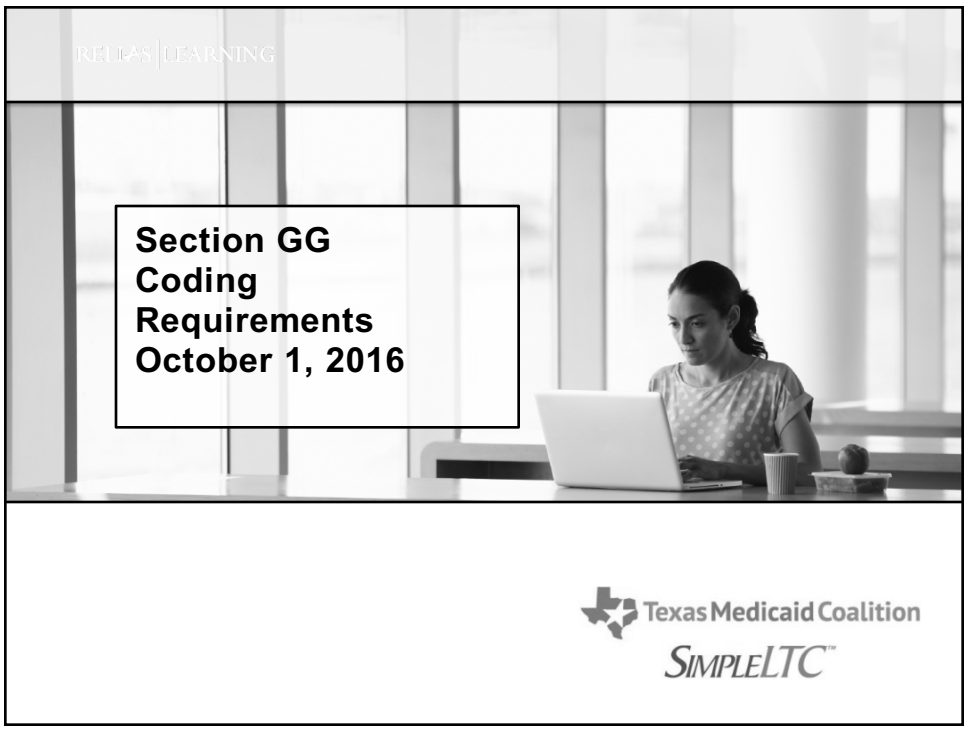


PRESENTER

- Ron Orth, RN, CMAC, NHA
- Senior Analyst: SNF Regulations and Clinical Reimbursement
- Former Chief Clinical Officer - AIS

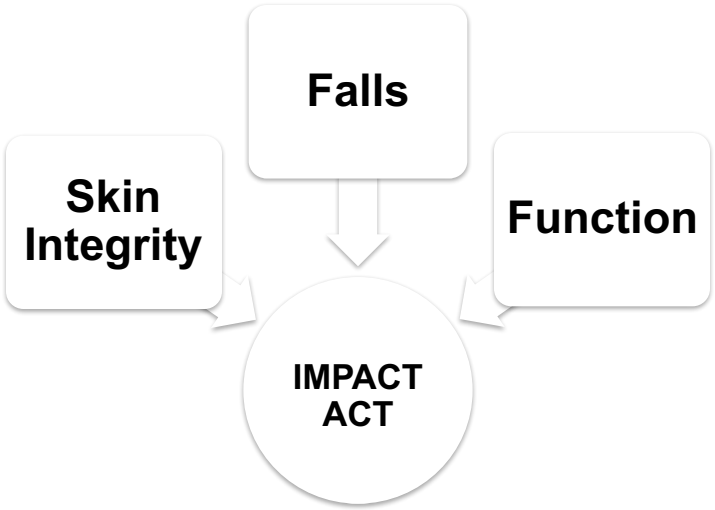
HANDOUTS

- PPT Handout
- Section GG
- Section GG Coding Algorithm
- CMS Q & A Document

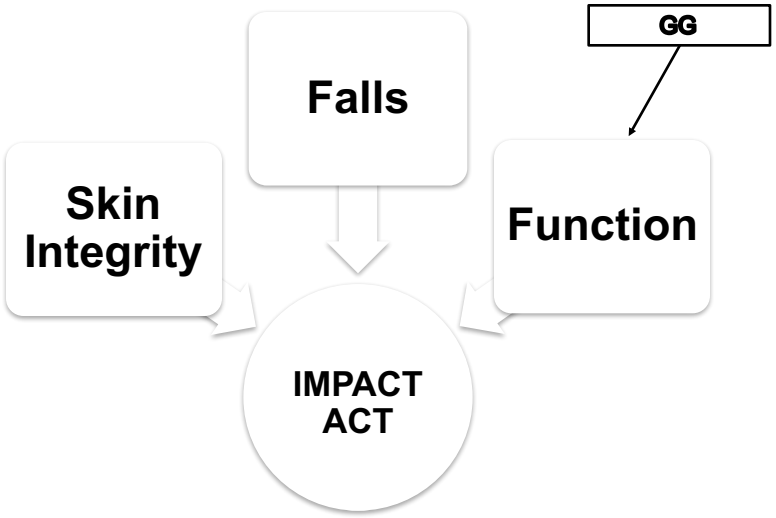
IMPACT ACT

- IMPACT – Improving Medicare Post-Acute Care Transformation Act – 2014
- Requires CMS makes resident assessments and quality measure data standardized amongst post-acute care providers
- Mandates QM data be implemented across three domains
- Measures will be part of the SNF Quality Reporting (QRP) program
- Requires additions of Section GG

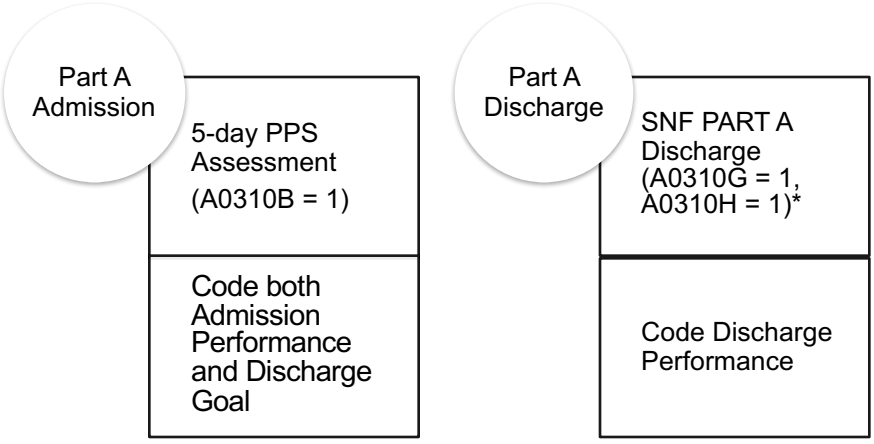
IMPACT ACT - QMs



IMPACT ACT - QMs



Section GG Completion Requirements



* Section GG not required upon discharge for unplanned discharges, Part A stays less than 3 days.

Discharge Assessments

- New Discharge item set being introduced 10/1/2016
  - Part A PPS Discharge (NPE) Item Set
- Required as part of new SNF Quality Reporting Program
  - Required to collection information at start of Medicare stay and end of Medicare stay
  - Currently no mechanism to collect information at end of Medicare stay.
- Part A PPS Discharge (NPE) Item Set
  - Includes 5 sections (A, GG, J and M and X).
  - Allows for collection of clinical data for the 3 QRP QMs at the end of a Medicare Part A stay.
    - Pressure Ulcers
    - Falls w/ Major Injury
    - Assessment of Functional Status

MDS 3.0 Section GG

Functional items divided into two main categories:

Self Care Activities

1. Admission Performance ↓ Enter Codes in Boxes ↓	2. Discharge Goal ↓ Enter Codes in Boxes ↓	
☐☐	☐☐	**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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1. Admission Performance ↓ Enter Codes in Boxes ↓	2. Discharge Goal ↓ Enter Codes in Boxes ↓	**Mobility Items**
☐☐	☐☐	**B. Sit to lying:** The ability to move from sitting on side of bed to lying flat on the bed.
☐☐	☐☐	**C. Lying to sitting on side of bed:** The ability to 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.
☐☐	☐☐	**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.
☐☐	☐☐	**E. Chair/bed-to-chair transfer:** The ability to safely transfer to and from a bed to a chair (or wheelchair).
☐☐	☐☐	**F. Toilet transfer:** The ability to safely get on and off a toilet or commode.
		☐ **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 GG0130, Self Care (Discharge) 1. **Yes** → Continue to GG0170R, Wheel 50 feet with two turns
☐☐	☐☐	**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.** 1. **Manual** 2. **Motorized**
☐☐	☐☐	**S. Wheel 150 feet:** Once seated in wheelchair/scooter, can wheel at least 150 feet in a corridor or similar space.
		☐ **SS1. Indicate the type of wheelchair/scooter used.** 1. **Manual** 2. **Motorized**

