"A ***Knowledgeable*** and ***Compassionate*** partner"

BROAD RIVER REHAB

PDPM Refresher Part 2: An Interdisciplinary Approach to Completing Section GG

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APPROVAL STATEMENT DISCLOSURE

- This nursing continuing professional development activity was approved by Broad River Rehab, an accredited approver by the American Nurses Credentialing Center's Commission on Accreditation.
- This course has been approved for 0.5 contact hours.

CONFLICT OF INTEREST DISCLOSURE

- Broad River Rehab is not charging for this educational offering and has no financial or other conflicts of interest regarding this program.

SUCCESSFUL COMPLETION REQUIREMENTS

- **Live, virtual**
  - In order to obtain nursing contact hours, you must participate in the entire program, participate in audience polling and/or Q&A and complete the evaluation.

DISCLOSURE OF THE EXPIRATION DATE FOR AWARDING CONTACT HOURS FOR ENDURING PROGRAMS

- Contact hours for this program will not be awarded after 1 week

PDPM Refresher Part 2: Section GG

Learning Objectives

- Understand Section GG coding principles
- Identify the IDT members who should be involved in accurate coding
- Describe the process of evaluating section GG data to arrive at an accurate "usual performance".
- Define the residual effects of section GG coding.

Resources

- Broad River Rehab Insiders™
- CMS PDPM Resource
- CMS MDS 3.0 page

The importance of section GG

- **CAAs and Care Plans**
  - Section GG is used is used as a Care Area Assessment (CAA) trigger for the following CAAs.
    - **CAA 5 –** ADL Functional/Rehabilitation Potential, **CAA 6** – Urinary Incontinence and Indwelling Catheter, **CAA 16** – Pressure Ulcer/Injury
  - Section GG is used is used as a means for further assessment in the following CAAs
    - **CAA 1 –** Delirium, **CAA 2** – Cognitive Loss/Dementia, **CAA 4** – Communication, **CAA 5** - ADL Functional/Rehabilitation Potential, **CAA 6** – Urinary Incontinence and Indwelling Catheter, **CAA 7** – Psychosocial Well-Being, **CAA 8** – Mood State, **CAA 10** – Activities, **CAA 11** – Falls, **CAA 12** – Nutritional Status, **CAA 14** – Dehydration/Fluid Maintenance, **CAA 15** – Dental Care, **CAA 16** – Pressure Ulcer/Injury, **CAA 17** – Psychotropic Medication Use, **CAA 18** – Physical Restraints, **CAA 19** – Pain, **CAA 20** – Return to Community Referral

The importance of section GG

- **Quality Measures**
  - Section GG is used either in the numerator and denominator and/or risk adjustment calculations in the following 5-star quality measures:
    - **Long Stay:** Percent of Residents Whose Need for Help with Activities of Daily Living Has Increased, Percent of Residents Whose Ability to Walk Independently Worsened, Percent of Residents With Pressure Ulcers, Percent of Residents With New or Worsened Bowel or Bladder Incontinence.
    - **Short Stay:** Discharge Function Score
    - **Staffing:** The Total Nursing Hours Per Resident Day, RN Hours Per Resident Day, and The Total Nursing Hours Per Resident Day on Weekend Days are all acuity adjusted by the case mix associated with the PDPM nursing category which relies on section GG items for accurate calculation.

The importance of section GG

- **PDPM**
  - Section GG is used in the rate setting calculations for PT, OT, and Nursing categories.
  - The GG function score determines a range of Case mix indexes that help determine resident acuity which contributes to how much the facility gets paid.

