Patient Tracking Sheet

(M0010) CMS Certification Number: __ __ __ __ __ __

(M0014) Branch State: __ __

(M0016) Branch ID Number: __ __ __ __ __ __ __ __ __ __

(M0018) National Provider Identifier (NPI) for the attending physician who has signed the plan of care:
__ __ __ __ __ __ __ __ __ __ ☐ **UK - Unknown or Not Available**

(M0020) Patient ID Number: __

(M0030) Start of Care Date: __ __ / __ __ /__ __ __ __
month day year

(M0032) Resumption of Care Date: __ __ / __ __ /__ __ __ __ ☐ **NA - Not Applicable**
month day year

(M0040) Patient Name: __
(First) (MI)
__ __
(Last) (Suffix)

(M0050) Patient State of Residence: __ __

(M0060) Patient Zip Code: __ __ __ __ __ - __ __ __ __

(M0063) Medicare Number: __ __ __ __ __ __ __ __ __ __ __ __ (including suffix) ☐ **NA - No Medicare**

(M0064) Social Security Number: __ __ __ - __ __ - __ __ __ __ ☐ **UK - Unknown or Not Available**

(M0065) Medicaid Number: __ __ __ __ __ __ __ __ __ __ __ __ __ __ ☐ **NA - No Medicaid**

(M0066) Birth Date: __ __ /__ __ /__ __ __ __
month day year

(M0069) Gender:

Enter Code	
☐	1-Male 2-Female

(M0140) Race/Ethnicity: (Mark all that apply)
- ☐ 1 - American Indian or Alaska Native
- ☐ 2 - Asian
- ☐ 3 - Black or African-American
- ☐ 4 - Hispanic or Latino
- ☐ 5 - Native Hawaiian or Pacific Islander
- ☐ 6 – White

(M0150) Current Payment Sources for Home Care: (Mark all that apply)
- ☐ 0 - None; no charge for current services
- ☐ 1 - Medicare (traditional fee-for-service)
- ☐ 2 - Medicare (HMO/managed care/Advantage plan)
- ☐ 3 - Medicaid (traditional fee-for-service)
- ☐ 4 - Medicaid (HMO/managed care)
- ☐ 5 - Workers' compensation
- ☐ 6 - Title programs (e.g., Title III, V, or XX)
- ☐ 7 - Other government (e.g., TriCare, VA, etc.)
- ☐ 8 - Private insurance
- ☐ 9 - Private HMO/managed care
- ☐ 10 - Self-pay
- ☐ 11 - Other (specify)_____
- ☐ UK – Unknown

Clinical Record Items

(M0080) Discipline of Person Completing Assessment:

Enter Code	
☐	1 – RN 2 – PT 3 – SLP/ST 4 – OT

(M0090) Date Assessment Completed: __ __ / __ __ / __ __ __ __
month day year

(M0100) This Assessment is Currently Being Completed for the Following Reason: Follow-Up

Enter Code	
☐	4 – Recertification (follow-up) reassessment ***[Go to M0110]*** 5 – Other follow-up ***[Go to M0110]***

(M0110) Episode Timing: Is the Medicare home health payment episode for which this assessment will define a case mix group an "early" episode or a "later" episode in the patient's current sequence of adjacent Medicare home health payment episodes?

Enter Code	
☐	1 – Early 2 – Later UK – Unknown NA – Not Applicable: No Medicare case mix group to be defined by this assessment.

Patient History and Diagnoses

(M1011) List each **Inpatient Diagnosis** and ICD-10-CM code at the level of highest specificity for only those conditions actively treated during an inpatient stay having a discharge date within the last 14 days (no V, W, X, Y, or Z codes or surgical codes):

	Inpatient Facility Diagnosis	**ICD-10-CM Code**
a.	_____	___ ___ ___ • ___ ___ ___ ___
b.	_____	___ ___ ___ • ___ ___ ___ ___
c.	_____	___ ___ ___ • ___ ___ ___ ___
d.	_____	___ ___ ___ • ___ ___ ___ ___
e.	_____	___ ___ ___ • ___ ___ ___ ___
f.	_____	___ ___ ___ • ___ ___ ___ ___

☐ NA - Not applicable (patient was not discharged from an inpatient facility)

