognitive, mood or behavior status, medical treatments, nursing monitoring, or risk of death.
J	Health Conditions	Document health conditions that impact the resident's functional status and quality of life.
K	Swallowing/Nutritional Status	Assess conditions that could affect the resident's ability to maintain adequate nutrition and hydration.
L	Oral/Dental Status	Record any oral or dental problems present.
M	Skin Conditions	Document the risk, presence, appearance, and change of pressure ulcers as well as other skin ulcers, wounds or lesions. Also includes treatment categories related to skin injury or avoiding injury.
N	Medications	Record the number of days that any type of injection, insulin, and/or select medications was received by the resident.
O	Special Treatments, Procedures and Programs	Identify any special treatments, procedures, and programs that the resident received during the specified time periods.
P	Restraints and Alarms	Record the frequency that the resident was restrained by any of the listed devices at any time during the day or night; record the frequency that any of the listed alarms were used.
Q	Participation in Assessment and Goal Setting	Record the participation of the resident, family and/or significant others in the assessment, and to understand the resident's overall goals.
V	Care Area Assessment (CAA) Summary	Document triggered care areas, whether or not a care plan has been developed for each triggered area, and the location of care area assessment documentation.
X	Correction Request	Request to modify or inactivate a record already present in the QIES ASAP database.
Z	Assessment Administration	Provide billing information and signatures of persons completing the assessment.

9



10

Medicare Program Integrity Manual

- *Medical review decisions are based on documentation provided to support the coding and medical necessity of services recorded on the MDS for the claim period billed. Medicare contractors focus on the unique, individualized needs, characteristics and goals of each patient, in conjunction with CMS payment policies, to determine the appropriateness of the case-mix classifier billed.*

11

Medicare Quality Reporting

12

CONTINUED

IMPACT Act: 2014

- Improving Medicare Post-Acute Care Transformation Act (IMPACT)
  - Requires standardized patient assessment data elements (SPADES) for the post-acute care (PAC):
    - Long-Term Care Hospitals (LTCHs)
    - Skilled Nursing Facilities (SNFs)
    - Home Health Agencies (HHAs)
    - Inpatient Rehabilitation Facilities (IRFs)

13

CONTINUED

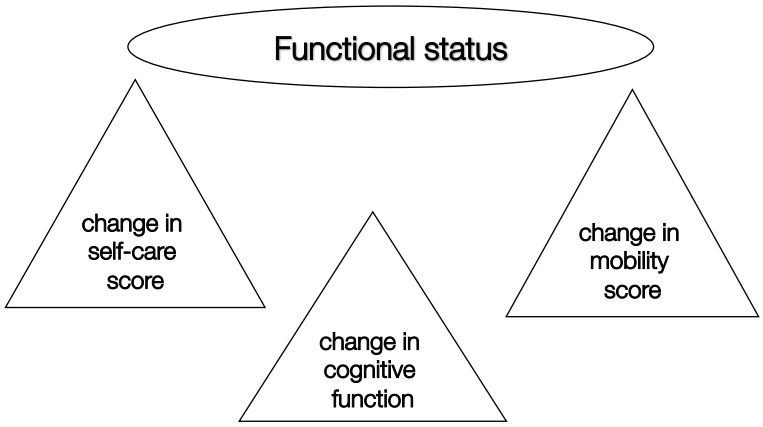
IMPACT Act: 2014

- IMPACT Act
  - Establishes a **quality reporting program (QRP) for SNFs**
  - Intends to **improve Medicare beneficiary outcomes** through:
    - Shared-decision making
    - Care coordination
    - Enhanced discharge planning

Q2

14

IMPACT Act Domain- Therapy Areas



Q3 15

Change in Function

- Therapists gather functional outcomes scores on evaluation and discharge summary
  - Functional Outcomes Measurements contribute to QRP of the SNF
  - Outcome scores are pulled from Section GG data

16

OT Areas – SNF Quality Reporting Program

Self-Care Areas for QRP
Eating
Oral Hygiene
Toileting Hygiene
Shower/Bathe Self
Upper Body Dressing
Lower Body Dressing
Putting On / Taking Off Footwear

Mobility Areas for QRP
*Mobility: Toilet Transfers

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PT Areas – SNF Quality Reporting Program