The importance of section GG

- **PDPM Physical Therapy Category**

PT Clinical Categories	Section GG Function Score	PT Case-Mix Group	PT Case-Mix Index	Urban Rate	Rural Rate
Major Joint Replacement or Spinal Surgery: (Major Joint Replacement or Spinal Surgery)	0-5	TA	1.45	$ 106.21	$ 121.08
	6-9	TB	1.61	$ 117.93	$ 134.44
	10-23	TC	1.78	$ 130.39	$ 148.63
	24	TD	1.81	$ 132.58	$ 151.14

The importance of section GG

- PDPM Nursing Category Special Care High

PDPM Nursing Case Mix Group	Clinical Condition/Extensive Service	Depression (PHQ-9 >= 10)	Restorative (2 or More)	GG Based Function Score	Nursing Case-Mix Index	Urban Rate	Rural Rate
HDE2	1. B0100, Section GG items Comatose and completely dependent or activity did not occur at admission (GG0130A1, GG0130C1, GG0170B1, GG0170C1, GG0170D1, GG0170E1, and GG0170F1, all equal 01, 09, or 88) 3. I2900, N0350A, B Diabetes with both of the following: Insulin injections (N0350A) for all 7 days insulin order changes on 2 or more days (N0350B)	Yes	-	0-5	2.27	$ 289.83	$ 276.92
HDE1	4. I5100, Quadriplegia with Nursing Function Score <= 11 6. J1550A, Fever and one of the following; I2000 Pneumonia J1550B Vomiting, K0300 Weight loss (1 or 2), K0520B2 or K0520B3 Feeding tube* **7. K0520A2 or K0520A3 Parenteral/IV feedings** 8. O0400D2 Respiratory therapy for all 7 days * **Tube feeding classification requirements:** (1) K0710A3 is 51% or more of total calories OR (2) K0710A3 is 26% to 50% of total calories and K0710B3 is 501 cc or more per day fluid enteral intake in the last 7 days.	No	-	0-5	1.88	$ 240.04	$ 229.34
HBC2		Yes	-	6-14	2.12	$ 270.68	$ 258.62
HBC1	(Note: if Nsg. function score is 15 or 16, skip to clinically complex)	No	-	6-14	1.76	$ 224.72	$ 214.70

GG The Basics

- **Rationale**
  - Residents may have self-care limitations on admission.
  - In addition, residents may be at risk of further functional decline during their stay in the facility.
  - Most nursing home residents need some physical assistance and are at risk of further physical decline. The amount of assistance needed and the risk of decline vary from resident to resident.
  - A wide range of physical, neurological, and psychological conditions and cognitive factors can adversely affect physical function.
  - Dependence on others for ADL assistance can lead to feelings of helplessness, isolation, diminished self-worth, and loss of control over one's destiny.
  - As inactivity increases, complications such as pressure ulcers, falls, contractures, depression, and muscle wasting may occur.

GG Steps for Assessment: General

- Assess the resident's self-care performance based on direct observation, incorporating resident self-reports and reports from qualified clinicians, care staff, or family
- **documented in the resident's medical record during the assessment period**.
- CMS anticipates that an **interdisciplinary team of qualified clinicians** is involved in assessing the resident during the assessment period.

GG Assessment Definitions

- **USUAL PERFORMANCE:**
  - A resident's functional status can be impacted by the environment or situations encountered at the facility.
  - Observing the resident's interactions with others in different locations and circumstances is important for a comprehensive understanding of the resident's functional status.
  - If the resident's functional status varies, record the resident's usual ability to perform each activity.
  - Do not record the resident's best performance and do not record the resident's worst performance but rather record the resident's usual performance.

GG Assessment Definitions

- **QUALIFIED CLINICIAN:**
  - Healthcare professionals practicing within their scope of practice and consistent with Federal, State, and local law and regulations.
- **PRIOR TO THE BENEFIT OF SERVICES:**
  - means prior to provision of any care by facility staff that would result in more independent coding.

GG General Coding Guidance

- Residents should be allowed to perform activities as independently as possible, as long as they are safe.
- 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). Consider only facility staff when scoring according to the amount of assistance provided.
- Activities may be completed with or without assistive device(s).
- For residents in a Medicare Part A stay, the admission functional assessment, when possible, should be conducted prior to the benefit of services in order to reflect the resident’s true admission baseline functional status.