(M1021/M1023/M1025) Diagnoses, Symptom Control, and Optional Diagnoses: List each diagnosis for which the patient is receiving home care in Column 1, and enter its ICD-10-CM code at the level of highest specificity in Column 2 (diagnosis codes only – no surgical or procedure codes allowed). Diagnoses are listed in the order that best reflects the seriousness of each condition and supports the disciplines and services provided. Rate the degree of symptom control for each condition in Column 2. ICD-10-CM sequencing requirements must be followed if multiple coding is indicated for any diagnoses. If a Z-code is reported in Column 2 in place of a diagnosis that is no longer active (a resolved condition), then optional item M1025 (Optional Diagnoses – Columns 3 and 4) may be completed. Diagnoses reported in M1025 will not impact payment.

Code each row according to the following directions for each column:

Column 1: Enter the description of the diagnosis. Sequencing of diagnoses should reflect the seriousness of each condition and support the disciplines and services provided.

Column 2: Enter the ICD-10-CM code for the condition described in column 1 – no surgical or procedure codes allowed. Codes must be entered at the level of highest specificity and ICD-10-CM coding rules and sequencing requirements must be followed. Note that external cause codes (ICD-10-CM codes beginning with V, W, X, or Y) may not be report in M1021 (Primary Diagnosis) but may be reported in M1023 (Secondary Diagnoses). Also note that when a Z-code is reported in Column 2, the code for the underlying condition can often be entered in Column 2, as long as it is an active on-going condition impacting home health care.

Rate the degree of symptom control for the condition listed in Column 1. Do not assign a symptom control rating if the diagnosis code is a V, W, X, Y or Z-code. Choose one value that represents the degree of symptom control appropriate for each diagnosis using the following scale:

0 - Asymptomatic, no treatment needed at this time
1 - Symptoms well controlled with current therapy
2 - Symptoms controlled with difficulty, affecting daily functioning; patient needs ongoing monitoring
3 - Symptoms poorly controlled; patient needs frequent adjustment in treatment and dose monitoring
4 - Symptoms poorly controlled; history of re-hospitalizations

Note that the rating for symptom control for the condition listed in Column 2 should not be used to determine the sequencing of the diagnoses listed in Column 1. These are separate items and sequencing may not coincide.

Column 3: (OPTIONAL) There is no requirement that HHAs enter a diagnosis code in M1025 (Columns 3 and 4). Diagnoses reported in M1025 will not impact payment. Agencies may choose to report an underlying condition in M1025 (Columns 3 and 4) when:

- A Z-code is reported in Column 2 AND
- The underlying condition for the Z-code in Column 2 is a resolved condition. An example of a resolved condition is uterine cancer that is no longer being treated following a hysterectomy.

Column 4: (OPTIONAL) If a Z-code is reported in M1021/M1023 (Column 2) and the agency chooses to report a resolved underlying condition that requires multiple diagnosis codes under ICD-10-CM coding guidelines, enter the diagnosis descriptions and the ICD-10-CM codes in the same row in Columns 3 and 4. For example, if the resolved condition is a manifestation code, record the diagnosis description and ICD-10-CM code for the underlying condition in Column 3 of that row and the diagnosis description and ICD-10-CM code for the manifestation in Column 4 of that row. Otherwise leave Column 4 blank in that row.