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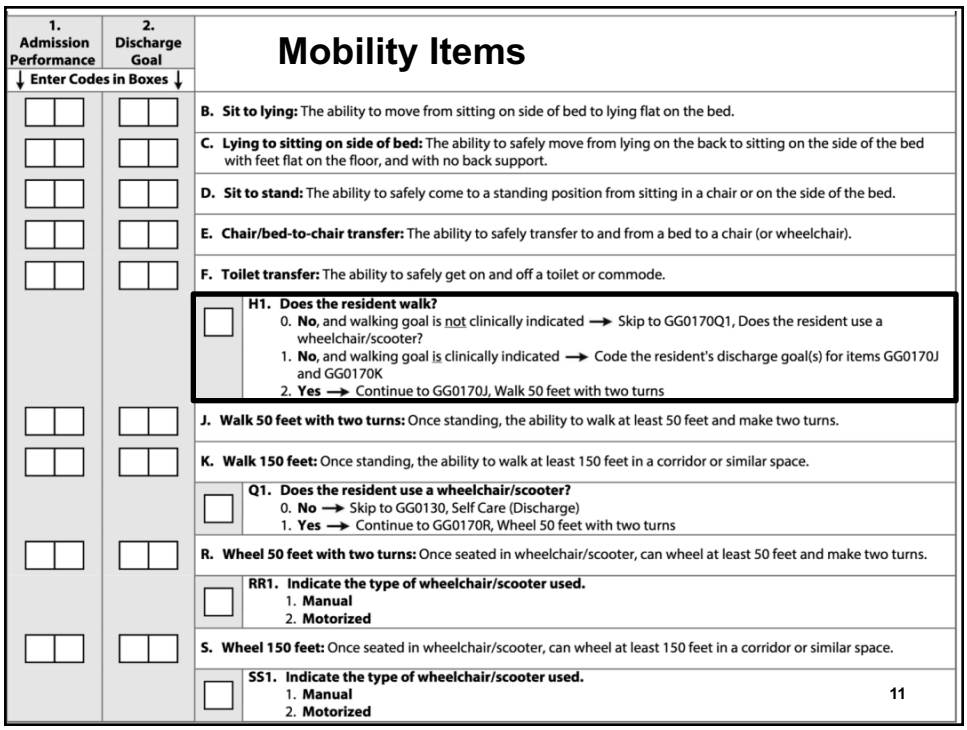

1. Admission Performance	2. Discharge Goal	Mobility Items (↓ Enter Codes in Boxes ↓)
		B. Sit to lying: The ability to move from sitting on side of bed to lying flat on the bed.
		C. Lying to sitting on side of bed: The ability to safely move from lying on the back to sitting on the side of the bed with feet flat on the floor, and with no back support.
		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.
		E. Chair/bed-to-chair transfer: The ability to safely transfer to and from a bed to a chair (or wheelchair).
		F. Toilet transfer: The ability to safely get on and off a toilet or commode.
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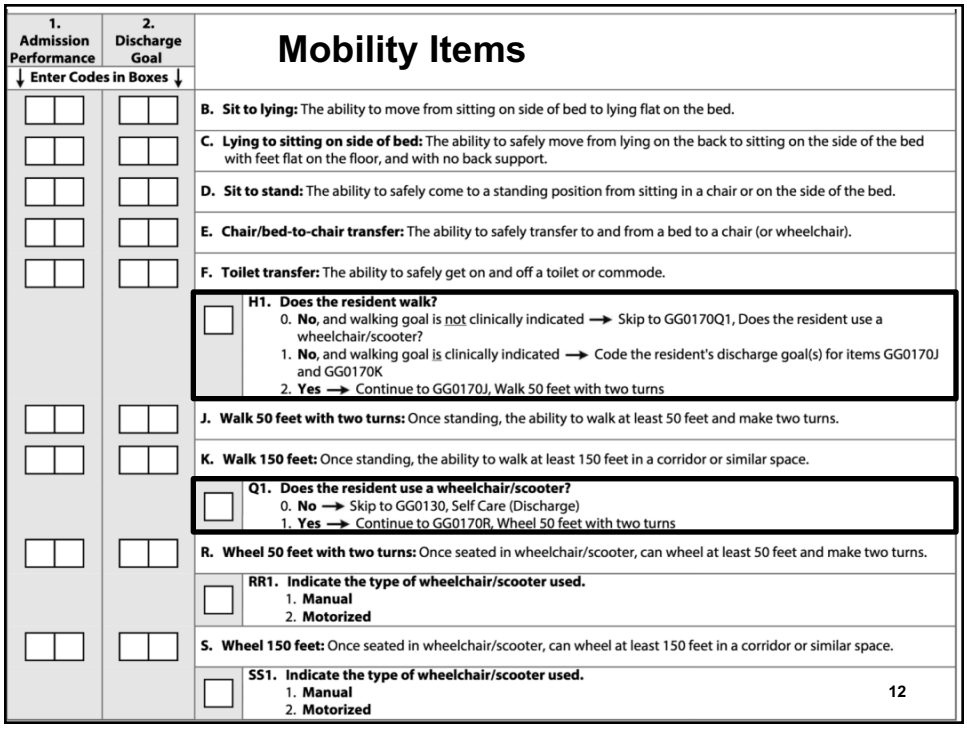
		J. Walk 50 feet with two turns: Once standing, the ability to walk at least 50 feet and make two turns.
		K. Walk 150 feet: Once standing, the ability to walk at least 150 feet in a corridor or similar space.
		Q1. Does the resident use a wheelchair/scooter? 0. **No** → Skip to GG0130, Self Care (Discharge) 1. **Yes** → Continue to GG0170R, Wheel 50 feet with two turns
		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. 1. **Manual** 2. **Motorized**
		S. Wheel 150 feet: Once seated in wheelchair/scooter, can wheel at least 150 feet in a corridor or similar space.
		SS1. Indicate the type of wheelchair/scooter used. 1. **Manual** 2. **Motorized**

11



1. Admission Performance	2. Discharge Goal	Mobility Items (↓ Enter Codes in Boxes ↓)
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		J. Walk 50 feet with two turns: Once standing, the ability to walk at least 50 feet and make two turns.
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		RR1. Indicate the type of wheelchair/scooter used. 1. **Manual** 2. **Motorized**
		S. Wheel 150 feet: Once seated in wheelchair/scooter, can wheel at least 150 feet in a corridor or similar space.
		SS1. Indicate the type of wheelchair/scooter used. 1. **Manual** 2. **Motorized**

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Section GG – Activity Definitions

- Pay close attention to the definition of each item
- Definition caveats:
  - Eating: Is oral intake only, food or fluid. Do not consider tube feeding. If resident eats orally and has tube feeding, consider only ability to intake oral food/fluids.
  - Toilet Hygiene: Looking at 3 distinct activities, pulling down pants/undergarment, cleansing perineal/perianal area, pulling pants undergarments up.
  - "Turns" = 2 separate 90 degree turns. Can be in same direction or opposite directions.
    - Example: Resident ambulates 30 feet, turns right down corridor, then turns left to enter their room. Total feet walk 50 or more.

MDS 3.0 Section GG

Coding – Column 1

- For the 5-day (Start of Medicare PPS SNF Stay) data collection period will be first 3 days of their stay.
  - Day 1 = A2400B Start Date of most Recent Medicare Stay
- Uses a 6 point rating scale.
- Also includes 3 options if activity was not attempted during the 3-day observation period.

1. Admission Performance	2. Discharge Goal	
↓ Enter Codes in Boxes ↓		
☐☐	☐☐	**B. Sit to lying:** The ability to move from sitting on side of bed to lying flat on the bed.
☐☐	☐☐	**C. Lying to sitting on side of bed:** The ability to 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.
☐☐	☐☐	**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.

MDS 3.0 Section GG

Coding – Column 1

- For the 5-day PPS assessment data collection period will be first 3 days of their stay.
  - Day 1 = A2400B Start Date of most Recent Medicare Stay
- Uses a 6 point rating scale.
- Also includes 3 options if activity was not attempted during the 3-day observation period.

1. Admission Performance ↓ Enter Codes in Boxes ↓	2. Discharge Goal	
☐☐	☐☐	**B. Sit to lying:** The ability to move from sitting on side of bed to lying flat on the bed.
☐☐	☐☐	**C. Lying to sitting on side of bed:** The ability to 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.
☐☐	☐☐	**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.

MDS 3.0 Section GG

Coding – Column 2

- Discharge Goal
- Uses same 6 point rating scale.
- Do not use 07, 09 or 88 to code Discharge Goal.

1. Admission Performance ↓ Enter Codes in Boxes ↓	2. Discharge Goal	
☐☐	☐☐	**B. Sit to lying:** The ability to move from sitting on side of bed to lying flat on the bed.
☐☐	☐☐	**C. Lying to sitting on side of bed:** The ability to 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.
☐☐	☐☐	**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.