Mobility Areas for QRP	
Roll left and right	Walking 10 feet on uneven surfaces
Sit to lying	1 step (curb)
Lying to sitting on side of bed	4 steps
Sit to stand	12 steps
Chair/bed-to-chair transfers	Picking up object
Car transfer	
Walk 10 feet	
Walk 50 feet with 2 turns	
Walk 150 feet	

18

Patient Driven Payment Model

PDPM

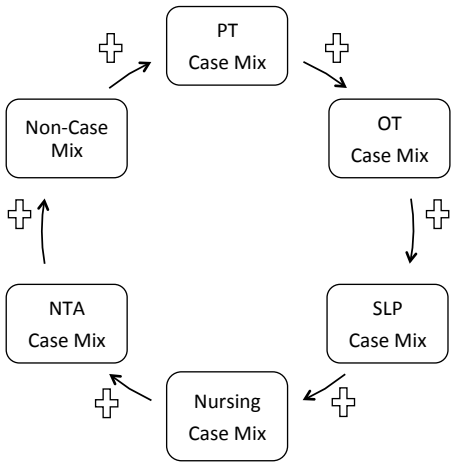
19

Patient Driven Payment Model (PDPM)

- Effective October 1, 2019
- PDPM replaced RUG-IV system
- Perspective payment system (PPS)
- Combines five different case-mix components (PT, OT, SLP, Nursing and Non-Therapy Ancillary)
- Interim Payment Assessments (IPA) for substantial changes in patient condition

Q4 20

PDPM Case Mix Groups



Total Rate =
Sum of all the PDPM Case Mix Groups combined

21

PDPM: OT and PT

- Section GG MDS: Functional Abilities and Goals
  - Prior Function
  - Admission Performance
  - Discharge Goals
  - Optional Interim (IPA)
  - Discharge Performance

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CONTINUED

Self-Care and Mobility Areas PDPM $

Self-Care Areas for PDPM
Eating
Oral hygiene
Toileting hygiene
Mobility for PDPM
Toilet transfers

Mobility Areas for PDPM
Sit to lying
Lying to sitting on side of bed
Sit to stand
Chair/bed-to-chair transfers
Walk 50 feet with 2 turns
Walk 150 feet

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CONTINUED

Summary

- Section GG impacts both reimbursement and quality measures
- Critical for PTs and OTs to be trained on the RAI manual guidelines
- Medical Review will be looking for consistency
- Discrepancies or inconsistency between MDS and documentation (therapy and nursing) will likely contribute to future audits, probes or denials

24

Summary continued

- Section GG needs to be an interdisciplinary assessment
  - If PT and OT are not in case, section still needs to be completed
  - Dollars are still allocated under PDPM for PT and OT even if no therapy
- Over 200 areas that impact payment on MDS!

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Scoring Section GG

26

Section GG Items

Section GG Items		Score
GG0130A1	Self-care: Eating	0-4
GG0130B1	Self-care: Oral hygiene	0-4
GG0130C1	Self-care: Toileting hygiene	0-4
GG0170B1 GG0170C1	Mobility: Sit to lying Mobility: Lying to sitting on side of bed	0-4 (average of 2 bed mobility items
GG0170D1	Mobility: sit to stand	0-4 (average of 3 transfer items)
GG0170E1	Mobility: Chair/bed-to-chair transfers	
GG0170F1	Mobility: Toilet transfers	
GG0170J1	Mobility: Walk 50 feet with 2 turns	0-4 (average of 2 walking items)
GG0170K1	Mobility: Walk 150 feet	

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Scoring Response for Section GG Items

Scoring Response for Section GG Items MDS		PDPM Function Score
05, 06	Set-up assistance, independent	4
04	Supervision or touching assistance	3
03	Partial/moderate assistance	2
02	Substantial/maximal assistance	1
01	Dependent	0

Q5 28

Scoring Response for Section GG Items

Scoring Response for Section GG Items MDS		PDPM Function Score
07	Resident refused	0
09	Not applicable- Not attempted and the resident did not perform this activity prior to the current illness, exacerbation, or injury	0
10	Not attempted due to environmental limitations: ex) lack of equipment, weather constraints	0
88	Not attempted due to medical condition or safety concerns	0
-	Dash	0

29

Clinical Presentation Example

Our patient presents with the ability to independently feed self. She requires set up assist for oral hygiene. She is able to complete toilet hygiene with min assist.

Bed mobility is min assist for sit to lying, min assist for lying to sitting and max assist for sit to stand.