(M1021) PRIMARY DIAGNOSIS & (M1023) OTHER DIAGNOSES		(M1025) PAYMENT DIAGNOSES (OPTIONAL)	
Column 1	Column 2	Column 3	Column 4
Diagnoses (Sequencing of diagnoses should reflect the seriousness of each condition and support the disciplines and services provided.)	ICD-10-CM and symptom control rating for each condition. Note that the sequencing of these ratings may not match the sequencing of the diagnoses.	May be completed if a Z-code is assigned to Column 2 and the underlying diagnosis is resolved	Complete **only if** the Optional Diagnosis is a multiple coding situation (for example: a manifestation code).
Description	**ICD-10-CM/ Symptom Control Rating**	**Description /ICD-9-CM**	**Description /ICD-9-CM**
(M1021) Primary Diagnosis a._____	**V, W, X, Y codes NOT allowed** a. ___ ___ ___•___ ___ ___ ___ ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4	**V, W, X, Y, Z codes NOT allowed** a. _____ ___ ___ ___•___ ___ ___ ___	**V, W, X, Y, Z codes NOT allowed** a. _____ ___ ___ ___•___ ___ ___ ___
(M1023) Other Diagnoses b._____	**All ICD-10-CM codes allowed** b. ___ ___ ___•___ ___ ___ ___ ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4	**V, W, X, Y, Z codes NOT allowed** b. _____ ___ ___ ___•___ ___ ___ ___	**V, W, X, Y, Z codes NOT allowed** b. _____ ___ ___ ___•___ ___ ___ ___
c._____	c. ___ ___ ___•___ ___ ___ ___ ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4	c. _____ ___ ___ ___•___ ___ ___ ___	c. _____ ___ ___ ___•___ ___ ___ ___
d._____	d. ___ ___ ___•___ ___ ___ ___ ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4	d. _____ ___ ___ ___•___ ___ ___ ___	d. _____ ___ ___ ___•___ ___ ___ ___
e._____	e. ___ ___ ___•___ ___ ___ ___ ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4	e. _____ ___ ___ ___•___ ___ ___ ___	e. _____ ___ ___ ___•___ ___ ___ ___
f._____	f. ___ ___ ___•___ ___ ___ ___ ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4	f. _____ ___ ___ ___•___ ___ ___ ___	f. _____ ___ ___ ___•___ ___ ___ ___

(M1030) Therapies the patient receives at home: **(Mark all that apply)**

☐ 1 – Intravenous or infusion therapy (excludes TPN)
☐ 2 – Parenteral nutrition (TPN or lipids)
☐ 3 – Enteral nutrition (nasogastric, gastrostomy, jejunostomy, or any other artificial entry into the alimentary canal)
☐ 4 – None of the above

Sensory Status

(M1200) Vision (with corrective lenses if the patient usually wears them):

Enter Code	
☐	0 - Normal vision: sees adequately in most situations; can see medication labels, newsprint. 1 - Partially impaired: cannot see medication labels or newsprint, but can see obstacles in path, and the surrounding layout; can count fingers at arm's length. 2 - Severely impaired: cannot locate objects without hearing or touching them or patient nonresponsive.

(M1242) Frequency of Pain Interfering with patient's activity or movement:

Enter Code	
☐	0 – Patient has no pain 1 – Patient has pain that does not interfere with activity or movement 2 – Less often than daily 3 – Daily, but not constantly 4 – All of the time

Integumentary Status

(M1306) Does this patient have at least one **Unhealed Pressure Ulcer at Stage 2 or Higher** or designated as Unstageable? (Excludes Stage 1 pressure ulcers and healed Stage 2 pressure ulcers)

Enter Code	
☐	0 – No ***[Go to M1322]*** 1 – Yes

(M1311) Current Number of Unhealed Pressure Ulcers at Each Stage:	Enter Number
A1. Stage 2: Partial thickness loss of dermis presenting as a shallow open ulcer with red pink wound bed, without slough, May also present as an intact or open/ruptured blister. **Number of Stage 2 pressure ulcers** [If 0 Go to M1311B1]	☐
A2. Number of these Stage 2 pressure ulcers that were present at most recent SOC/ROC - enter how many were noted at the time of most recent SOC/ROC	☐
B1. Stage 3: Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon, or muscle is not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling. **Number of Stage 3 pressure ulcers** [If 0 Go to M1311C1]	☐
B2. Number of these Stage 3 pressure ulcers that were present at most recent SOC/ROC - enter how many were noted at the time of most recent SOC/ROC	☐
C1. Stage 4: Full thickness tissue loss with exposed bone, tendon, or muscle. Slough or eschar may be present on some parts of the wound bed. Often includes undermining and tunneling. **Number of Stage 4 pressure ulcers** [If 0 Go to M1311D1]	☐
C2. Number of these Stage 4 pressure ulcers that were present at most recent SOC/ROC - enter how many were noted at the time of most recent SOC/ROC	☐
D1. Unstageable: Non-removable dressing: Known but not stageable due to non-removable dressing/device. **Number of unstageable pressure ulcers due to non-removable dressing/device** [If 0 Go to M1311E1]	☐
D2. Number of these unstageable pressure ulcers that were present at most recent SOC/ROC - enter how many were noted at the time of most recent SOC/ROC	☐
E1. Unstageable: Slough and/or eschar: Known but not stageable due to coverage of wound bed by slough and/or eschar **Number of unstageable pressure ulcers due to coverage of wound bed by slough and/or eschar** [If 0 Go to M1311F1]	☐
E2. Number of these unstageable pressure ulcers that were present at most recent SOC/ROC - enter how many were noted at the time of most recent SOC/ROC	☐
F1. Unstageable: Deep tissue injury: Suspected deep tissue injury in evolution **Number of unstageable pressure ulcers with suspected deep tissue injury in evolution** [If 0 - Go to M1322]	☐
F2. Number of these unstageable pressure ulcers that were present at most recent SOC/ROC - enter how many were noted at the time of most recent SOC/ROC	☐