GG General Coding Guidance

- When reviewing the medical record, interviewing staff, and observing the resident, be familiar with the definition for each activity
- An activity can be completed independently with or without devices.
- Documentation in the medical record is used to support assessment coding of Section GG. Data entered should be consistent with the clinical assessment documentation in the resident's medical record.
- Do not code self-care and mobility activities with use of a device that is restricted to resident use during therapy sessions (e.g., parallel bars, exoskeleton, or overhead track and harness systems).
- When coding the resident's usual performance, "effort" refers to the type and amount of assistance a helper provides in order for the activity to be completed.
- Code based on the resident's performance. Do not record the staff's assessment of the resident's potential capability to perform the activity.

GG Coding Instructions

- When coding the resident's usual performance, **use the six-point scale**, or use one of the four "activity was not attempted" codes to specify the reason why an activity was not attempted.
  - **Code 06**, **Independent**: if the resident completes the activity by themself 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/contact guard 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. The resident requires only verbal cueing to complete the activity safely.

GG Coding Instructions

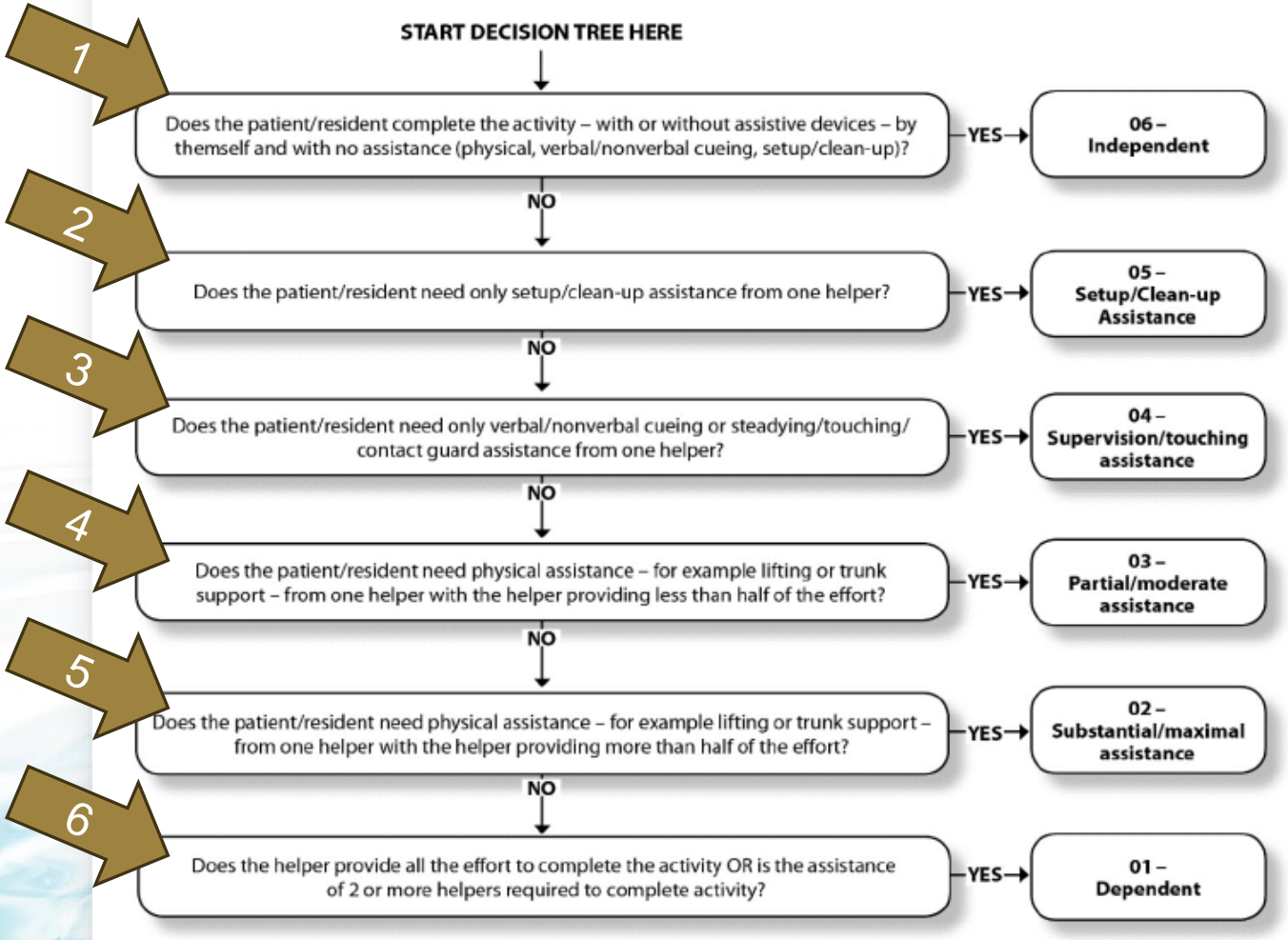
- When coding the resident's usual performance, **use the six-point scale**, or use one of the four "activity was not attempted" codes to specify the reason why an activity was not attempted.
  - **Code 03, Partial/moderate assistance**: if the helper does LESS THAN HALF the effort. Helper lifts, holds, 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 two helpers are required for the safe completion of an activity, even if the second helper provides supervision/stand-by assist only and does not end up needing to provide hands-on assistance.
    - if a resident requires the assistance of two helpers to complete an activity (one to provide support to the resident and a second to manage the necessary equipment to allow the activity to be completed).