Transfers to chair, bed to chair and toilet transfers are also max assist.

Currently the patient is not able to walk 10 feet but PT does indicate that goals are appropriate for the plan of care.

30

CONTINUED

Section GG

Section GG	Functional Abilities at Admission
6. Independent	**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.
5. Setup or Clean-Up Assistance	**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.]
3. Partial/Moderate Assistance	**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.
3. Partial/Moderate Assistance	**B. Sit to lying:** The ability to move from sitting on side of bed to lying flat on the bed.
3. Partial/Moderate Assistance	**C. Lying to sitting on the 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.
2. Substantial/Maximal Assistance	**D. Sit to Stand:** The ability to safely come to a standing position from sitting in a chair or on the side of the bed.
2. Substantial/Maximal Assistance	**E. Chair/Bed-To-Chair Transfer:** The ability to safely transfer to and from a bed to a chair (or wheelchair).
2. Substantial/Maximal Assistance	**F. Toilet Transfer:** The ability to safely get on and off a toilet or commode.
1. No, and walking goal is clinically indicated	**I. Does the resident walk 10 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.

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CONTINUED

Calculating PDPM Score for PT/OT

- Calculate score to determine GG score which translate to case mix group under PDPM

Discipline	Category	GG Score	Group	CMI	Pay
PT	Medical Management	13	TK	1.5200	$107.33
OT	Medical Management	13	TK	1.5400	$101.23

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Compliance to Code the MDS

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Compliance with Coding

- Therapists gather functional data that contributes to the MDS.
- It is critical that therapists are trained on how to assess and code based on RAI guidelines.
- Payment is directly related to many of the GG areas.
- Audits or probes will be looking at this information very carefully and if not supported, payments will be denied.

34

PT and OT Contributions to Section GG

- GG0100: Prior Functioning:
- Coded only at the start of SNF PPS stay:

Everyday Activities
- Self-Care
- Indoor Mobility
- Stairs
- Functional Cognition

- Independent
- Needed Some Help
- Dependent
- Unknown
- Not Applicable

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PT and OT Contributions to Section GG

- GG0110: Prior Device Use

- Manual Wheelchair
- Motorized wheelchair and/or scooter
- Mechanical Lift
- Walker (all types)
- Orthotics/Prosthetics
- None of the above

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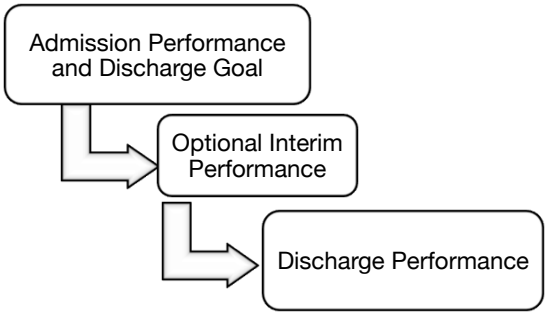
PT and OT Contributions:

- Section GG:
- GG0130: Self Care and GG0170: Mobility



Q6 37

Discharge Goal Writing

- Determined at the time of admission
- Interdisciplinary
- Based upon:
  - Medical condition; discussions with family and patient
  - Patient motivation
  - Anticipated length of stay
  - Discharge disposition

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Discharge Goal Example

Mrs. Smith was admitted to the SNF after a fall with femur fracture. Prior to admission, she used a walker and was modified independent with mobility and self-care.

- Admission Assessment: GG0170K: Walk 150 feet:
  - 03 Partial/Moderate Assist
- Patient's goal was to return home at a walker level
- GG Discharge goal: Code 06 Independent
  - Interdisciplinary team agreed that the goal was to be discharged as independently as possible

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Steps for Performance Assessment

- Assess performance based on direct observation
- Patient should be allowed to perform activity as independently as possible, as long as they are safe
- A "helper" is defined as facility staff

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RAI Definition of Helper

- Facility staff
  - Rehab Staff (including contract therapy staff)
  - Nursing Staff (including agency staff)
- This does **not** include:
  - Hired individuals
  - Hospice staff
  - Students

Q7 41

Steps for Assessment, continued

- Activities may be completed with or without assistive device(s).
- Use of assistive device(s) should not affect coding of the activity.
- Assessment should be conducted prior to the resident benefitting from treatment interventions in order to truly reflect the patient's baseline.