MDS 3.0 Section GG

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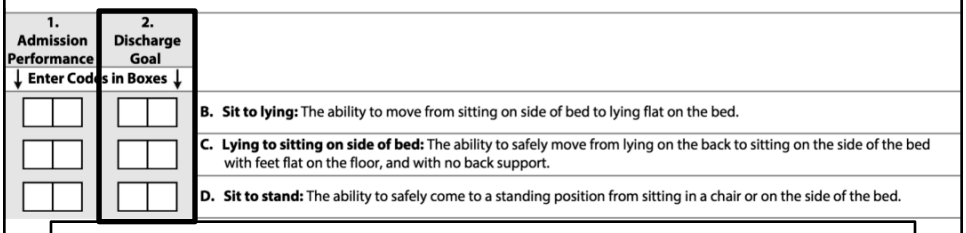

1. Admission Performance ↓ Enter Codes in Boxes ↓	2. Discharge Goal	
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		D. **Sit to stand:** The ability to safely come to a standing position from sitting in a chair or on the side of the bed.

MDS 3.0 Section GG

Discharge Goals

Discharge Goal Code Is ***Higher*** than Admission Performance Code

Discharge Goal Code Is the ***Same*** as Admission Performance Code

Discharge Goal Code Is ***Lower*** than Admission Performance Code

MDS 3.0 Section GG

Discharge Goals

- Use the 6-point scale to code the resident's discharge goal(s).
- Licensed clinicians can establish a resident's discharge goal(s) at the time of admission based on the admission assessment, discussions with the resident and family, professional judgment, and the professional's standard of practice. Goals should be established as part of the resident's care plan.

A minimum of <u>one</u> self-care OR mobility function goal must be coded.

MDS 3.0 Section GG

Coding

- For the **<u>End of Medicare SNF PPS</u>** Stay coding will be based on **<u>the last 3 days</u>** of the Medicare SNF stay.
  - Ending with A2400C End Date of Most Recent Medicare Stay
- Use same coding conventions as upon admission (5-day PPS).
- Also includes same 3 options if activity was not attempted during the last 3 days of the stay.

3. Discharge Performance Enter Codes in Boxes	
☐☐	**B. Sit to lying:** The ability to move from sitting on side of bed to lying flat on the bed.
☐☐	**C. Lying to sitting on side of bed:** The ability to 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.
☐☐	**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.

MDS 3.0 Section GG

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- For the **End of Medicare SNF PPS** Stay coding will be based on **the last 3 days** of the Medicare SNF stay.
  - Ending with A2400C End Date of Most Recent Medicare Stay
- Use same coding conventions as upon admission (5-day PPS).
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☐☐	**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.

MDS 3.0 Section GG

Coding

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

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 or TOUCHING/STEADYING 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.**
88. Not attempted due to **medical condition or safety concerns.**

MDS 3.0 Section GG

Coding

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

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MDS 3.0 Section GG

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

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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.

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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.**
88. Not attempted due to **medical condition or safety concerns.**

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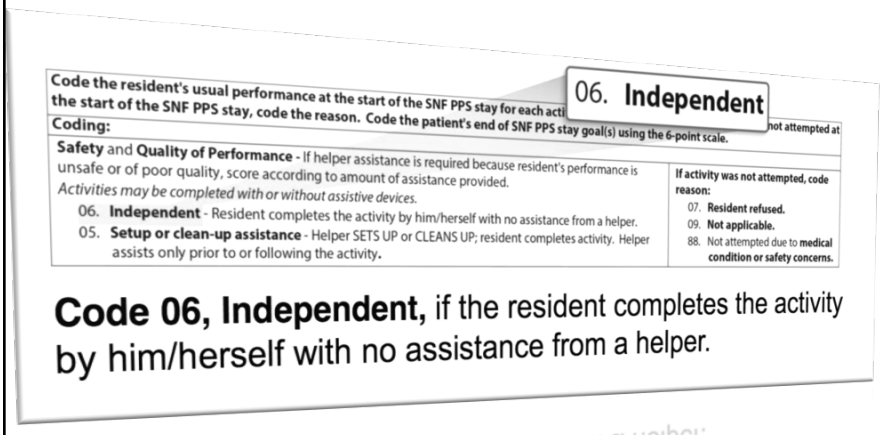
MDS 3.0 Section GG

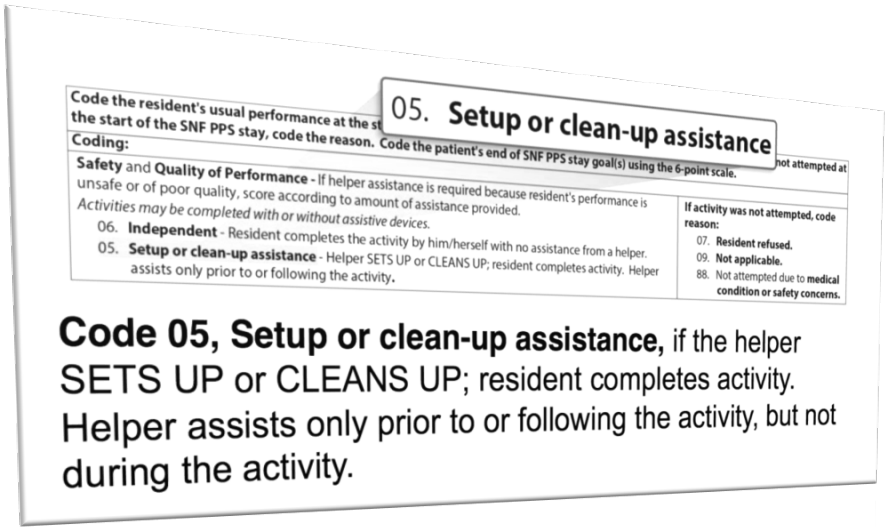
”Helper”

- 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).
- Does not include individuals hired, compensated or not, by individuals outside of the facility’s management and administration such as hospice staff, nursing/CNA students, etc.
- Therefore, when helper assistance is required because a resident’s performance is unsafe or of poor quality, only consider facility staff assistance when scoring according to amount of assistance provided.

MDS 3.0 Section GG - Coding



MDS 3.0 Section GG



Code 05, Setup or clean-up assistance, if the helper SETS UP or CLEANS UP; resident completes activity. Helper assists only prior to or following the activity, but not during the activity.

MDS 3.0 Section GG - Coding

Setup or clean-up assistance (05)

Eating: The dietary aide opens all of Mr. S's cartons and containers on his food tray before leaving the room. There are no safety concerns regarding Mr. S's ability to eat. Mr. S eats the food himself, bringing the food to his mouth using appropriate utensils and swallowing the food safely.

Coding: GG0130A. Eating would be coded 05, Setup or clean-up assistance.

Rationale: The helper provided setup assistance prior to the eating activity.

MDS 3.0 Section GG - Coding

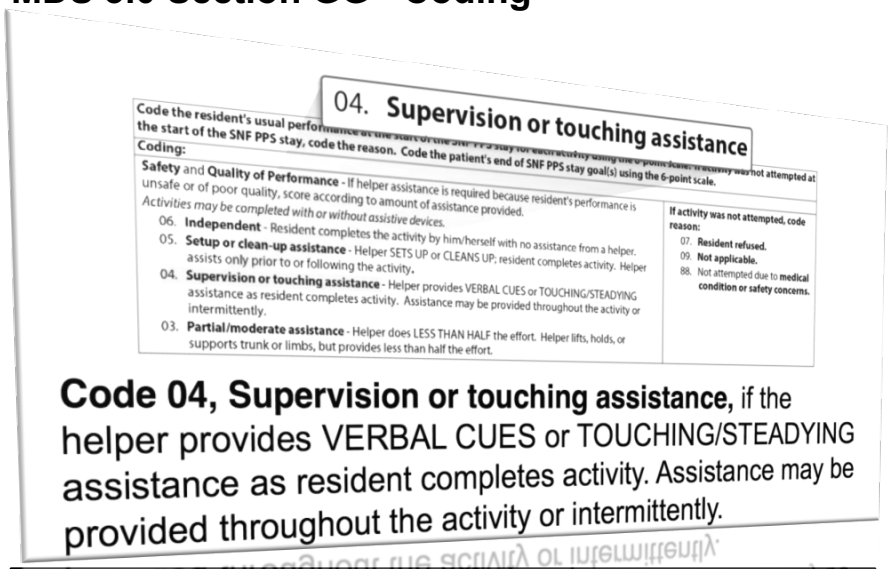
Setup or clean-up assistance (05)

Oral hygiene: In the morning and at night, Mrs. F brushes her teeth while sitting on the side of the bed. The CNA gathers her toothbrush, toothpaste, water, and an empty cup and puts them on the bedside table for her before leaving the room. Once Mrs. F is finished brushing her teeth, which she does without any help, the certified nursing assistant returns to gather her items and dispose of the waste.