GG Coding Instructions

- When coding the resident's usual performance, use the six-point scale, or use one of the four "**activity was not attempted" codes** to specify the reason why an activity was not attempted.
  - **Code 07, Resident refused**: if the resident refused to complete the activity.
  - **Code 09, Not applicable**: if the activity was not attempted and the resident did not perform this activity prior to the current illness, exacerbation, or injury.
  - **Code 10, Not attempted due to environmental limitations**: if the resident did not attempt this activity due to environmental limitations. Examples include lack of equipment and weather constraints.
  - **Code 88,** Not attempted due to medical condition or safety concerns: if the activity was not attempted due to medical condition or safety concerns.

Decision Tree

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



GG0130: Self-Care

1. Admission Performance Enter Codes in Boxes ↓		
X	X	A. **Eating:** The ability to use suitable utensils to bring food and/or liquid to the mouth and swallow food and/or liquid once the meal is placed before the resident. **CAA: 5**
X	X	B. **Oral hygiene:** The ability to use suitable items to clean teeth. Dentures (if applicable): The ability to insert and remove dentures into and from the mouth, and manage denture soaking and rinsing with use of equipment. **CAA: 5**
X	X	C. **Toileting hygiene:** The ability to maintain perineal hygiene, adjust clothes before and after voiding or having a bowel movement. If managing an ostomy, include wiping the opening but not managing equipment. **CAA: 5**
X	X	E. **Shower/bathe self:** The ability to bathe self, including washing, rinsing, and drying self (excludes washing of back and hair). Does not include transferring in/out of tub/shower. **CAA: 5**
X	X	F. **Upper body dressing:** The ability to dress and undress above the waist; including fasteners, if applicable. **CAA: 5**
X	X	G. **Lower body dressing:** The ability to dress and undress below the waist, including fasteners; does not include footwear. **CAA: 5**
X	X	H. **Putting on/taking off footwear:** The ability to put on and take off socks and shoes or other footwear that is appropriate for safe mobility; including fasteners, if applicable. **CAA: 5**
		I. **Personal hygiene:** The ability to maintain personal hygiene, including combing hair, shaving, applying makeup, washing/drying face and hands (excludes baths, showers, and oral hygiene). **CAA: 5**

GG Coding Tips

Eating:

O If the resident does not eat or drink by mouth and relies solely on nutrition and liquids through tube feedings or total parenteral nutrition (TPN) because of a new (recent-onset) medical condition, code GG0130A as 88, Not attempted due to medical condition or safety concerns.

O If the resident does not eat or drink by mouth at the time of the assessment, and the resident did not eat or drink by mouth prior to the current illness, injury, or exacerbation, code GG0130A as 09, Not applicable - Not attempted and the resident did not perform this activity prior to the current illness, exacerbation, or injury.