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Steps for Assessment, continued

- Record the patient's **usual performance** over the assessment period
  - Do not record the patient's best performance.
  - Do not record the patient's worst performance.
- Interdisciplinary Assessment
  (not only therapy's responsibility)

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Steps for Assessment, continued

- Direct Observation
- Patient Self-report
- Family report
  - Remember though these are very specific, multi-step areas of function that need to be gathered using the RAI language

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Language Translation

- Therapy and Nursing speak different languages.
- Therapists should understand the specific guidelines.
- The *RAI Manual* is the guide for coding Section GG.
- Language is not necessarily as described in our textbooks, i.e.: *Physical Rehabilitation.*
- We have created a translation crosswalk.

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1/1/2020 PDPMPro LANGUAGE TRANSLATOR

	RAI MANUAL	THERAPY TEXT	MDS CODE
INDEPENDENT	Completes activity with or without assistive device, by themselves and with no assistance (physical, verbal/non verbal cueing, set up/clean up)	**Independent:** Completes activity with no assistance or supervision from person or device and is safe to complete task freely or ab lib	06
MODIFIED INDEPENDENT	See above	**Modified Independent** Completes task using a device (walker, cane, grab bar, bed side commode, etc) and/or requires extra time to complete task	06
SETUP/CLEAN UP ASSISTANCE	Completes activity with only set up/clean up assistance from one helper. Helper assists only prior to or following an activity.		05
SUPERVISION/ TOUCHING	Completes activity with only verbal/nonverbal cueing or steadying/touching/contact guard assistance from one helper. Assistance may be provided throughout the activity or intermittently.	**Supervision/SBA**: No physical contact required from staff person, however, staff should be close to maximize safety. **Contact Guard Assistance** requires light physical touch from staff; but no actual assistance (hand is lightly placed on back to steady patient)	04
PARTIAL/ MODERATE ASSISTANCE	Patient requires physical assistance, for example, lifting or trunk support from one helper; with helper providing LESS than half of the effort	**Min Assist:** Patient requires at least 25% assistance or support to safely complete task. Effort by patient is 75% or less	03
SUBSTANTIAL/ MAXMIAL ASSIST	Patient requires physical assistance, for example lifting or trunk support, from one helper; with helper providing MORE than half of the effort	**Mod Assist**: Patient requires at least 50% assistance from staff. Effort by patient is 50% or less. **Max Assist:** Requires 75% assistance or support to safely complete task. Effort by patient is 25% or less	02
DEPENDENT	Helper provides all of the effort to complete the activity or the help of 2 or more helpers is required to complete the activity	**Dependent:** Requires 100% assistance or support from staff member to complete the task safely	01

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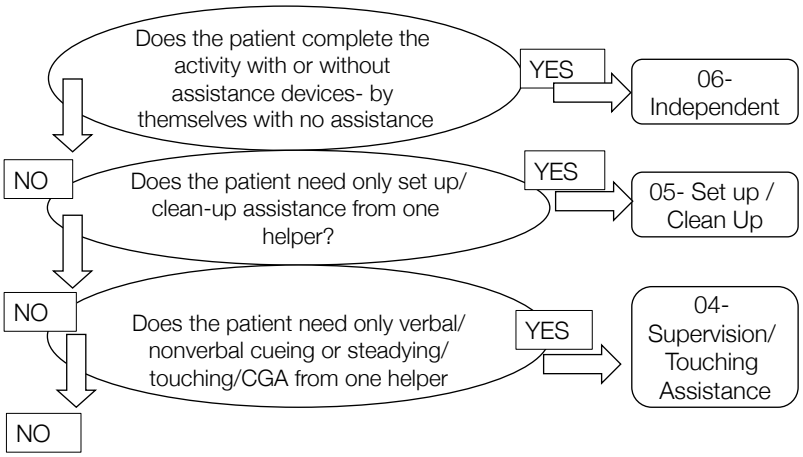
CONTINUED

