# Inpatient Rehabilitation Facilities
## Quality Reporting Program Provider Training


# Section H:
## Bladder and Bowel

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# Today's Presenter

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INPATIENT REHABILITATION FACILITIES
POST-ACUTE CARE PROGRAM

# Section H: Objectives

- Illustrate a working knowledge of Section H: Bladder and Bowel.
- Articulate the intent of Section H.
- Interpret the coding options for each new item and when they would be applied.
- Apply coding instructions in order to accurately code practice scenarios.

# Section H: New Items

- All items in Section H are **new.**
  - **H0350,** Bladder Continence.
  - **H0400,** Bowel Continence.

- Section H is assessed on admission.

# Section H: Intent

To gather information on bladder and bowel continence.

# H0350

## Bladder Continence

# H0350 Item Rationale

- Bladder incontinence can:
  - Interfere with participation in activities.
  - Be socially embarrassing and lead to increased feelings of dependency and social isolation.
  - Increase risk of longer length of stay.
  - Increase risk of skin rashes and breakdown, and development and/or worsening of pressure ulcers.
  - Increase risk of repeated urinary tract infections.
  - Increase the risk of falls and injuries resulting from attempts to reach a toilet unassisted.

# H0350 Item Rationale (cont.)

- For many patients, bladder incontinence can be resolved or minimized by:
  - Identifying and treating underlying potentially reversible conditions.
  - Eliminating environmental barriers to accessing commodes, bedpans, and urinals.
  - Prompted voiding or scheduled toileting and other interventions.
- Direct care staff should establish a plan to maintain skin dryness and minimize exposure to urine for all patients.

# H0350 Steps for Assessment

- Review the medical record for bladder incontinence:
  - Records or flow sheets.
  - Nursing assessments and progress notes.
  - Physician history and physical examination.

# H0350 Steps for Assessment (cont.)

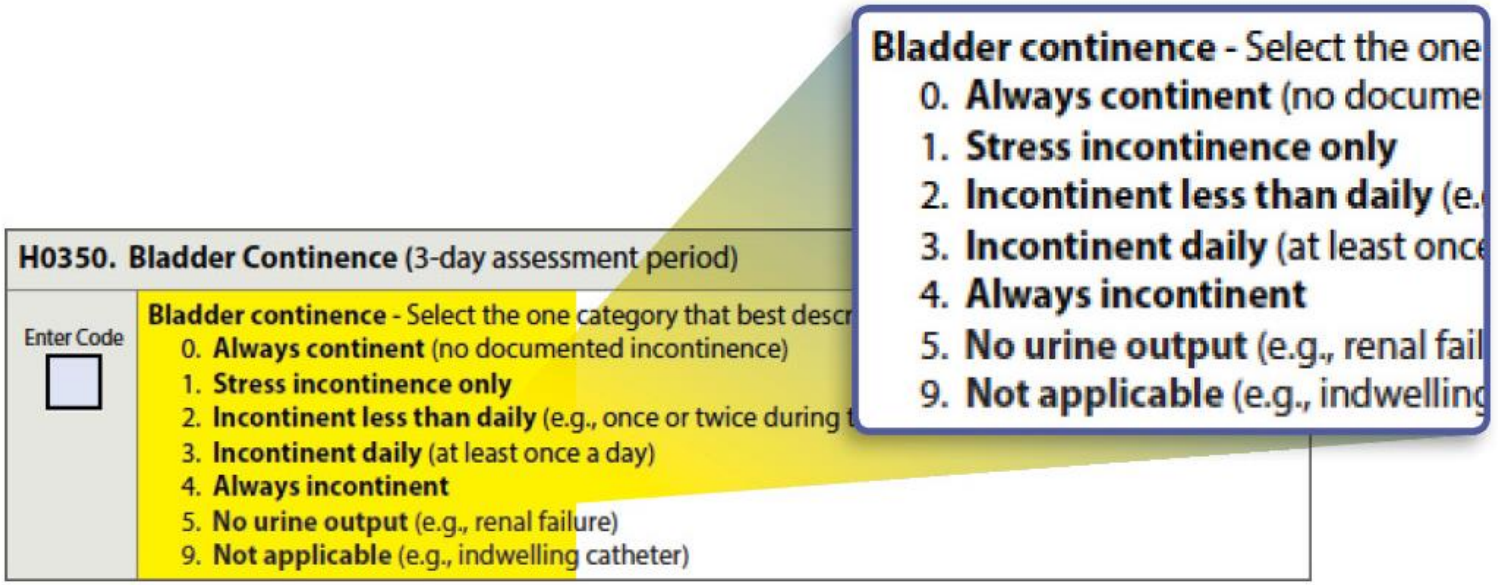
- Interview the patient if he or she is capable of reliably reporting his or her bladder continence.
- Speak with family members or significant others if the patient is not able to report on bladder continence.
- Ask direct care staff who routinely work with the patient about incontinence episodes.