(M1322) Current Number of Stage 1 Pressure Ulcers: Intact skin with non-blanchable redness of a localized area usually over a bony prominence. The area may be painful, firm, soft, warmer or cooler as compared to adjacent tissue.

Enter Code	
☐	0 1 2 3 4 or more

(M1324) Stage of Most Problematic Unhealed Pressure Ulcer that is Stageable: (Excludes pressure ulcer that cannot be staged due to a non-removable dressing/device, coverage of wound bed by slough and/or eschar, or suspected deep tissue injury.)

Enter Code	
☐	1 – Stage 1 2 – Stage 2 3 – Stage 3 4 – Stage 4 NA – Patient has no pressure ulcers or no stageable pressure ulcers

(M1330) Does this patient have a **Stasis Ulcer**?

Enter Code	
☐	0 – No ***[Go to M1340]*** 1 – Yes, patient has BOTH observable and unobservable stasis ulcers 2 – Yes, patient has observable stasis ulcers ONLY 3 – Yes, patient has unobservable stasis ulcers ONLY (known but not observable due to non-removable dressing/device) ***[Go to M1340]***

(M1332) Current Number of Stasis Ulcer(s) that are Observable:

Enter Code	
☐	1 – One 2 – Two 3 - Three 4 - Four or more

(M1334) Status of Most Problematic (Observable) Stasis Ulcer:

Enter Code	
☐	1 – Fully granulating 2 – Early / partial granulation 3 – Not healing

(M1340) Does this patient have a **Surgical Wound**?

Enter Code	
☐	0 – No ***[Go to M1400]*** 1 – Yes, patient has at least one observable surgical wound 2 – Surgical wound known but not observable due to non-removable dressing/device ***[Go to M1400]***

(M1342) Status of Most Problematic Surgical Wound that is Observable:

Enter Code	
☐	0 – Newly epithelialized 1 – Fully granulating 2 – Early / partial granulation 3 – Not healing

Respiratory Status

(M1400) When is the patient dyspneic or noticeably **Short of Breath?**

Enter Code	
☐	0 – Patient is not short of breath 1 – When walking more than 20 feet, climbing stairs 2 – With moderate exertion (for example, while dressing, using commode or bedpan, walking distances less than 20 feet) 3 – With minimal exertion (for example, while eating, talking, or performing other ADLs) or with agitation 4 – At rest (during day or night)

Elimination Status

(M1610) Urinary Incontinence or Urinary Catheter Presence:

Enter Code	
☐	0 - No incontinence or catheter (includes anuria or ostomy for urinary drainage) ***[Go to M1620]*** 1 - Patient is incontinent 2 - Patient requires a urinary catheter (specifically, external, indwelling, intermittent, suprapubic) ***[Go to M1620]***

(M1620) Bowel Incontinence Frequency:

Enter Code	
☐	0 - Very rarely or never has bowel incontinence 1 - Less than once weekly 2 - One to three times weekly 3 - Four to six times weekly 4 - On a daily basis 5 - More often than once daily NA - Patient has ostomy for bowel elimination UK - Unknown

(M1630) Ostomy for Bowel Elimination: Does this patient have an ostomy for bowel elimination that (within the last 14 days): a) was related to an inpatient facility stay; or b) necessitated a change in medical or treatment regimen?

Enter Code	
☐	0 - Patient does not have an ostomy for bowel elimination. 1 - Patient's ostomy was not related to an inpatient stay and did not necessitate change in medical or treatment regimen. 2 - The ostomy was related to an inpatient stay or did necessitate change in medical or treatment regimen.