Coding: GG0130B. Oral hygiene would be coded 05, Setup or clean-up assistance.

Rationale: The helper provides setup and clean-up assistance. The resident brushes her teeth without any help

MDS 3.0 Section GG - Coding



MDS 3.0 Section GG - Coding

Supervision/Touching Assistance (04)

Eating: Mrs. V has had difficulty seeing on her left side since her stroke. During meals, the certified nursing assistant has to remind her to scan her entire meal tray to ensure she has seen all the food.

Coding: GG0130A. Eating would be coded 04, Supervision or touching assistance.

Rationale: The helper provides verbal cueing assistance during meals as Mrs. V completes the activity of eating. Supervision, such as reminders, may be provided throughout the activity or intermittently.

MDS 3.0 Section GG - Coding

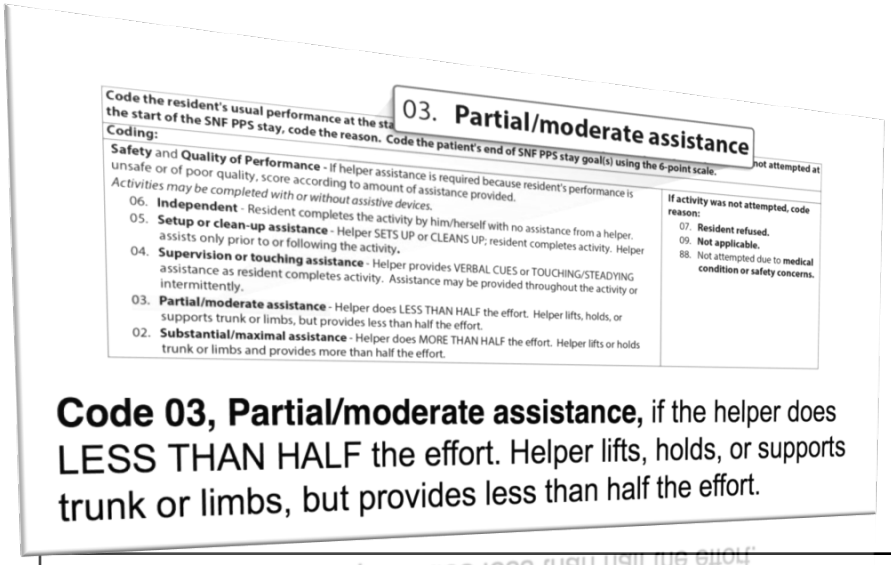
Supervision/Touching Assistance (04)

Sit to Stand: Mr. M has osteoarthritis and is recovering from sepsis. Mr. M transitions from a sitting to a standing position with the steadying assistance of the nurse's hand on Mr. M's trunk.

Coding: GG0170D. Sit to stand would be coded 04, Supervision or touching assistance.

Rationale: The helper provides touching assistance only.

MDS 3.0 Section GG - Coding



MDS 3.0 Section GG - Coding

Partial/moderate assistance (03)

Sit to stand: Ms. R has severe rheumatoid arthritis and uses forearm crutches to ambulate. The certified nursing assistant brings Ms. R her crutches and helps her to stand at the side of the bed. The certified nursing assistant provides some lifting assistance to get Ms. R to a standing position but provides less than half the effort to complete the activity.

Coding: GG0170D. Sit to stand would be coded 03, Partial/moderate assistance.

Rationale: The helper provided lifting assistance and less than half the effort for the resident to complete the activity of sit to stand.

MDS 3.0 Section GG - Coding

Partial/moderate assistance (03)

Toilet transfer: The therapist supports Mrs. M's trunk with a gait belt as Mrs. M pivots and lowers herself onto the toilet. The therapist provides less than half the effort during the toilet transfer.

Coding: GG0170F. Toilet transfer would be coded 03, Partial/moderate assistance.

Rationale: The helper provides less than half the effort to complete the activity.

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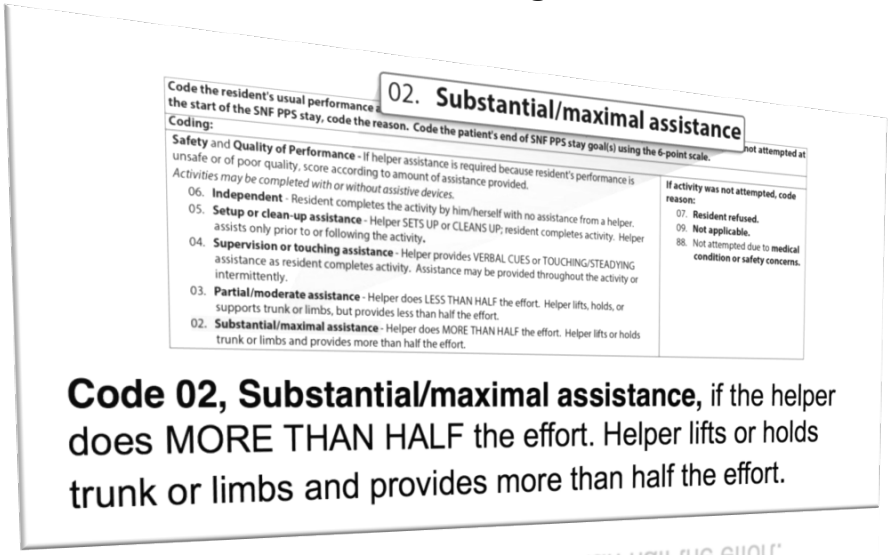
MDS 3.0 Section GG - Coding



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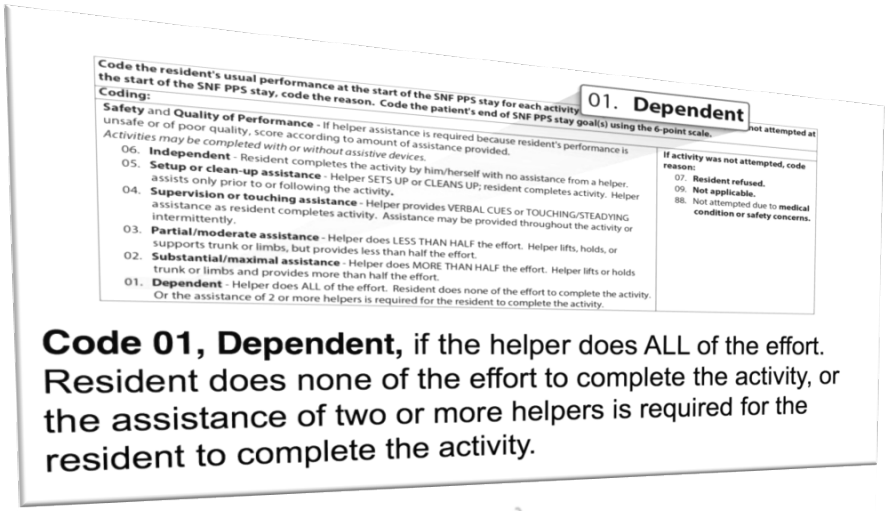
MDS 3.0 Section GG - Coding

Substantial/maximal assistance (02)

Walk 50 feet with two turns: Mrs. U has an above-the-knee amputation, severe rheumatoid arthritis, and uses a prosthesis. Mrs. U is assisted to stand and, after walking 10 feet, requires progressively more help as she nears the 50-foot mark. Mrs. U is unsteady and typically loses her balance when turning, requiring significant support to remain upright. The therapist provides more than half of the effort.

Coding: GG0170J. Walk 50 feet with two turns would be coded 02, Substantial/ maximal assistance.
Rationale: The helper provided more than half of the effort for the resident to complete the activity of walk 50 feet with two turns.

MDS 3.0 Section GG - Coding



MDS 3.0 Section GG - Coding

Dependent (01)

Chair/bed-to-chair transfer: Mr. F's medical conditions include morbid obesity, diabetes mellitus, and sepsis, and he recently underwent bilateral above-the-knee amputations. Mr. F requires full assistance with transfers from the bed to the wheelchair using a lift device. Two CNAs are required for safety when using the device to transfer Mr. F from the bed to a wheelchair. Mr. F is unable to assist in the transfer from his bed to the wheelchair.

Coding: GG0170E. Chair/bed-to-chair transfer would be coded 01, Dependent.

Rationale: The two helpers completed all the effort for the activity of chair/bed-to-chair transfer. If two or more helpers are required to assist the resident to complete an activity, code as 01, Dependent.

