**Therapy Team Competency Checklist – Section GG Coding**

*State logo added here. If not, delete text box*

**Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Title:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

| **Skill Area** | **Evaluation** | **Method of Evaluation**D = Skills DemonstrationO = Performance Observation | **Recommendations** |
| --- | --- | --- | --- |
| **Competency** | **Needs Additional Training** |
| **D** | **O** |  |
| **Competency** | Verbalizes an understanding of GG self-care and GG mobility  |  |  |  |  |  |
| Completes comprehensive evaluation and develops care plan within 48 hours of admission |  |  |  |  |  |
| Therapy plan of care is signed by physician  |  |  |  |  |  |
| Correctly completes functional skills assessment within 3 days from the date of admission. |  |  |  |  |  |
| Collaborates with nursing to complete section GG |  |  |  |  |  |
| Completes the Medicare NPE discharge assessment on the last day of therapy or within one day of the last covered day.  |  |  |  |  |  |
| Monitors group and concurrent minutes to not exceed 25% of a total episode of care. |  |  |  |  |  |
| Participate in pre-claim billing review as indicated by the facility.  |  |  |  |  |  |
|  | New employees demonstrate competency in completing section GG.  |  |  |  |  |  |

**References and Resources**

Centers for Medicare & Medicaid Services. State Operations Manual, Appendix PP – Guidance to Surveyors for Long Term Care Facilities. <https://www.cms.gov/medicare/provider-enrollment-and-certification/guidanceforlawsandregulations/downloads/appendix-pp-state-operations-manual.pdf>

Centers for Medicare & Medicaid Services. Long-Term Care Facility Resident Assessment Instrument 3.0 User’s Manual. Version 1.18.11, October 2023: <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/MDS30RAIManual>

**\*I certify that I have received orientation in the above-mentioned areas.**

**\*Employee:**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_

**Initials**  **Signature**  **Date**

**Evaluator/Trainer:**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_

**Initials Signature Date**

***(PLACE IN EMPLOYMENT FILE)***