O If the resident eats and drinks by mouth, and relies partially on obtaining nutrition and liquids via tube feedings or parenteral nutrition, code Eating based on the amount of assistance the resident requires to eat and drink by mouth.

O Assistance with tube feedings or parenteral nutrition is not considered when coding the item Eating.

Toileting Hygiene:

O Toileting hygiene (managing clothing and perineal cleansing) takes place before and after use of the toilet, commode, bedpan, or urinal.

O If a resident manages an ostomy, toileting hygiene includes wiping the opening of the ostomy or colostomy bag, but not management of the equipment.

O If a resident has an indwelling catheter, toileting hygiene includes perineal hygiene to the indwelling catheter site, but not management of the equipment.

Upper body dressing, Lower body dressing, and Putting on/taking off footwear:

O Upper body dressing items used for coding include bra, undershirt, T-shirt, button-down shirt, pullover shirt, dresses, sweatshirt, sweater, nightgown (not hospital gown), and pajama top. Upper body dressing cannot be assessed based solely on donning/doffing a hospital gown, thoracic-lumbar-sacrum orthosis (TLSO), abdominal binder, back brace, stump sock/shrinker, upper body support device, neck support, hand or arm prosthetic/orthotic.

O Lower body dressing items used for coding include underwear, incontinence brief, slacks, shorts, capri pants, pajama bottoms, and skirts, knee brace, elastic bandage, stump sock/shrinker, lower-limb prosthesis.

O Footwear dressing items used for coding include socks, shoes, boots, and running shoes, ankle-foot orthosis (AFO), elastic bandages, foot orthotics, orthopedic walking boots, compression stockings (considered footwear because of dressing don/doff over foot).

GG0170: Mobility

1. Admission Performance		
Enter Codes in Boxes ↓		
X X	A.	**Roll left and right:** The ability to roll from lying on back to left and right side, and return to lying on back on the bed. **CAA: 5, *16**
X X	B.	**Sit to lying:** The ability to move from sitting on side of bed to lying flat on the bed. **CAA: 5, *16**
X X	C.	**Lying to sitting on side of bed:** The ability to move from lying on the back to sitting on the side of the bed and with no back support. **CAA: 5, *16**
X X	D.	**Sit to stand:** The ability to come to a standing position from sitting in a chair, wheelchair, or on the side of the bed. **CAA: 5**
X X	E.	**Chair/bed-to-chair transfer:** The ability to transfer to and from a bed to a chair (or wheelchair). **CAA: 5**
X X	F.	**Toilet transfer:** The ability to get on and off a toilet or commode. **CAA: 5**
	FF.	**Tub/shower transfer:** The ability to get in and out of a tub/shower. **CAA: 5**
X X	G.	**Car transfer:** The ability to transfer in and out of a car or van on the passenger side. Does not include the ability to open/close door or fasten seat belt.
X X	I.	**Walk 10 feet:** Once standing, the ability to walk at least 10 feet in a room, corridor, or similar space. If admission performance is coded 07, 09, 10, or 88 → Skip to GG0170M, 1 step (curb) **CAA: 5**
X X	J.	**Walk 50 feet with two turns:** Once standing, the ability to walk at least 50 feet and make two turns. **CAA: 5**
X X	K.	**Walk 150 feet:** Once standing, the ability to walk at least 150 feet in a corridor or similar space. **CAA: 5**

GG0170: Mobility

1. Admission Performance		
Enter Codes in Boxes ↓		
X	X	**L. Walking 10 feet on uneven surfaces:** The ability to walk 10 feet on uneven or sloping surfaces (indoor or outdoor), such as turf or gravel.
X	X	**M. 1 step (curb):** The ability to go up and down a curb and/or up and down one step. If admission performance is coded 07, 09, 10, or 88 → Skip to GG0170P, Picking up object
X	X	**N. 4 steps:** The ability to go up and down four steps with or without a rail. If admission performance is coded 07, 09, 10, or 88 → Skip to GG0170P, Picking up object
X	X	**O. 12 steps:** The ability to go up and down 12 steps with or without a rail.
X	X	**P. Picking up object:** The ability to bend/stoop from a standing position to pick up a small object, such as a spoon, from the floor.