Section GG : Decision Tree



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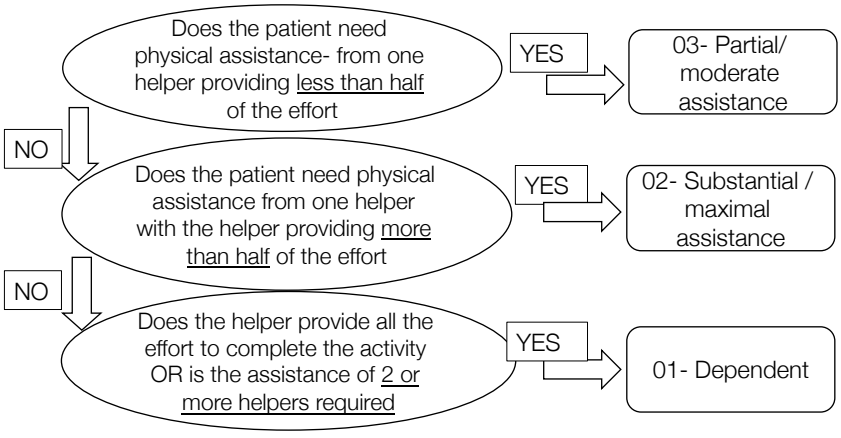
Section GG : Decision Tree

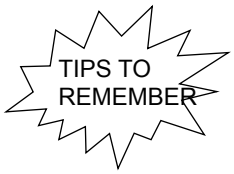


√ RESOURCE: RAI Manual Link
https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/MDS30RAIManual

48

GG0130- Self care; GG0170- Mobility

- Assess the resident's self care based on direct observation
- The patient should perform the activity as independently as possible
- Code the **usual performance** at the start of the stay- 3 day assessment period
- Code the **usual performance** at the end of the stay- 3 day assessment period
- Assessment should be conducted prior to resident benefiting from treatment observations* (true admission baseline, only considered with admission)



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Interim Assessments (IPA)

- Facility will decide if needed or not (optional)
- Reports on the last 3 days of "usual" performance
  - =Assessment Reference Date (ARD) + 2 days prior

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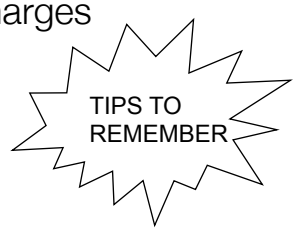
Discharge Assessments

- Should be completed as close to the time of the resident's discharge from Part A as possible
- Required for last 3 calendar days of the Medicare A stay
- Required for planned discharges



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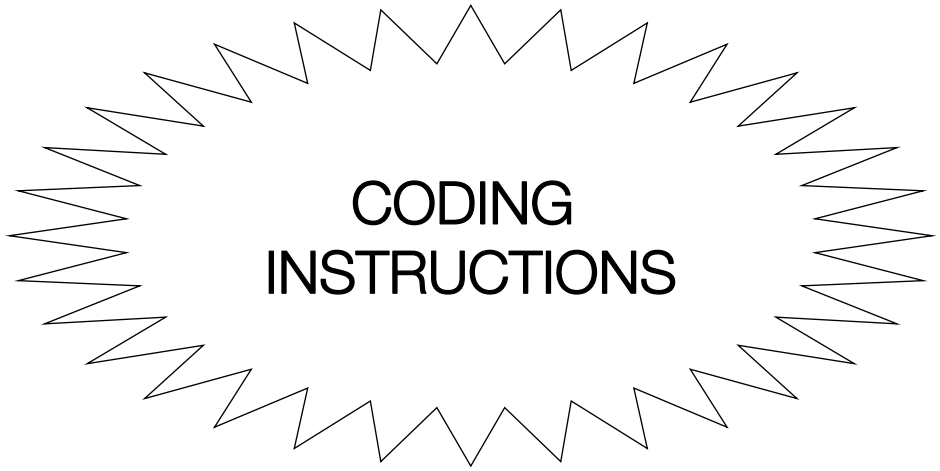

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Coding Instructions-
06 Independent

PER RAI MANUAL

Code 06: Completes activity with or without assistive device, by themselves and with no assistance (this includes no physical, no verbal/ nonverbal cueing, no set up/clean up)

Versus:

PER Susan B. O'Sullivan; Thomas J Schmitz; Physical Rehabilitation: Assessment and Treatment Fourth Edition, copyright 2001; page 314

Independent: Completes activity with no assistance or supervision from person or device and is safe to complete task freely or ab lib.

Modified Independent: Completes task using a device (walker, cane, grab bar, bed side commode, etc.) and/or requires extra time to complete task.

- Example: Wheel 150 feet

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Coding Instructions-
05 Setup or Clean-up Assistance

PER RAI MANUAL

Code 05: Completes activity with only set up/clean up assistance from one helper. Helper only assists prior to or following the activity; but not during activity.