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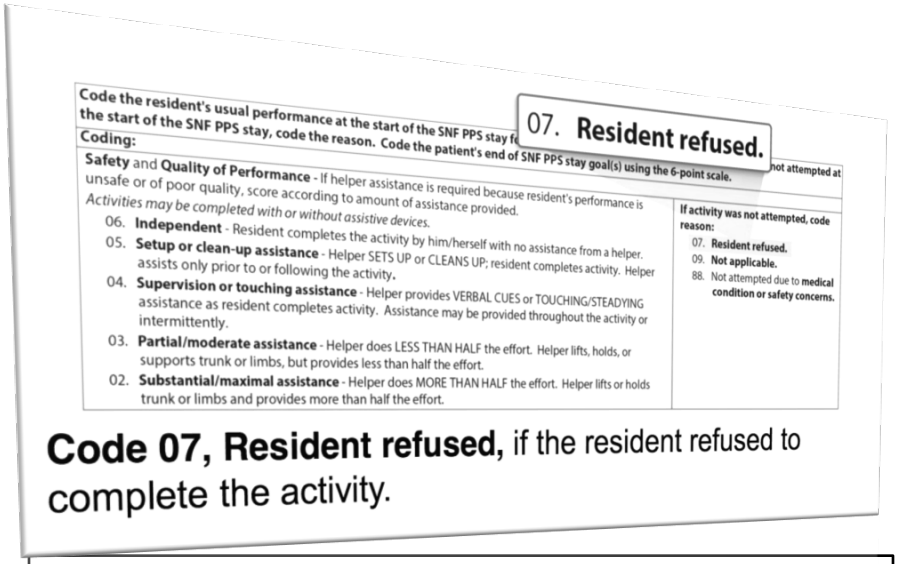
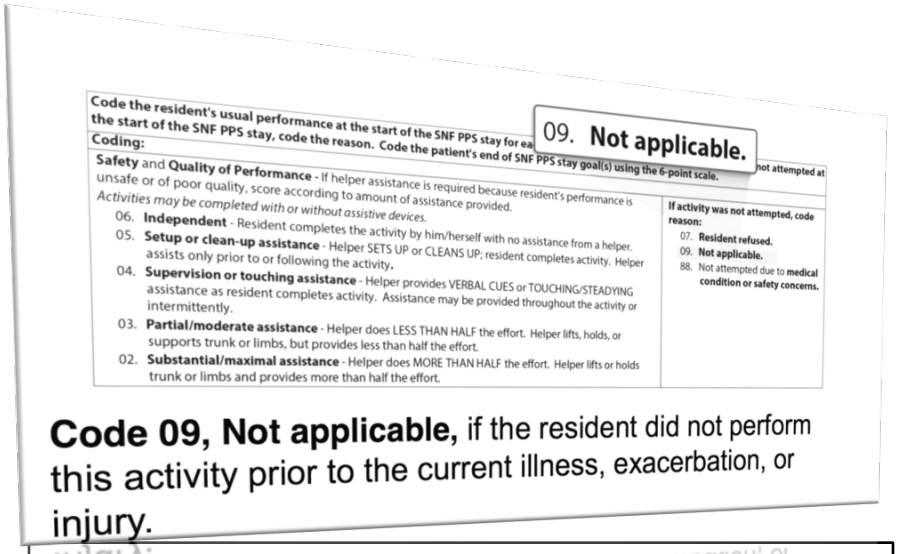
MDS 3.0 Section GG - Coding



40

MDS 3.0 Section GG - Coding



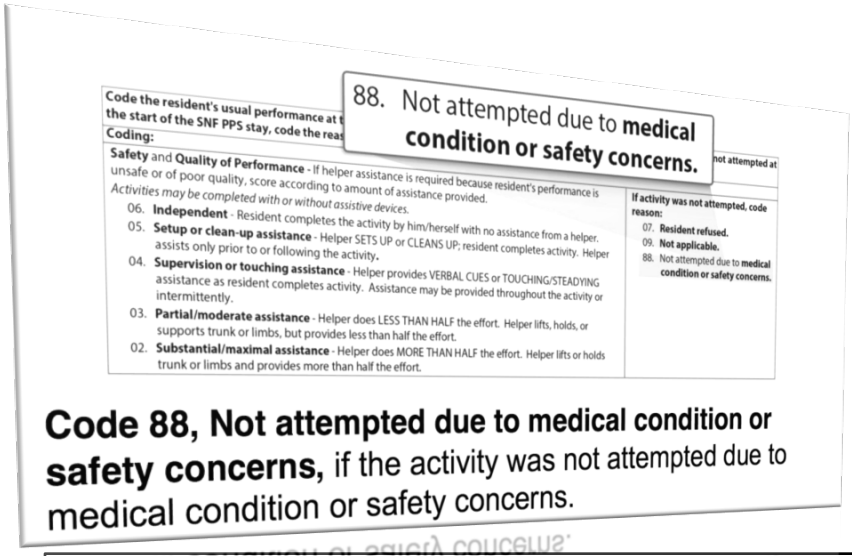
MDS 3.0 Section GG - Coding

Not Applicable (09)

Eating: 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. Mr. R has been 100% tube fed for many years and is not a new condition related to his current illness.

Coding: GG0130A. Eating would be coded 09, Not applicable
Rationale: The resident did not perform the activity of Eating prior to the current illness, exacerbation, or injury.

MDS 3.0 Section GG - Coding



MDS 3.0 Section GG - Coding

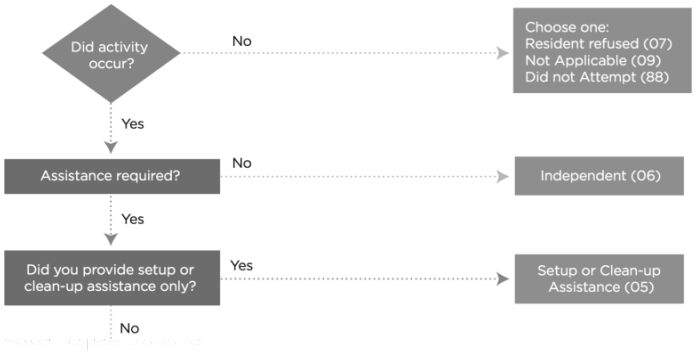
Not attempted…... (88)

Eating: 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. Prior to his current illness he was able to eat normally without any difficulty.

Coding: GG0130A. Eating would be coded 88, Not attempted due to medical condition or safety concerns.
Rationale: The resident does not eat by mouth at this time. Assistance with G-tube feedings is not considered when coding the item Eating.

RELIAS LEARNING

MDS 3.0 Section GG Coding Algorithm



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MDS 3.0 Section GG - Coding

Coding

- Coding is based on the resident's "usual" performance or **baseline** performance on admission.
- Do not base on most dependent or most independent episodes.
- The intent of this item is to capture a picture of the resident's functional "ability" upon "admission" and upon "discharge" from their Part A stay.
- The assessment should occur **prior** to the start of therapeutic intervention in order to capture the resident's true admission **baseline** status.

RELIAS LEARNING 46

MDS 3.0 Section GG - Coding

- Review documentation in the medical record for the 3-day assessment period.
- Talk with direct care staff.
- Use probing questions.
- Observe the resident as he/she performs each self-care activity.
- Be specific in evaluating each component.
- Record the resident's actual ability to perform each activity.
- Score will be based on the amount of assistance/effort provided.
- Activities may be completed with or without assistive devices.

MDS 3.0 Section GG – Possible Documentation

Receiving Rehab Services

- Therapy and/or Nursing completes a formal evaluation of GG items.
- Reconcile any differences based on other observations or medical record documentation, if applicable.
- Determine appropriate coding of Section GG items.

No Rehab Services

- Nursing completes a formal evaluation/assessment of functional abilities
- Reconcile any differences based on other observations or medical record documentation at end of 3 day "observation period".
- Determine appropriate coding of Section GG items.

MDS 3.0 Section GG - Implementation

- Section GG is effective with assessments completed with an ARD on 10/1/16 or after
  - 5-day PPS; and
  - Medicare Part A PPS Discharge Assessments
- Awaiting CMS directives on how to complete Section GG for residents admitted prior to 10/1 but have 5-day ARD after 10/1.
  - Example: Resident admitted 9/28; 5-day PPS ARD 10/5
- Awaiting CMS directives on how to complete Section GG for residents admitted prior to 10/1 but discharged after 10/1.

QRP Function
Quality Measure

SNF QRP Function QM

Purpose: To determine percentage of residents who have their functional status assessed upon admission and discharge AND who have at least one functional goal established.