ADL/IADLs

(M1810) Current **Ability to Dress Upper Body** safely (with or without dressing aids) including undergarments, pullovers, front-opening shirts and blouses, managing zippers, buttons, and snaps:

Enter Code	
☐	0 - Able to get clothes out of closets and drawers, put them on and remove them from the upper body without assistance. 1 - Able to dress upper body without assistance if clothing is laid out or handed to the patient. 2 - Someone must help the patient put on upper body clothing. 3 - Patient depends entirely upon another person to dress the upper body.

(M1820) Current **Ability to Dress Lower Body** safely (with or without dressing aids) including undergarments, slacks, socks or nylons, shoes:

Enter Code	
☐	0 - Able to obtain, put on, and remove clothing and shoes without assistance. 1 - Able to dress lower body without assistance if clothing and shoes are laid out or handed to the patient. 2 - Someone must help the patient put on undergarments, slacks, socks or nylons, and shoes. 3 - Patient depends entirely upon another person to dress lower body

(M1830) Bathing: Current ability to wash entire body safely. **Excludes grooming (washing face, washing hands, and shampooing hair).**

Enter Code	
☐	0 - Able to bathe self in shower or tub independently, including getting in and out of tub/shower. 1 - With the use of devices, is able to bathe self in shower or tub independently, including getting in and out of the tub/shower. 2 - Able to bathe in shower or tub with the intermittent assistance of another person: (a) for intermittent supervision or encouragement or reminders, OR (b) to get in and out of the shower or tub, OR (c) for washing difficult to reach areas. 3 - Able to participate in bathing self in shower or tub, but requires presence of another person throughout the bath for assistance or supervision. 4 - Unable to use the shower or tub, but able to bathe self independently with or without the use of devices at the sink, in chair, or on commode. 5 - Unable to use the shower or tub, but able to participate in bathing self in bed, at the sink, in bedside chair, or on commode, with the assistance or supervision of another person. 6 - Unable to participate effectively in bathing and is bathed totally by another person.

(M1840) Toilet Transferring: Current ability to get to and from the toilet or bedside commode safely and transfer on and off toilet/commode.

Enter Code	
☐	0 - Able to get to and from the toilet and transfer independently with or without a device. 1 - When reminded, assisted, or supervised by another person, able to get to and from the toilet and transfer. 2 - Unable to get to and from the toilet but is able to use a bedside commode (with or without assistance). 3 - Unable to get to and from the toilet or bedside commode but is able to use a bedpan/urinal independently. 4 - Is totally dependent in toileting.

(M1850) Transferring: Current ability to move safely from bed to chair, or ability to turn and position self in bed if patient is bedfast.

Enter Code	
☐	0 - Able to independently transfer. 1 - Able to transfer with minimal human assistance or with use of an assistive device. 2 - Able to bear weight and pivot during the transfer process but unable to transfer self. 3 - Unable to transfer self and is unable to bear weight or pivot when transferred by another person. 4 - Bedfast, unable to transfer but is able to turn and position self in bed. 5 - Bedfast, unable to transfer and is unable to turn and position self.

(M1860) Ambulation/Locomotion: Current ability to walk safely, once in a standing position, or use a wheelchair, once in a seated position, on a variety of surfaces.

Enter Code	
☐	0 - Able to independently walk on even and uneven surfaces and negotiate stairs with or without railings (specifically, needs no human assistance or assistive device). 1 - With the use of a one-handed device (for example, cane, single crutch, hemi-walker), able to independently walk on even and uneven surfaces and negotiate stairs with or without railings. 2 - Requires use of a two-handed device (for example, walker or crutches) to walk alone on a level surface and/or requires human supervision or assistance to negotiate stairs or steps or uneven surfaces. 3 - Able to walk only with the supervision or assistance of another person at all times. 4 - Chairfast, unable to ambulate but is able to wheel self independently. 5 - Chairfast, unable to ambulate and is unable to wheel self. 6 - Bedfast, unable to ambulate or be up in a chair.