Versus:

?

PER FIM – Uniform Data Set for Medical Rehabilitation (Adult Functional Independence Measure)

Supervision or Set up: Patient requires no more help than standby, cueing or coaxing, without physical contact, or, someone is needed to set up needed items or apply orthoses; requires supervision and/or verbal cues to complete activity (may not always be done safely or correctly)

- Example: Toilet transfer

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Coding Instructions-
04 Supervision / Touching

PER RAI MANUAL

Code 04: Completes activity with only verbal/nonverbal cueing or steadying/ touching/contact guard assistance from one helper. Assistance may be provided throughout the activity or intermittently.

Versus:

PER Physical Rehabilitation: Assessment and Treatment

Supervision/SBA: No physical contact required from staff person; however, staff should be close to maximize safety.

Contact Guard Assistance: Requires light physical touch from staff; but no actual assistance (hand is lightly placed on back to steady patient).

- Example: Oral hygiene

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Coding Instructions-
03 Partial / Moderate Assistance

PER RAI MANUAL

Code 03: Patient requires physical assistance, for example, lifting or trunk support from one helper; with helper providing ***LESS*** **than half of the effort.**

Versus:

PER Physical Rehabilitation: Assessment and Treatment

Min Assist: Patient requires at least 25% assistance or support to safely complete task. Effort by patient is 75% or less.

- Example: Eating

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Coding Instructions-
02 Substantial / Maximal Assist

PER RAI MANUAL

Code 02: Patient requires physical assistance, for example lifting or trunk support, from one helper; with helper providing ***MORE*** **than half of the effort**

Versus:

PER Physical Rehabilitation: Assessment and Treatment

Mod Assist: Patient requires at *least 50% assistance* from staff. Effort by patient is 50% or less.

Max Assist: Requires 75% assistance or support to safely complete task. Effort by patient is 25% or less.

- Example: Dressing upper body

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Coding Instructions-
01 Dependent

PER RAI MANUAL

Code 01: Helper provides all of the effort to complete the activity

or

The help of **2 or more helpers is required** to complete the activity

Versus:

PER Physical Rehabilitation: Assessment and Treatment

Dependent: Requires 100% assistance or support from staff member to complete the task safely

- Example: Roll left and right

Q8

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Coding Tips:

Self-Care GG0130
&
Mobility GG0170

59

GG0130A, Eating

- Eating involves bringing food and liquids to mouth and swallowing food.
- This includes modified food consistency.
- The administration of tube feedings and parenteral nutrition is NOT considered when coding this activity.

60

GG0130A, Eating

Examples in RAI Manual:

- If resident does not eat or drink by mouth and relies 100% on tube feedings or TPN because of a new condition- code 88/not attempted.
- If resident does not eat or drink by month ***and*** didn't prior to onset of illness, code 09/not applicable.
- If the resident eats by mouth by partially relies on tube feeding, code based off the assistance needed to eat by mouth. The tube feeding is not considered when coding eating.

61

GG0130B, Oral Hygiene

- The ability to use suitable items to clean teeth
- Dentures: caring for dentures, ability to insert and remove dentures
- Brushing gums- if no teeth

62

GG0130C, Toilet Hygiene

- Includes managing undergarments, clothing and performing perineal cleansing before and after voiding or having a bowel movement
  - If they don't normally wear underwear, assess lower body clothing management and perineal hygiene
  - Includes using the toilet, commode, bedpan or urinal
- If the resident has an indwelling catheter, and has bowel movements, code the toilet hygiene required for the BM.

63

GG0130E, Shower/Bathe Self

- Includes the ability to wash, rinse and dry the face, upper and lower body, perineal area and feet
  - Does not include the back or hair nor the transfer in/out of tub/shower
- Assessment can take place in shower, bath or at sink side or bed side (full body sponge bath)

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GG0130F, Upper Body Dressing; GG0130G, Lower Body Dressing

- When coding upper body dressing and lower body dressing, helper assistance with buttons and/or fasteners is considered touching assistance
- Upper body dressing cannot be assessed based solely on donning/doffing a hospital gown.
  - Items used for above the waist dressing include bra, undershirt, button-down shirt, pull-over shirt, dresses, sweatshirt, sweater, nightgown (not hospital gown) and pajama top

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GG0130G, Lower Body Dressing