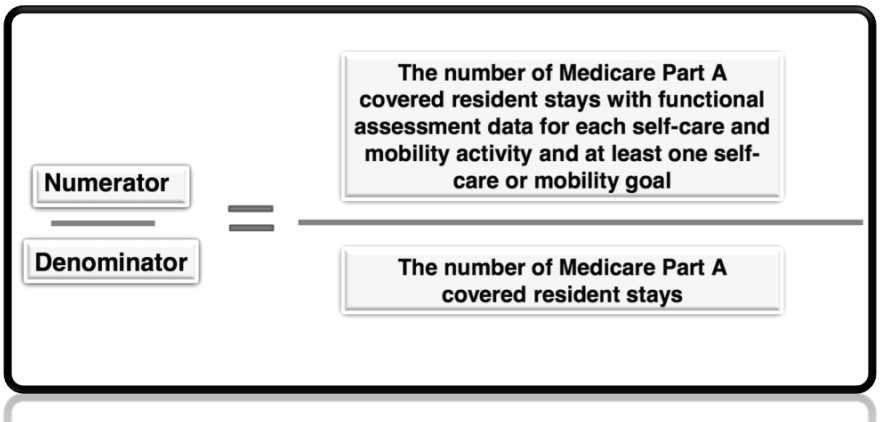
First Reporting Period: 10/1 – 12/31/2016

- Only residents admitted on 10/1 or after and discharged on or after 12/31/16 will be included.

SNF QRP Function QM

- Section GG
  - Address self care and mobility items
  - Using different standards for coding
    - Process measurement versus Outcome measurement
      - Assess functional status and determine a goal
      - Not looking at improvement or decline

SNF QRP Function QM



No Risk Adjustments

SNF QRP Function QM

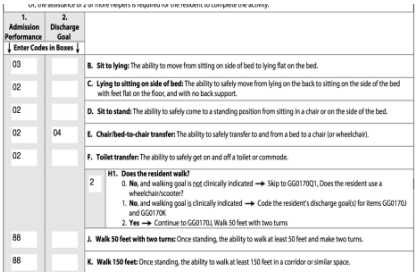
Quality Measure differentiates between "Complete" and "Incomplete" stays.

Incomplete Stays

Unplanned Discharge = incomplete stay

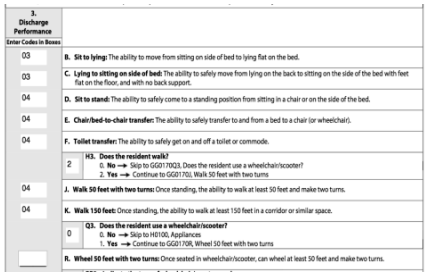
Complete Stay Example

5-day Assessment



1. Admission Performance	2. Discharge Goal	
↓ Enter Codes in Boxes ↓		
03		**B. Sit to lying:** The ability to move from sitting on side of bed to lying flat on the bed.
02		**C. 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.
02		**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.
02	04	**E. Chair/bed-to-chair transfer:** The ability to safely transfer to and from a bed to a chair (or wheelchair).
02		**F. Toilet transfer:** The ability to safely get on and off a toilet or commode.
	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
88		**J. Walk 50 feet with two turns:** Once standing, the ability to walk at least 50 feet and make two turns.
88		**K. Walk 150 feet:** Once standing, the ability to walk at least 150 feet in a corridor or similar space.

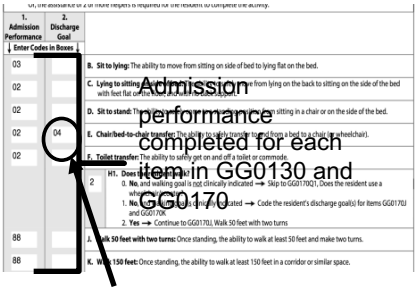
Part A Discharge Assessment



3. Discharge Performance	
Enter Codes in Boxes	
03	**B. Sit to lying:** The ability to move from sitting on side of bed to lying flat on the bed.
03	**C. 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.
04	**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.
04	**E. Chair/bed-to-chair transfer:** The ability to safely transfer to and from a bed to a chair (or wheelchair).
04	**F. Toilet transfer:** The ability to safely get on and off a toilet or commode.
2	**H3. Does the resident walk?** 0. **No** → Skip to GG0170Q3, Does the resident use a wheelchair/scooter? 1. **Yes** → Continue to GG0170J, Walk 50 feet with two turns
04	**J. Walk 50 feet with two turns:** Once standing, the ability to walk at least 50 feet and make two turns.
04	**K. Walk 150 feet:** Once standing, the ability to walk at least 150 feet in a corridor or similar space.
0	**Q3. Does the resident use a wheelchair/scooter?** 0. **No** → Skip to H0100, Appliances 1. **Yes** → Continue to GG0170R, Wheel 50 feet with two turns
	R. Wheel 50 feet with two turns: Once seated in wheelchair/scooter, can wheel at least 50 feet and make two turns.

Complete Stay Example

5-day Assessment

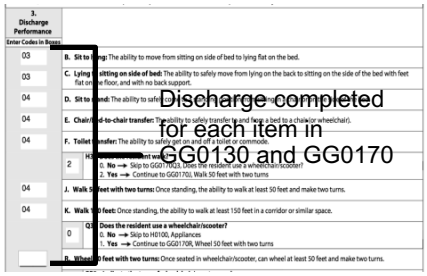


1. Admission Performance	2. Discharge Goal	
↓ Enter Codes in Boxes ↓		
03		**B. Sit to lying:** The ability to move from sitting on side of bed to lying flat on the bed.
02		**C. Lying to sitting on side of bed:** The ability to safely move from lying on the back to sitting on the side of the bed with feet flat on the floor, and with no back support.
02		**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.
02	04	**E. Chair/bed-to-chair transfer:** The ability to safely transfer to and from a bed to a chair (or wheelchair).
02		**F. Toilet transfer:** The ability to safely get on and off a toilet or commode.
	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
88		**J. Walk 50 feet with two turns:** Once standing, the ability to walk at least 50 feet and make two turns.
88		**K. Walk 150 feet:** Once standing, the ability to walk at least 150 feet in a corridor or similar space.

Admission performance completed for each item in GG0130 and GG0170

At least one goal identified in GG0130 OR GG0170

Part A Discharge Assessment

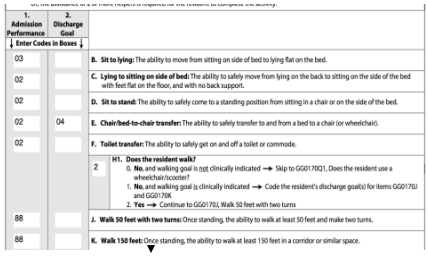


3. Discharge Performance	
Enter Codes in Boxes	
03	**B. Sit to lying:** The ability to move from sitting on side of bed to lying flat on the bed.
03	**C. Lying to sitting on side of bed:** The ability to safely move from lying on the back to sitting on the side of the bed with feet flat on the floor, and with no back support.
04	**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.
04	**E. Chair/bed-to-chair transfer:** The ability to safely transfer to and from a bed to a chair (or wheelchair).
04	**F. Toilet transfer:** The ability to safely get on and off a toilet or commode.
2	**H3. Does the resident walk?** 0. **No** → Skip to GG0170Q3, Does the resident use a wheelchair/scooter? 1. **Yes** → Continue to GG0170J, Walk 50 feet with two turns
04	**J. Walk 50 feet with two turns:** Once standing, the ability to walk at least 50 feet and make two turns.
04	**K. Walk 150 feet:** Once standing, the ability to walk at least 150 feet in a corridor or similar space.
0	**Q3. Does the resident use a wheelchair/scooter?** 0. **No** → Skip to H0100, Appliances 1. **Yes** → Continue to GG0170R, Wheel 50 feet with two turns
	R. Wheel 50 feet with two turns: Once seated in wheelchair/scooter, can wheel at least 50 feet and make two turns.

Discharge completed for each item in GG0130 and GG0170

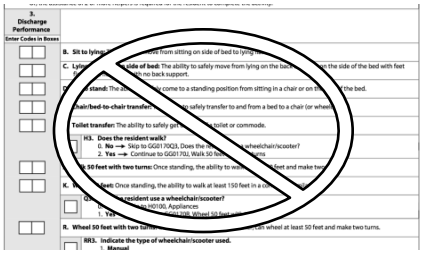
Incomplete Stay Example

5-day Assessment



1. Admission Performance	2. Discharge Goal	
↓ Enter Codes in Boxes ↓		
03		B. Sit to lying: The ability to move from sitting on side of bed to lying flat on the bed.
02		C. 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.
02		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.
02	04	E. Chair/bed-to-chair transfer: The ability to safely transfer to and from a bed to a chair (or wheelchair).
02		F. Toilet transfer: The ability to safely get on and off a toilet or commode.
		H1. Does the resident walk?
	2	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
88		J. Walk 50 feet with two turns: Once standing, the ability to walk at least 50 feet and make two turns.
88		K. Walk 150 feet: Once standing, the ability to walk at least 150 feet in a corridor or similar space.