# H0350 Assessment Guidelines

- If intermittent catheterization is used to drain the bladder, code incontinence level based on continence between catheterizations.

# H0350 Coding Instructions

- Code according to the number of episodes of incontinence that occur during the assessment period.






INPATIENT REHABILITATION FACILITIES
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# H0350 Coding Instructions (cont.)

- **Code 0, Always continent,** if throughout the 3-day assessment period the patient was continent of urine, without any episodes of incontinence.
- **Code 1, Stress incontinence only,** if during the 3-day assessment period the patient had episodes of incontinence only associated with physical movement or activity such as coughing, sneezing, laughing, lifting heavy objects, or exercise.
- **Code 2, Incontinent less than daily,** if during the 3-day assessment period the patient was incontinent of urine once or twice.

# H0350 Coding Instructions (cont.)

- **Code 3, Incontinent daily,** if during the 3-day assessment period the patient was incontinent of urine at least once a day.
- **Code 4, Always incontinent,** if during the 3-day assessment period the patient had no continent voids.
- **Code 5, No urine output,** if during the 3-day assessment period, the patient had no urine output (e.g., renal failure, on chronic dialysis with no urine output) for the entire 3 days.
- **Code 9, Not applicable,** if during the 3-day assessment period the patient had an indwelling bladder catheter, condom catheter, or ostomy for the entire 3 days.

# Stress Incontinence

- Stress incontinence has its own code.
- Associated with physical movement or activity such as:
  - Coughing.
  - Sneezing.
  - Laughing.
  - Lifting heavy objects.
  - Exercise.
- Staff observations would be helpful in distinguishing incontinence from stress incontinence in nonverbal patients.

# H0350 Coding Tips

- 3-day assessment period only.
- Incontinence is the same as leakage.
- Review all documentation and discuss with staff to determine the frequency.

# H0350 Coding Scenario (1)

- Mrs. M is an 86-year-old patient and has had longstanding stress incontinence for many years.
- When she has an upper respiratory infection and is coughing, she involuntarily leaks urine.
- However, during the current 3-day assessment period, the patient has been free of respiratory symptoms and has not had an episode of incontinence.

**How would you code H0350?**
**What is your rationale?**

# H0350 Coding Scenario (2)

- Mr. A is recovering from a traumatic brain injury.
- He was incontinent of urine twice on day 1 of the 3-day assessment period, once on day 2, and once on day 3.

**How would you code H0350?**
**What is your rationale?**

# H0350 Practice Coding Scenario (1)

- Mrs. T had one urinary incontinence episode during the 3-day assessment period.
- All other voids were continent because the certified nursing assistant followed a timed toileting schedule to assist Mrs. T to the toilet.

# H0350 Practice Coding Scenario (2)

- Mrs. W had an indwelling catheter that remained in place during the entire 3-day assessment period.
- There were no episodes of urinary incontinence.

# H0350 Practice Coding Scenario (3)

- Ms. R was diagnosed with chronic renal failure.
- She had no urinary output during the 3-day assessment period.

# Important Distinctions

## Section H Items:

- 3-day assessment period.
- Codes according to the number of episodes of incontinence.

## FIM®:

- 7-day assessment period.
  - 3-day assessment period at the IRF and 4-day assessment prior to the IRF admission.
- Scores accidents.