Q1. Does the resident use a wheelchair and/or scooter?

☐
0. **No** → Skip to GG0130, Self Care (Discharge)
1. **Yes** → Continue to GG0170R, Wheel 50 feet with two turns

X	X	**R. Wheel 50 feet with two turns:** Once seated in wheelchair/scooter, the ability to wheel at least 50 feet and make two turns. **CAA: 5**

RR1. Indicate the type of wheelchair or scooter used.

☒
1. **Manual**
2. **Motorized**

X	X	**S. Wheel 150 feet:** Once seated in wheelchair/scooter, the ability to wheel at least 150 feet in a corridor or similar space. **CAA: 5**

SS1. Indicate the type of wheelchair or scooter used.

☒
1. **Manual**
2. **Motorized**

GG Coding Tips

Lying to Sitting on the Side of Bed:

O The activity includes resident transitions from lying on their back to sitting on the side of the bed without back support. The residents' ability to perform each of the tasks within this activity and how much support the residents require to complete the tasks within this activity is assessed.

Sit to Stand:

O If a sit-to-stand (stand assist) lift is used and two helpers are needed to assist with the sit-to-stand lift, then code as 01, Dependent.

O If a full-body mechanical lift is used to assist in transferring a resident for a chair/bed-to-chair transfer, code GG0170D, Sit to stand with the appropriate "activity not attempted" code.

O Code as 05, Setup or clean-up assistance, if the only help a resident requires to complete the sit-to-stand activity is for a helper to retrieve an assistive device or adaptive equipment, such as a walker or ankle-foot orthosis.

Chair/Bed to chair Transfer:

O If a mechanical lift is used to assist in transferring a resident for a chair/bed-to-chair transfer and two helpers are needed to assist with the mechanical lift transfer, then code as 01, Dependent, even if the resident assists with any part of the chair/bed-to-chair transfer.

Walking:

O A walking activity cannot be completed without some level of resident participation that allows resident ambulation to occur for the entire stated distance. A helper cannot complete a walking activity for a resident.

O During a walking activity, a resident may take a brief standing rest break. If the resident needs to sit to rest during a Section GG walking activity, consider the resident unable to complete the walking activity and use the appropriate activity not attempted code.

GG Coding Tips

Steps:

O If, at the time of the assessment, a resident is unable to complete the activity because of a physician-prescribed restriction of no stair climbing, they may be able to complete the stair activities safely by some other means (e.g., stair lift, bumping/scooting on their buttocks). If so, code based on the type and amount of assistance required to complete the activity.

O While a resident may take a break between ascending or descending the 4 steps or 12 steps, once they start the activity, they must be able to ascend (or descend) all the steps, by any safe means, without taking more than a brief rest break to consider the stair activity completed.

Wheelchair:

O The intent of the wheelchair mobility items is to assess the ability of residents who are learning how to self-mobilize using a wheelchair or who used a wheelchair for self-mobilization prior to admission. Use clinical judgment to determine whether a resident's use of a wheelchair is for self-mobilization as a result of the resident's medical condition or safety.

O If the resident used a wheelchair for self-mobilization prior to admission to the facility, indicate 1, Yes, to the gateway wheelchair items on the initial assessment.

O If a wheelchair is used for transport purposes only, then GG0170Q1, GG0170Q3, and/or GG0170Q5, Does the resident use a wheelchair or scooter? is coded as 0, No; then follow the skip pattern to continue coding the assessment.

GG Steps for Assessment: Timeframes

- For residents in a Medicare Part A stay, the admission assessment period is the first 3 days of the Part A stay starting with the date in **A2400B**, **the Start of Most Recent Medicare Stay**.
- The admission assessment period for residents who are not in a Medicare Part A stay is the first 3 days of their stay starting with the date in **A1600, Entry Date**.
- If A0310B = 01 and A0310A = 01 – 06 indicating a 5-day PPS assessment combined with an OBRA assessment, the assessment period is the first 3 days of the stay beginning on A2400B.