- Lower body dressing items include underwear, brief, slacks, shorts, capri pants, pajama bottoms and skirts (below the waist)
- Footwear items include socks, shoes, boots and running shoes

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GG0130F, Upper Body Dressing; GG0130G, Lower Body Dressing

- Count bandages/elastic stockings, orthotics or prosthetics as a piece of clothing when determining the need of assistance for dressing
  - Upper body: TLSO, Abdominal binder, back brace, stump sock/shrinker, hand/arm prosthesis
  - Lower body: knee brace, stump sock/shrinker, lower limb prosthesis

Q9 67

GG0130H, Donning Footwear

- Count bandages/elastic stockings, orthotics or prosthetics as a piece of clothing when determining the need of assistance for dressing
  - Footwear: AFO, elastic bandages, foot orthotics, compression stockings

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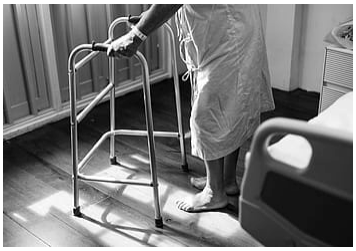
MOBILITY GG0170

- Activities may be completed with or without an assistive device
  - This should not affect coding of the activity



69

GG0170A, 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

70

GG0170B, Sit to Lying

- The ability to move from sitting on side of bed to lying flat on the bed

71

GG0170C, Lying to Sitting on Side of Bed

- Activity includes transition from lying on back to sitting on side of bed, with feet flat on the floor and sitting upright on the bed without back support

72

GG0170D, Sit to Stand and GG0170E, Chair/Bed-to-chair Transfers

- Sit to Stand: Begins with patient sitting in a chair or wheelchair or sitting upright at the edge of bed and returning to sitting in a chair or wheelchair or sitting upright at the edge of the bed
- Chair/bed-to-chair transfers: transferring to and from a bed to a chair (or wheelchair)
  - two helpers or if a mechanical lift is used to assist in transferring the patient, then code 01 Dependent

73

GG0170F, Toilet Transfer

- The ability to get safely on and off a **toilet or commode**
- RAI manual example:

*Ms. W has PVD and sepsis, LE pain and LE weakness. She uses a **bedside commode** when having a BM. The helper raised the bed to a height that helps with transfer. Ms. W initiated lifting her buttocks from the bed and in addition, requires some of her weight to be lifted by helper. Ms. W then reaches and grabs onto armrest of the bedside commode to steady herself. The helper provide assistance by lowering her to the bedside commode.*

Coding: 02: Substantial / maximal assist; helper provides more than half of the effort

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GG0170G, 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

75

GG0170I-L, Walking Items

- GG0170I: Walk 10 feet
  - Once standing, the ability to walk at least 10 feet in a room, corridor or similar
  - If this section is coded 07, 09, 10 or 88, then we skip to 1 step curb GG0170M
- GG0170J: Walk 50 feet with two turns
  - Once standing, the ability to walk at least 50 feet and make two 90-degree turns

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GG0170I-L, Walking Items

- GG0170K: Walk 150 feet
  - Once standing the ability to walk at least 150 feet in corridor or similar place
- GG0170L: Walk 10 feet on uneven surface
  - Walk on uneven or sloping surfaces (indoor or outdoor)

77

GG0170M, 1 Step (curb)

- The ability to go up and down a curb and/or up and down one step
  - If coded 07, 09, 10 or 88- skip to GG0170P, picking up object

78

GG0170N, 4 Steps

- GG0170N: 4 steps
  - The ability to go up and down 4 steps with or without a rail
  - If coded 07, 09, 10 or 88- skip to GG0170P, picking up object

79

GG0170O, 12 Steps

- GG0170O: 12 steps
- The ability to go up and down 12 steps with or without a rail

80

GG0170P, 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
- Could also occur if the resident is upright in a wheelchair

81

GG0170R and GG0170S, Wheelchair Items

- Intent: assess the ability of the patient who are learning to self-mobilize using a wheelchair or who used a wheelchair prior to admission
- Do not code w/c mobility if the resident uses a w/c only when transported between locations within the facility
- Admission assessment for w/c items should be coded for residents who used a w/c prior to admission

82

GG0170Q1, Wheelchair / Scooter

- Does the resident use a wheelchair or scooter?
  - Yes- continues to next item
  - No – skips to next section of the MDS (for admission assessment)