Part A Discharge Assessment



A. Discharge Performance	
Enter Codes in Boxes	
	B. Sit to lying:
	C. Lying
	D.
	Chair/bed-to-chair transfer:
	Toilet transfer: The ability to safely get
	H3. Does the resident walk?
	0. No → Skip to GG0170Q3, Does the
	2. Yes → Continue to GG0170J, Walk 50
	50 feet with two turns: Once standing, the ability to walk
	K.
	resident use a wheelchair/scooter?
	R. Wheel 50 feet with two turns
	RR3. Indicate the type of wheelchair/scooter used.
	1. Manual

Use of Dashes

- Should be a rare occurrence for completing Section GG
- Do not use a ”dash” if the item was not assessed because:
  - Resident Refused, use 07
  - Item not applicable, use 09
  - Activity was not attempted due to medical or safety reasons, use 88
- Completion of only one discharge goal is required.
  - Other goals may be dashed without any repercussions.

Use of dashes

Penalty

- No direct impact on RUG rates, HOWEVER
- 2% penalty to market basket increase beginning beginning 10/1/2017 if more than 80% of the MDSs submitted do not contain 100% of the data elements needed to calculate all 3 of the new QRP Quality Measures.

- Do not use dashes (-)!

Final RAI MDS 3.0 User's Manual
https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursinghomeQualityInits/MDS30RAIManual.html

QRP Training Materials
https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/Skilled-Nursing-Facility-Quality-Reporting-Program/SNF-Quality-Reporting-Program-Training.html

Section GG You Tube Videos (4 part series).
https://www.youtube.com/results?search_query=Section+GG


ais
Assessment &
Intelligence Systems
is now part of
RELIAS LEARNING
RELIAS LEARNING
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Section GG — Functional Abilities and Goals - Admission (Start of SNF PPS Stay)

GG0130. Self-Care (Assessment period is days 1 through 3 of the SNF PPS Stay starting with A2400B)
Complete only if A0310B = 01

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

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 or TOUCHING/STEADYING 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.**
88. Not attempted due to **medical condition or safety concerns.**

1. Admission Performance	2. Discharge Goal	
↓ Enter Codes in Boxes ↓		
☐☐	☐☐	**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.

Section GG — Functional Abilities and Goals - Admission (Start of SNF PPS Stay)

GG0170. Mobility (Assessment period is days 1 through 3 of the SNF PPS Stay starting with A2400B)
Complete only if A0310B = 01

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

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 or TOUCHING/STEADYING 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.**
88. Not attempted due to **medical condition or safety concerns.**

1. Admission Performance	2. Discharge Goal	
↓ Enter Codes in Boxes ↓		
☐☐	☐☐	**B. Sit to lying:** The ability to move from sitting on side of bed to lying flat on the bed.
☐☐	☐☐	**C. Lying to sitting on side of bed:** The ability to 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.
☐☐	☐☐	**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.
☐☐	☐☐	**E. Chair/bed-to-chair transfer:** The ability to safely transfer to and from a bed to a chair (or wheelchair).
☐☐	☐☐	**F. Toilet transfer:** The ability to safely get on and off a toilet or commode.
		☐ **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 GG0130, Self Care (Discharge) 1. **Yes** → Continue to GG0170R, Wheel 50 feet with two turns
☐☐	☐☐	**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.** 1. **Manual** 2. **Motorized**
☐☐	☐☐	**S. Wheel 150 feet:** Once seated in wheelchair/scooter, can wheel at least 150 feet in a corridor or similar space.
		☐ **SS1. Indicate the type of wheelchair/scooter used.** 1. **Manual** 2. **Motorized**

Section GG | Functional Abilities and Goals - Discharge (End of SNF PPS Stay)

GG0130. Self-Care (Assessment period is the last 3 days of the SNF PPS Stay ending on A2400C)
Complete only if A0310G is not = 2 **and** A0310H = 1 **and** A2400C minus A2400B is greater than 2 **and** A2100 is not = 03

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

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 or TOUCHING/STEADYING 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.**
88. Not attempted due to **medical condition or safety concerns.**

3. Discharge Performance	
Enter Code ☐☐	**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.
Enter Code ☐☐	**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.]
Enter Code ☐☐	**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.

Section GG | Functional Abilities and Goals - Discharge (End of SNF PPS Stay)

GG0170. Mobility (Assessment period is the last 3 days of the SNF PPS Stay ending on A2400C)
Complete only if A0310G is not = 2 **and** A0310H = 1 **and** A2400C minus A2400B is greater than 2 **and** A2100 is not = 03

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

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 or TOUCHING/STEADYING 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.**
88. Not attempted due to **medical condition or safety concerns.**

3. Discharge Performance **Enter Codes in Boxes**	
☐☐	**B. Sit to lying:** The ability to move from sitting on side of bed to lying flat on the bed.
☐☐	**C. Lying to sitting on side of bed:** The ability to 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.
☐☐	**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.
☐☐	**E. Chair/bed-to-chair transfer:** The ability to safely transfer to and from a bed to a chair (or wheelchair).
☐☐	**F. Toilet transfer:** The ability to safely get on and off a toilet or commode.
☐	**H3. Does the resident walk?** 0. **No** → Skip to GG0170Q3, Does the resident use a wheelchair/scooter? 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.
☐	**Q3. Does the resident use a wheelchair/scooter?** 0. **No** → Skip to H0100, Appliances 1. **Yes** → Continue to GG0170R, Wheel 50 feet with two turns
☐☐	**R. Wheel 50 feet with two turns:** Once seated in wheelchair/scooter, can wheel at least 50 feet and make two turns.
☐	**RR3. Indicate the type of wheelchair/scooter used.** 1. **Manual** 2. **Motorized**
☐☐	**S. Wheel 150 feet:** Once seated in wheelchair/scooter, can wheel at least 150 feet in a corridor or similar space.
☐	**SS3. Indicate the type of wheelchair/scooter used.** 1. **Manual** 2. **Motorized**

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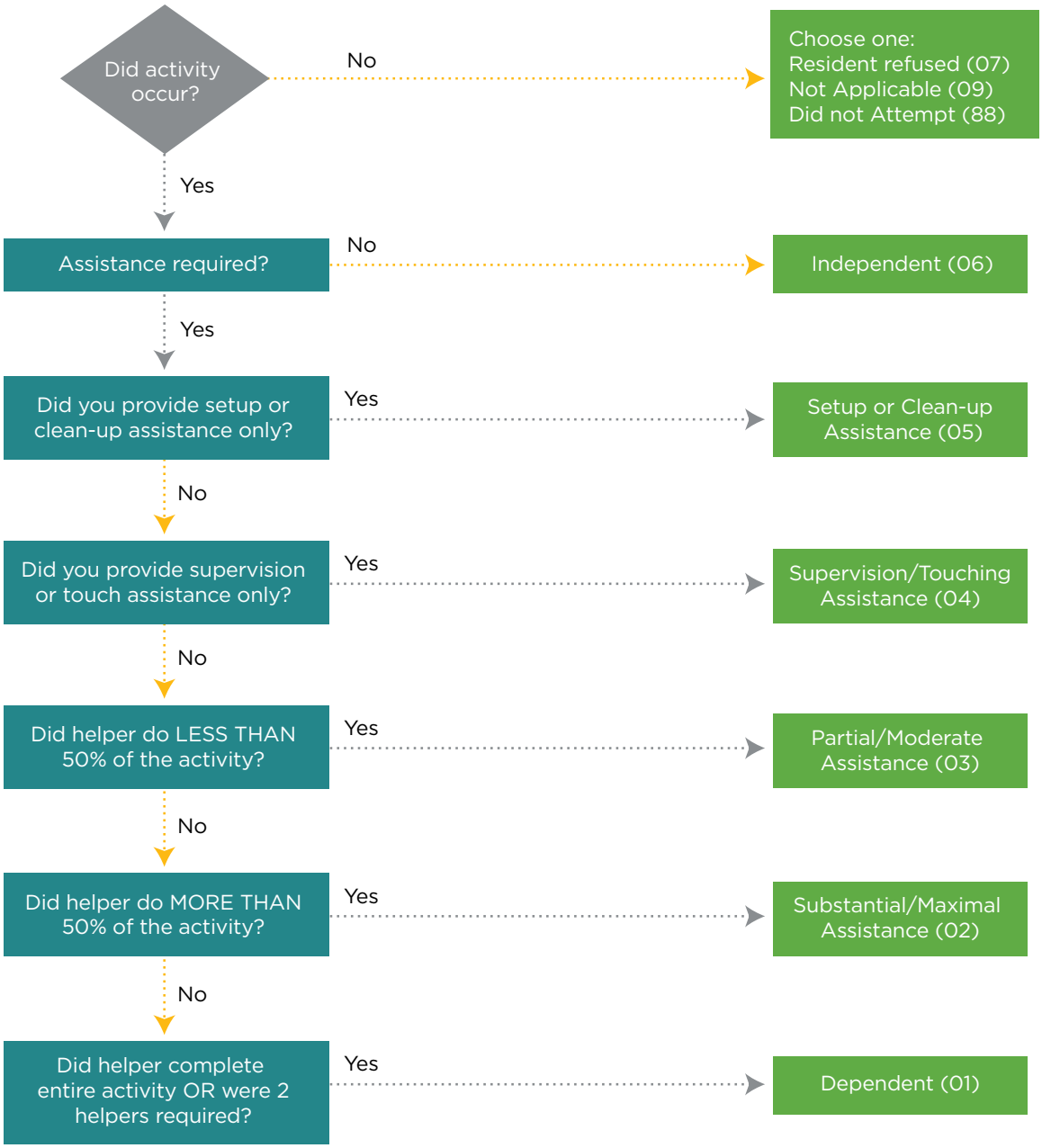
MDS 3.0 Section GG Coding Algorithm



Section GG Coding Scale and Coding Tips

Use the following coding scale to identify the resident's Admission Performance (Column 1) and at least one Discharge Goal (Column 2) in GG0130 and GG0170, on the 5-day PPS assessment. Use this same scale to identify the resident's discharge performance in GG0130 and GG0170 on the SNF PPS Part A Discharge assessment.