# Coding Scenario

- During the 3-day assessment period, Mrs. T is incontinent four times, maintained in an incontinence pad, voids in the toilet the other times, and requires no assistance to use these pads.
- One time during the assessment period, Mrs. T did not wear an incontinence pad and leaked urine only once onto linen and her clothing.
- During the 4 days prior to admission to the IRF, Mrs. T had an indwelling Foley catheter that was removed on admission to the IRF.

**How would you code H0350?**

# Comparison

- **Item H0350:** Even if the patient has successfully used an incontinence pad during the assessment period, it will be counted as an incontinent episode.
- **FIM®:** If the patient has successfully used an incontinence pad (linens and clothing are dry), there is no scoring of an accident.

# H0400

## Bowel Continence

# H0400 Item Rationale

- Bowel incontinence can:
  - Interfere with participation in activities.
  - Be socially embarrassing and lead to increased feelings of dependency and social isolation.
  - Increase risk of longer length of stay.
  - Increase risk of skin rashes and breakdown, and development and/or worsening of pressure ulcers.
  - Increase the risk of falls and injuries resulting from attempts to reach a toilet unassisted due to urgency.

# H0400 Item Rationale (cont.)

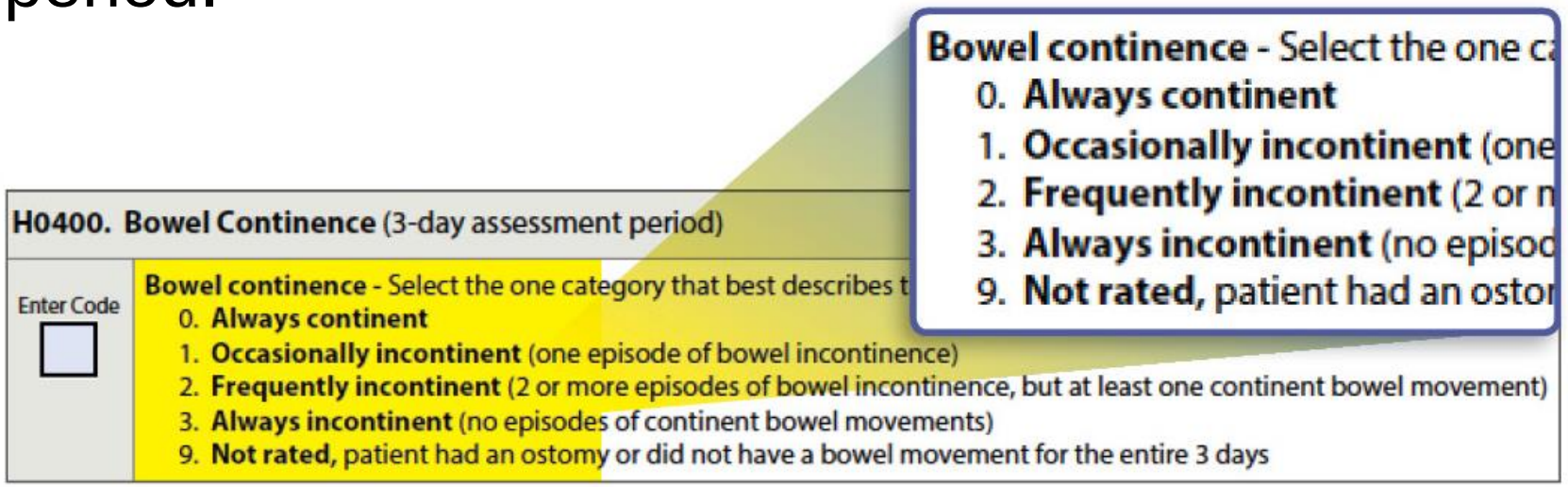
- For many patients, bowel incontinence can be resolved or minimized by:
  - Identifying and managing underlying and potentially reversible conditions.
  - Eliminating environmental barriers to accessing commodes, bedpans, and urinals.
- Direct care staff should establish a plan to maintain skin dryness and minimize exposure to stool for all patients.

# H0400 Steps for Assessment

- Review the medical record:
  - Bowel incontinence flow sheets.
  - Nursing assessments and progress notes.
  - Physician history and physical examination.
- Interview the patient if he or she is capable of reliably reporting his or her bowel habits.
- Speak with family members or significant others if the patient is unable to report on continence.
- Ask direct care staff who routinely work with the patient about incontinence episodes.