83

GG0170R, Wheel 50 Feet with Two Turns

- Code performance once seated in wheelchair
- Once seated in wheelchair/scooter, the ability to wheel at least 50 feet and make two turns
- GG0170RR1: Indicate the type of wheelchair / scooter used
  1. Manual
  2. Motorized

84

GG0170S, Wheel 150 Feet

- Code performance once seated to mobilize self down a corridor or hallway at least 150 feet
- GG0170SS1: Indicate the type of wheelchair / scooter used
  1. Manual
  2. Motorized

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Section GG Wrap Up

- Rules are 67 pages long
- MDS nurse is responsible for taking our assessments and coding per the manual
- Our job is to understand the instructions of the MDS- in the RAI manual so that we can provide accurate information that contributes to both quality measures and payment.

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CMS YouTube Videos on GG

- CMS Training GG 0130H:
  - https://youtu.be/hS4Ytpog7lg

- CMS Training GG0130B:
  - https://youtu.be/kV3FgiHCPlg

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Create a Plan of Care Supporting the Coding of Section GG

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Compare / Contrast / Conflict

- What level of care does your therapy documentation display?
- What level of care does your section GG score display?
- Do these coincide or do these conflict?

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Example 1: OT
Is this correct?

- OT Eval: Toileting
  - Status on eval: Max assist x 2
  - Goal on eval: Pt will be Mod I with toileting
  - Section GG score: Substantial / Maximal 02
  - Discharge GG goal: Pt will be Independent 06 with toileting

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Answer: Example 1

- OT Eval: Toileting
  - Status on eval: Max assist x 2
  - Goal on eval: Pt will be Mod I with toileting
  - Section GG score: Substantial / Maximal 02
    - No, maximal assist of two should be scored as 01: dependent
  - Discharge GG goal: Pt will be Independent 06
    - Yes, this is correct - Independent 06

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Example 2: PT
Is this correct?

- PT Eval Bed Mobility: Max assist
  - Status on eval: Max Assist
  - Goal on eval: Pt will be Independent with bed mobility
  - Section GG: Roll side to side: 02 Substantial / maximal assist
  - Discharge GG goal: Pt will be Independent: 06 with bed mobility

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Answer: Example 2

- PT Eval Bed Mobility: Max assist
  - Status on eval: Max Assist
  - Goal on eval: Pt will be Independent with bed mobility
  - Section GG: Roll side to side: 02 Substantial / maximal assist
    - Yes! Both the PT eval status and the GG code reflect the same level of assist
  - Discharge GG goal: Pt will be Independent 06 with bed mobility
    - Yes, this is correct - independent 06

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Example 3: Toilet transfers: *Is this correct?*

- OT status on eval: Mod assist
- OT goal: Pt will be Mod I with toilet transfers
- GG score: Partial/Moderate Assistance 03
- Discharge GG goal: Pt will be Independent 06 with toilet transfers

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Example 3: Toilet Transfers

- OT status on eval: Mod assist
- OT goal: Pt will be Mod I with toilet transfers

- GG score: Partial/Moderate Assistance 03
  - No! GG score should be 02: Substantial /Maximal Assist if the helper is providing more than half of the effort. By rehab definition, mod assist requires at least 50% assistance from helper and 02: Substantial /maximal assist by definition has the helper providing more than half of the effort
- Discharge GG goal: Pt will be Independent 06 with toilet transfers
  - Yes, this is correct - independent 06

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Final Comments

Thank you!

Questions?

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Acronyms in this Presentation

- AFO: Ankle foot orthosis
- ARD Assessment Reference Date
- CMS: Centers for Medicare and Medicaid Services
- IMPACT: Improving Medicare Post-Acute Care Transformation Act
- PAC: Post acute care
- PPS: Prospective Payment System
- LPN: Licensed Practical Nurse
- MDS: Minimum Data Set
- Min: minimal
- Mod: moderate
- Max: maximal
- OT: Occupational Therapy /Therapist
- PDPM: Patient Driven Payment Model
- PT: Physical Therapy /Therapy
- QRP: quality reporting program
- RAI: Resident Assessment Instrument
- RN: Registered Nurse
- SBA: Stand by assistance
- SLP: Speech Language Pathologist
- SNF: Skilled Nursing Facility
- ST: Speech Therapy
- TLSO: Thoracic-lumbar-sacrum orthosis

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