GG Steps for Assessment: Timeframes

- For residents in a Medicare Part A stay, the assessment period for the Interim Payment Assessment **(A0310B = 08)** is the last 3 days (i.e., the ARD plus 2 previous calendar days).
- For residents in a Medicare Part A stay, the discharge assessment period is the End Date of Most Recent Medicare Stay **(A2400C)** plus 2 previous calendar days.
- For all other Discharge assessments, the assessment period is **A2000**, Discharge Date plus 2 previous calendar days.

GG Steps for Assessment: Timeframes

- When completing an OBRA-required assessment other than an Admission assessment **(i.e., A0310A = 02 – 06),** the assessment period is the ARD plus 2 previous calendar days.

GG Practical IDT Approach (Example State Requirements)

- **Does require:**
- Documentation during the observation period to accurately capture resident usual performance.
- Initials and dates to authenticate the medical record entries including signatures and titles to authenticate initials per episode.
- The key for coding Section GG must include all the MDS options and be equivalent to the intent and definition of the MDS key.
- Key definitions must align with the definition in the RAI manual and must be available to the RN Reviewer and understood by facility staff.
- Self-Care and Mobility definitions must include all tasks and components related to the specific activity.

GG Practical IDT Approach (Example State Requirements)

- **Does require:**
- If using narrative notes to support Section GG, each occurrence must include the specific activity. Wording must be equivalent to MDS key definitions for example “The ability to use suitable utensils to bring food and/or liquid to the mouth and swallow food and/or liquid once the meal is placed before the resident”.
- Facilities utilizing one designated documentation collection tool should note corrections or references to additional documentation on that tool.
- During the IDT meeting, facilities should determine usual performance based on the data gathered, document the IDT decision, and enter into the medical record.
- All documentation to be considered for the review must be clearly identified and presented to the reviewer in an organized manner representing how the usual performance was determined.
- Documentation must be maintained as part of the permanent original legal medical record and be readily accessible during the review.

GG Practical IDT Approach (Example State Requirements)

- **Does NOT include:**
- Individuals hired, compensated or not, by individuals outside the facility's management and administration.
- Services provided other than by staff in the facility; such as family, hospice staff, nursing/CNA students and other visitors.

GG Practical IDT Approach (Example Resource)

Section GG – Functional Abilities

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BIG IDEA #1 - Code based on the resident's performance and do not record the staff assessment of the resident's capability to perform the activity – do ask questions of the resident, staff and family to get the whole picture

BIG IDEA #2 - Do not code the best nor the worst level of performance, instead code the usual level of performance

BIG IDEA #3 - If the activity requires a 2 person assist – code DEPENDENT

Coding Definitions

- **Code 06, Independent:** if the resident completes the activity by him/herself with no assistance from a helper.

You know activity was done, but resident did it completely by self and no supervision for completion or safety required.

- **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). *You set up items for the activity but did not have to stay during it to provide supervision for completion or safety or You set up items for the activity but did not stay and after activity was completed, you returned and cleaned up items from activity or Resident performed activity completely by self, but you cleaned up items after resident finished.*

GG Practical IDT Approach (Example Resource)

Self-Care Activities

Eating ($$ CATs QM ★ QRP VBP): The ability to use suitable utensils to bring food and/or liquid to the mouth and swallow food and/or liquid once the meal is presented on a table/tray. Includes modified food consistency. Clinicians may code the eating item using the appropriate response codes if the resident eats using his/her hands rather than using utensils (e.g., can feed himself/herself using finger foods).

Oral hygiene ($$ CATs QM ★ QRP VBP): The ability to use suitable items to clean teeth. [Dentures (if applicable): The ability to insert and remove dentures into and from the mouth, and manage denture soaking and rinsing with use of equipment.]

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

Shower/bathe self (CATs QRP): The ability to bathe self, including washing, rinsing, and drying self (excludes washing of back and hair). Does not include transferring in/out of tub/shower.

