PROPRIETARY STATEMENT

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compliance@htstherapy.com

Section GG Function Score Quick Tips

Section GG Functional Abilities

- CMS anticipates that an interdisciplinary team of qualified clinicians is involved in assessing the resident during the three-day assessment period.
- 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.
- The admission function scores are to reflect the resident's admission baseline status and are to be based on an assessment. The scores should reflect the resident's status prior to any benefit from interventions. The assessment should occur, when possible, prior to the resident benefitting from treatment interventions in order to determine the resident's true admission baseline status.
- Refer to facility, Federal, and State policies and procedures to determine which staff members may complete an assessment. Resident assessments are to be done in compliance with facility, Federal, and State requirements.

Assessment & Documentation Quick Tips

1. Familiarize staff with the definition for each activity
2. Assessment Performance:
    a. Include direct observations
    b. Incorporate resident self-reports and reports from qualified clinicians, care staff, or family documented in the resident's medical record during the three-day assessment period
3. An IDT of qualified clinicians is involved in assessing the resident during the 3-day assessment period
4. Allow the resident to perform the activity as independently as possible, as long as they are safe
5. Activities may be completed with or without assistive device(s)
6. Do not record staff's assessment of resident's potential capability to perform the activity
7. If the resident does not attempt the activity and helper does not complete the activity for resident during the entire assessment period, code 07, 09, 10, or 88
8. Code 09 only if the activity did not occur at the time of the assessment and prior to the current illness, injury, or exacerbation (PLOF)
9. If two or more helpers are required to assist resident to complete activity, code as 01, Dependent
10. MDS data entered should be consistent with clinical assessment documentation in the resident's medical record
11. A dash (-) indicates "No information." CMS expects dash use to be a rare occurrence
12. Document IDT note to support coding decisions during the ARD look-back period, or no later than MDS completion date

Examples: Documentation to Support IDT Collaboration

1. IDT, consisting of nursing, MDS, therapy and SS met this date and reviewed usual performance for Section GG self-care and mobility items based on nursing and therapy direct observation during first 3 days of stay. Resident and direct care staff interviews (see NN 10/27 by MDS) were also incorporated. Refer to Initial Medicare Assessment for final coding decisions.

2. IDT, consisting of nursing, MDS, & therapy met & reviewed self-care and mobility usual performance during first 3 days of stay. Based on nursing and therapy assessments documented in the assessment period, team determined usual performance for Section GG coding of initial MDS assessment.

MDS ASSESSMENT PERIODS		
Admission Performance	**Interim Performance**	**Discharge Performance**
Medicare Part A (5 day): First 3 calendar days of the Medicare stay based on Medicare start day as coded in A2400B	Medicare Part A (IPA): ARD and 2 days prior. Reported on the Interim Payment Assessment.	PPS Discharge (NPE): Last 3 days of the Medicare Part A stay. A2400C and the 2 previous calendar days.
OBRA Admission: First 3 calendar days of the stay based on the date of entry/reentry as coded in A1600	OBRA: Required assessment: ARD and 2 days prior. Reported on the Quarterly, Annual, and Significant Change in Status Assessments.	OBRA Discharge: Last 3 days of the stay. OBRA discharge date (A2000) and the 2 previous calendar days

Center for Medicare and Medicaid Services. (2023). MDS 3.0 RAI Manual. https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/MDS30RAIManual.html

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