(M2030) Management of Injectable Medications: Patient's current ability to prepare and take all prescribed injectable medications reliably and safely, including administration of correct dosage at the appropriate times/intervals. **Excludes IV medications.**

Enter Code	
☐	0 - Able to independently take the correct medication(s) and proper dosage(s) at the correct times. 1 - Able to take injectable medication(s) at the correct times if: (a) individual syringes are prepared in advance by another person; OR (b) another person develops a drug diary or chart. 2 - Able to take medication(s) at the correct times if given reminders by another person based on the frequency of the injection 3 - Unable to take injectable medication unless administered by another person. NA - No injectable medications prescribed

Therapy Need and Plan of Care

(M2200) Therapy Need: In the home health plan of care for the Medicare payment episode for which this assessment will define a case mix group, what is the indicated need for therapy visits (total of reasonable and necessary physical, occupational, and speech-language pathology visits combined)? **(Enter zero ["000"] if no therapy visits indicated.)**

(☐☐☐) Number of therapy visits indicated (total of physical, occupational and speech-language pathology combined).

☐ NA - Not applicable: No case mix group defined by this assessment.

Section GG: Functional Abilities and Goals

(GG0130) Self-Care

Code the patient's usual performance at Follow-Up for each activity using the 6-point scale. If activity was not attempted at Follow-Up, code the reason.

Coding:

Safety and **Quality of Performance** - If helper assistance is required because patient'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 -** Patient completes the activity by him/herself with no assistance from a helper.
05. **Setup or clean-up assistance -** Helper sets up or cleans up; patient completes activity. Helper assists only prior to or following the activity.
04. **Supervision or touching assistance -** Helper provides verbal cues and/or touching/steadying and/or contact guard assistance as patient 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 the effort. Patient does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the patient to complete the activity.

If the activity was not attempted, code reason:

07. **Patient refused.**
09. **Not applicable -** Not attempted and the patient did not perform this activity prior to the current illness, exacerbation or injury.
10. **Not attempted due to environmental limitations** (e.g., lack of equipment, weather constraints)
88. **Not attempted due to medical conditions or safety concerns**

4. Follow-Up Performance	
Enter Codes in Boxes	
☐☐	**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 patient.
☐☐	**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
☐☐	**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.

(GG0170) Mobility

Code the patient's usual performance at Follow-Up for each activity using the 6-point scale. If activity was not attempted at Follow-Up, code the reason.

Coding:

Safety and **Quality of Performance** - If helper assistance is required because patient'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 -** Patient completes the activity by him/herself with no assistance from a helper.
05. **Setup or clean-up assistance -** Helper sets up or cleans up; patient completes activity. Helper assists only prior to or following the activity.
04. **Supervision or touching assistance -** Helper provides verbal cues and/or touching/steadying and/or contact guard assistance as patient 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 the effort. Patient does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the patient to complete the activity.

If the activity was not attempted, code reason:

07. **Patient refused.**
09. **Not applicable -** Not attempted and the patient did not perform this activity prior to the current illness, exacerbation or injury.
10. **Not attempted due to environmental limitations** (e.g., lack of equipment, weather constraints)
88. **Not attempted due to medical conditions or safety concerns**

4. Follow-Up Performance	
Enter Codes in Boxes	
☐☐	**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.
☐☐	**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 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 come to a standing position from sitting in a chair, wheelchair, or on the side of the bed.
☐☐	**E. Chair/bed-to-chair transfer:** The ability to transfer to and from a bed to a chair (or wheelchair).
☐☐	**F. Toilet transfer:** The ability to get on and off a toilet or commode.
☐☐	**I. Walk 10 feet:** Once standing, the ability to walk at least 10 feet in a room, corridor, or similar space. *If Follow-Up performance is coded 07, 09, 10 or 88 →skip to GG0170M, 1 step (curb)*
☐☐	**J. Walk 50 feet with two turns:** Once standing, the ability to walk 50 feet and make two turns.
☐☐	**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.
☐☐	**M. 1 step (curb):** The ability to go up and down a curb and/or up and down one step .
☐☐	**N. 4 steps:** The ability to go up and down four steps with or without a rail.
	☐ **Q. Does the patient use wheelchair/scooter?** **0. No** →*skip GG0170R* **1. Yes** →*Continue to GG0170R, Wheel 50 feet with two turns*
☐☐	**R. Wheel 50 feet with two turns:** Once seated in wheelchair/scooter, the ability to wheel at least 50 feet and make two turns.