Upper body dressing (CATs QRP): The ability to dress and undress above the waist; including fasteners, if applicable.

Lower body dressing (CATs QRP): The ability to dress and undress below the waist; including fasteners, does not include footwear. **Putting on/taking off footwear** (CATs QRP): The ability to put on and take off socks and shoes or other footwear that is appropriate for safe mobility; including fasteners, if applicable.

Personal hygiene (CATs): The ability to maintain personal hygiene, including combing hair, shaving, applying makeup, washing/drying face and hands (excludes baths, showers, and oral hygiene).

GG Practical IDT Approach (Example Resource)

BROAD RIVER REHAB

Resident Name: _____ **MDS ARD:** _____ **Code Date:**

Coding:

Safety & Quality 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 helper.

05. SETUP or CLEAN-UP ASSISTANCE:
Helper sets up or cleans up; resident completes activity. Helper **ASSIST ONLY PRIOR TO or FOLLOWING ACTIVITY**.

04. SUPERVISION or TOUCHING ASSIST:
Helper provides **VERBAL CUES &/or TOUCHING/STEADYING &/or CONTACTGUARD ASSISTANCE** as resident completes the activity. Assistance may be provided throughout the activity or intermittently.

03. PARTIAL/MODERATE ASSISTANCE:
Helper does **LESS THAN HALF** the effort. Helper **LIFTS or HOLDS trunk or limbs but provides LESS THAN HALF the effort.**

02. SUBSTANTIAL/MAX ASSISTANCE:
Helper does **MORE THAN HALF** the effort. Helper **LIFTS or HOLDS trunk or limbs & provides MORE THAN HALF the effort.**

01.DEPENDENT:
Helper does **ALL the effort.** Resident does none of the effort to complete the activity OR **THE ASSISTANCE OF 2 or MORE helpers required** for the resident to complete the activity.
*

If activity not attempted, code reason:

07. RESIDENT REFUSED:
09. NOT APPLICABLE: Not attempted & resident did not perform activity prior to the current illness, excaerbation, or injury.
10. NOT ATTEMPTED DUE TO ENVIRONMENTAL LIMITATIONS: (eg lack of equipment, weather conditions)
88. NOT ATTEMPTED DUE TO MEDICAL CONDITION or SAFETY CONCERNS

Section GG items	Code	Code	Code
Eating			
Oral Hygiene			
Toileting Hygiene			
Shower/Bathe Self			
Upper Body Dressing			
lower Body Dressing			
Putting on taking off footwear			
Personal Hygiene			
Roll Left and right			
Sit to lying			

By my signature, I am attesting that this information is based on direct patient observation, patient self-report, and interviews with direct care staff who have been assisting patient with ADLs since patient's admission to this facility.

Next Steps

- Remember how influential section GG is, for example: GG0130A **Eating (**$$ CATs QM ★ QRP VBP).
- The IDT approach to coding section GG is mandated in the RAI Manual. A one-person or one discipline approach is incorrect and can lead to inaccurate coding.
- Involve multiple IDT members.
- Keep all IDT member who contribute up to date. Regular education is a must.
- Don’t burden documentation contributors with the definition of Usual Performance. Coding definitions will suffice.
- Ask questions. Don’t accept coding that does not reflect an accurate representation of the level of helper assistance that the resident needs.
- Documentation is key to support the care provided.

Questions?

Don’t Forget!

2025 BRR Reflections

- **July 21st** - BRR Reflections – PDPM Refresher Part 3: The PHQ 2 to 9

2025 BRR Insiders™ Summer Series (CMS 100-2 Chapter 8 Refresher)

All sessions are from 12:00 pm – 21:30 pm EST, 0.5 hours NAB and ANCC

- **July 11th** – Physician Certification and Recertification requirements (Dr. Gwen Pointer)
- **July 25th** – Denial of Payment for New Admissions Criteria (Joel VanEaton)
- **August 8th** – Consolidated Billing (Joel VanEaton)
- **August 22nd** – Direct Nursing Skilled Services and Indirect Nursing Skilled Services (Amy Garrison)