# H0400 Coding Instructions

- Code according to the number of episodes of bowel incontinence that occur during the assessment period.



**H0400. Bowel Continence** (3-day assessment period)

Enter Code ☐

**Bowel continence** - Select the one category that best describes t
0. **Always continent**
1. **Occasionally incontinent** (one episode of bowel incontinence)
2. **Frequently incontinent** (2 or more episodes of bowel incontinence, but at least one continent bowel movement)
3. **Always incontinent** (no episodes of continent bowel movements)
9. **Not rated,** patient had an ostomy or did not have a bowel movement for the entire 3 days

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9. **Not rated,** patient had an ostor

# H0400 Coding Instructions (cont.)

- **Code 0, Always continent,** if during the 3-day assessment period the patient was continent for all bowel movements, without any episodes of incontinence.
- **Code 1, Occasionally incontinent,** if during the 3-day assessment period the patient was incontinent for one bowel movement. This includes incontinence of any amount of stool at any time.
- **Code 2, Frequently incontinent,** if during the 3-day assessment period the patient was incontinent of bowel at least twice, but also had at least one continent bowel movement. This includes incontinence of any amount of stool at any time.

# H0400 Coding Instructions (cont.)

- **Code 3, Always incontinent,** if during the 3-day assessment period the patient was incontinent for all bowel movements (i.e., had no continent bowel movements).
- **Code 9, Not rated,** if during the 3-day assessment period the patient had an ostomy or other device, or the patient did not have a bowel movement during the entire 3 days. Note that patients who have not had a bowel movement for 3 days should be evaluated for constipation.

# H0400 Coding Tips

- Being continent has to do with the ability to voluntarily release stool in a commode, toilet, or bedpan or as a result of prompted toileting, assisted toileting, or scheduled toileting.
- If the patient *cannot* voluntarily control the passage of stool, which results in involuntary passage of stool, then he or she is considered incontinent.

# H0400 Coding Tips (cont.)

- Patients who require assistance to maintain the passage of stool via artificial initiation (e.g., manual stimulation, rectal suppositories, or enema) would be considered *continent* of bowel as long as the result of releasing the stool was in a commode, toilet, or bedpan.
- Bowel incontinence precipitated by loose stools or diarrhea from any cause (including laxatives) would count as incontinence.

# H0400 Coding Scenario (1)

- The day shift nurse notes that Mr. S has a bowel movement every morning, but no episodes of bowel incontinence on her shift during the 3-day assessment period.
- The nurse checks the medical record and notes no documentation of bowel incontinence on any shift during the 3-day assessment period.
- The nurse confirms this with the certified nursing assistant who is assigned to Mr. S to assist him to the toilet.

**How would you code H0400?**

**What is your rationale?**

# H0400 Coding Scenario (2)

- Mr. G has Parkinson's disease and finds it very difficult to get to the bathroom in time to move his bowels.
- Mr. G made it to the bathroom and defecated in the toilet one time during the 3-day assessment period.
- Otherwise, he was incontinent of stool multiple times on the other 2 days during the assessment period.

**How would you code H0400?**

**What is your rationale?**

# H0400 Practice Coding Scenario (1)

- Mr. D has a temporary colostomy.
- He had no episodes of bowel incontinence during the 3-day assessment period.

# H0400 Practice Coding Scenario (2)

- Mrs. F had a stroke and has cognitive limitations.
- She is not aware of when she has to go to the bathroom to move her bowels.
- She soils the bedsheets or her incontinence garment every day during the 3-day assessment period.
- She has not had any continent episodes.

# Section H: Summary

- Section H is new.
- Section H is coded on admission.
- Difference in definition of incontinence and accidents.
- The reference dates are different.
  - 3-day assessment vs. 7-day look-back period.
- Stress incontinence has its own code.

# Section H: Action Plan

- Evaluate current documentation to ensure terminology aligns with items in the IRF-PAI v1.4.
- Need to differentiate between accidents and incontinence for Section H.
- Regularly remind staff that coding and scoring numbers may not match.
- Practice coding a variety of scenarios with staff.

# Questions?