If Self-Care or Mobility activity was performed:

- **Code 06, Independent:** if the resident completes the activity by him/herself with no assistance from a helper.
- **Code 05, Setup or clean-up assistance:** if the helper SETS UP or CLEANS UP; resident completes activity. Helper assists only prior to or following the activity, but not during the activity. For example, the resident requires assistance cutting up food or opening container, or requires setup of hygiene item(s) or assistive device(s).
- **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. For example, the resident requires verbal cueing, coaxing, or general supervision for safety to complete activity; or resident may require only incidental help such as contact guard or steadying assist during the activity.
- **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.
- **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.
- **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.

If Self-Care or Mobility activity was not performed (do not use for Discharge Goal):

- **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.

Coding Tips

- Section GG required on 5-day PPS assessment and SNF PPS Discharge assessment for "planned" discharges only.
- Code Admission Performance based on resident assessment information collected in the first 3 days of the resident's Part A stay.
- Code Discharge Performance based on resident assessment information collected in the last 3 days of the resident's Part A stay.
- Each item in GG0130 and GG0170 must have an Admission Performance code entered.
- Only one discharge goal is required for any item in GG0130 or GG0170. Additional goals may be entered.
- Code Admission Performance based on usual performance or "Baseline" performance.
- Do not use "dashes" when completing Section GG.
- Discharge goal code may be higher, the same or lower than the Admission Performance code.

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RELIAS LEARNING

Skilled Nursing Facility Quality Reporting Program

Provider Training Questions and Feedback on MDS 3.0:

- **Part A PPS Discharge Combinations**
- **Section GG**
- **SNF QRP Pressure Ulcer quality measure**

Completion of MDS 3.0 Assessments and APU information related to the SNF QRP:

- The Assessment Reference Date (ARD) coded in item A2300 will determine the version of the MDS 3.0 that providers are to complete and submit to CMS. Specifically, if the ARD is on or after October 1, 2016, providers should use MDS 3.0 version 1.14.1. Version 1.14.1 is the version that has all of the items required for submission for the SNF QRP, including a Section new to the MDS 3.0, Section GG.
- For the quality measures used in the SNF QRP, we will begin calculating these measures using records submitted with an actual admission date on or after 10/01/2016. Assessments submitted that are used in order to calculate the quality measures for the NHQI will continue as required.
- The Annual Payment Update threshold for FY 2018 is not based on the final calculation of a quality measure, nor complete stays. Rather it is based on the determination of the completion of the items necessary to calculate the quality measure, which we note includes the risk adjustment items. The threshold is based on the completion of items on a record regardless of whether the stay has been completed.
    - For example, if a resident is admitted on December 20th, and the SNF has completed all items on the resident's 5-Day PPS assessment that is used to calculate the SNF QRP quality measures, then this record would be among those considered compliant. A provider must have 100% of all the items necessary to calculate the measure on at least 80% of the records submitted that would be used to calculate (and risk adjust) the quality measure.
    - We wish to note that missing data (e.g., dashes) are already very low for SNFs. We further note that the calculation of the SNF QRP measures are stay-based and are therefore calculated using the 5-day PPS for the admission and either the SNF Part A PPS discharge or the OBRA Discharge, depending on which the SNF submits to CMS.

PART A PPS Discharge

- The Part A PPS Discharge cannot be combined with unscheduled PPS assessments (OMRAs), as it was determined that the volume of cases where these combinations might exist was so low that it did not warrant the creation of the additional item sets and submission specifications that would be required. Therefore, when a Part A PPS Discharge is required and an OMRA (unscheduled PPS assessment) is also required, the Part A PPS Discharge and the OMRA are to be completed separately.
- The Part A PPS Discharge may be combined with OBRA and scheduled PPS assessments following the combination rules established in Chapter 2 of the RAI Manual and the instructions for the completion of the MDS items on the combined assessment, in Chapter 3 of the RAI Manual. We note that while the Part A PPS Discharge can be combined with OBRA and scheduled PPS assessments, it cannot be used in substitution of these.

Section GG Clarifications

- The Section GG items are required on both admission and discharge to the SNF when the resident is covered under a Medicare Part A stay.
    - On admission, these items are completed only when A0310B=01 (5-Day PPS assessment). The assessment period for Section GG on admission, is the first three days of the Part A stay starting with the date in A2400B.
    - On discharge, these items are completed only if A0310G is not =2 **and** A0310H = 1 **and** A2400C minus A2400B is greater than 2 **and** A2100 is not = 03. The assessment period for the Section GG Discharge items is the last three days of the Part A stay ending with the date in A2400C.
- Providers have had questions concerning how to interpret the coding instruction on the Section GG Discharge items GG0130 and GG0170, which states: "Complete only if A0310G is not =2 **and** A0310H = 1 **and** A2400C minus A2400B is greater than 2 **and** A2100 is not = 03," and requested additional guidance as to when to complete the Section GG Discharge items.
    - To simplify, it may be helpful to remember that when a resident's Part A stay ends (i.e., the resident is "discharged" from Part A), the Section GG Discharge items are required to be completed unless the resident is being physically discharged from the facility and the discharge is:
        - an unplanned discharge,
        - a Part A stay that was less than three days, or
        - the resident is being discharged to an acute hospital.
    - This coding instruction is included on the MDS 3.0 item set to alert providers as to the circumstances under which the Section GG Discharge items are to be completed. Based on how **all** of these specific Section A items are coded, the Section GG Discharge items will either be active or not active on discharge.
    - The coding instruction is also included on the item set for providers who may be completing MDS 3.0 item sets on paper. It is important to remember that items

displayed on a paper item set contain all of the possible items that might be active depending on how other items are coded. For example, if an assessor codes an assessment that a resident is Comatose (B0100 = 1, Yes), then the person completing the assessment would skip several items, per instructions on the item set, and in the RAI Manual; yet the items that will be skipped still remain on the paper version of the item set.

- It is also important to note, that as long as the provider is using MDS computer software in which the vendor has incorporated the CMS data submission specifications or is using CMS' jRAVEN software to enter this data, the determination as to when items are active or not active on a specific item set are "invisible" to the provider. That is, the software, based on the submission specifications and how providers code certain items, would either display the Section GG Discharge items or not.

- When completing a standalone Part A PPS Discharge, Section GG items are to be completed when the Medicare Part A stay ends and the resident is remaining in the facility.

- If a resident is being physically discharged on the day of or one day after the end date of the most recent Medicare stay, both the Part A PPS Discharge and the OBRA Discharge are required but may be combined. When this occurs, the submission specifications will allow for the Section GG Discharge items to be completed.

SNF QRP Pressure Ulcer QM

- Regarding Section M items M0300 and M0800 for the SNF QRP Pressure Ulcer QM, providers need to be aware that nothing has changed in how the assessor is to complete these items. The difference is simply in how the measures are calculated for the different quality programs. For the Nursing Home Quality Initiative (NHQI), the Short-Stay version of the Pressure Ulcer QM is calculated using M0800. For the SNF QRP, the Pressure Ulcer QM is calculated using M0300.
    - Please refer to the *MDS 3.0 Quality Measure User's Manual* for the specifications related to the NHQI Short-Stay PU QM, available at: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/Downloads/MDS-30-QM-Users-Manual-V10.pdf

    - Please refer to the document titled, *Skilled Nursing Facility Quality Reporting Program - Specifications for Percent of Residents or Patients with Pressure Ulcers That are New or Worsened (NQF #0678)* for the specifications related to the SNF QRP Pressure Ulcer QM, available at: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/Downloads/SNF-QRP-Measure-Specifications_August-2016_updated-PU.docx

Resources:

- Training related to the SNF QRP is available on SNF Quality Reporting Program Training webpage
- For SNF Quality Reporting Program comments or questions: SNFQualityQuestions@cms.hhs.gov
- Sign up for the latest SNF QRP updates and announcements