Sections B, GG, H, I, & K

Objectives

- State the intent of Sections B, GG, H, I, and K of the LTCH CARE data sets.
- Describe the information required to complete each section.
- Code each item correctly and accurately.

LTCH CARE Sections

- This lesson covers Sections B, GG, H, I, and K of the LTCH CARE data sets.
- These sections document information about the patient's clinical status.
  - Section B. Hearing, Speech and Vision
  - Section GG. Functional Status
  - Section H. Bladder and Bowel
  - Section I. Active Diagnoses
  - Section K. Swallowing/ Nutrition

Section B

Hearing, Speech, & Vision

B0100 Comatose

- Documents whether the patient is comatose or in a persistent vegetative state.
- Patients who are in a coma or persistent vegetative state are at risk for the complications of immobility.
  - Skin breakdown
  - Joint contractures
- Included only on the Admission and Planned and Unplanned Discharge data sets.

Assessing Comatose State

- Review the medical record.
- Determine if a neurological diagnosis of comatose or persistent vegetative state has been documented by licensed staff as permitted by state law:
  - Physician
  - Physician Assistant
  - Nurse Practitioner
  - Clinical Nurse Specialist

B0100 Coding Instructions

- **Code 0. No**

  If diagnosis of coma or persistent vegetative state is not present in the 3-day assessment period.

- **Code 1. Yes**

  If this diagnosis is documented in the medical record during 3-day assessment period.

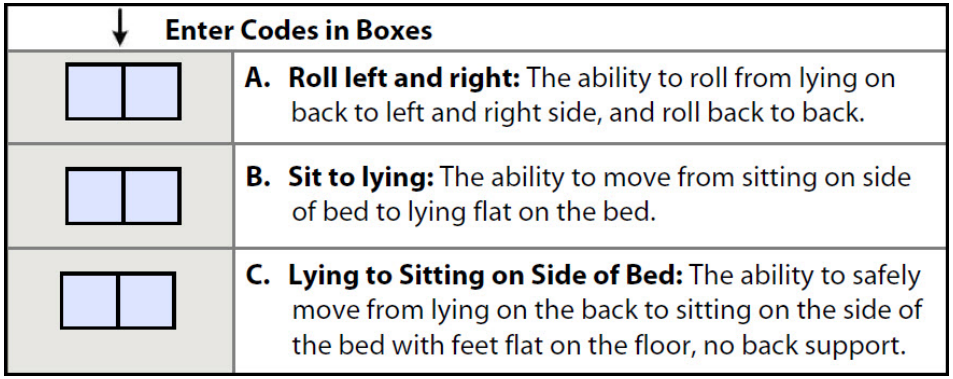
B0100. Comatose	
Enter Code ☐	**Persistent vegetative state/no discernible consciousness at time of assessment.** 0. **No** 1. **Yes**

Section GG

Functional Status

GG0160 Functional Mobility

- Documents the level of independence/ dependence for 3 activities:
  - Roll left and right
  - Sit to lying
  - Lying to Sitting on side of bed



- Complete only for Admission, Planned Discharge, and Unplanned Discharge assessments.

Risks of Mobility Limitations

- Many patients in LTCHs have mobility limitations.
- Most are at risk of further functional decline.
- Complications may occur as inactivity increases:
  - Pressure ulcers
  - Falls
  - Contractures
  - Depression
  - Muscle wasting

Assessing Functional Mobility

- Review documentation in the medical record for the 3-day assessment period.
- Talk with direct care staff.
- Observe the patient as he/she performs each mobility activity.
- Be specific in evaluating each component.
- Use probing questions.

GG0160 Coding Guidelines

- Code for each functional activity listed.
- Record the patient's **actual** ability to perform each activity.
- Score will be based on the amount of assistance/ effort provided.
- Activities may be completed with or without assistive devices.

GG0160 Coding Instructions

- Enter the code that best reflects the patient's ability to complete each activity.

06. Independent

05. Setup or clean-up assistance

04. Supervision or touching assistance

03. Partial/ moderate assistance

02. Substantial/ maximal assistance

01. Dependent

07. Patient refused

09. Not applicable (not attempted)

88. Not attempted due to medical condition or safety concerns

GG0160 Coding Definitions

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 or TOUCHING/ STEADYING 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 of the effort. Patient does none of the effort to complete the task.

Key Questions

- Does the patient need assistance (physical, verbal/ non-verbal cueing, setup/ clean-up) to complete the activity?
  - If no, **Level 6 – Independent**
  - If yes…
- Does the patient need only setup or clean-up assistance?
  - If yes, **Level 5 – Setup or cleanup**
  - If no….

Key Questions$_2$

- Does the patient need only verbal/ non-verbal cueing, or steadying/ touching assistance?
  - If yes, **Level 4 – Supervision or touching assistance**
  - If no…
- Does the patient need lifting assistance or trunk support with the helper providing ***less*** than half of the effort?
  - If yes, **Level 3 – Partial/ moderate assistance**
  - If no….

Key Questions$_3$

- Does the patient need lifting assistance or trunk support with the helper providing ***more*** than half of the effort?
  - If yes, **Level 2 – Substantial/maximal assistance**
  - If no….
- Does the helper provide ***all*** of the effort to complete the activity?
  - If yes, **Level 1 – Dependent**

Coding Issues

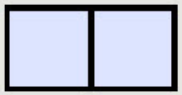
- If more than one helper provides assistance, score level 1 – Dependent.
- If the activity was ***not*** completed, indicate the reason:

  07. Patient refused

  09. Not applicable (not attempted)

  88. Not attempted due to medical condition or safety concerns

Functional Mobility: Roll Left and Right

	**A. Roll left and right:** The ability to roll from lying on back to left and right side, and roll back to back.
	**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 safely move from lying on the back to sitting on the side of the bed with feet flat on the floor, no back support.

GG0160 Scenario #1

- Mr. C.'s medical issues include cellulitis, non-healing ulcers, COPD, morbid obesity and uncontrolled diabetes.
- Mr. C. is lying on his back and will roll to his left and right side.
- The therapist instructs Mr. C. to bend his right leg and roll to his left side. Mr. C. bends his right leg, but is unable to roll onto his left side or back to the supine position. The therapist completes the task for Mr. C.
- When rolling to the right side, Mr. C. bends his left leg and the therapist completes the task for Mr. C.

How Should GG0160A Roll Left and Right be Coded?

06. Independent

05. Setup or clean-up assistance

04. Supervision or touching assistance

03. Partial/ moderate assistance

02. Substantial/ maximal assistance

01. Dependent

GG0160A Scenario #1 Coding

- The correct code is **02 Substantial/ Maximal Assistance**.
- Mr. C. bends his legs only. The therapist performs more than half of the effort.

GG0160 Scenario #2

- Mr. L. has two Stage 3 pressure ulcers and one Stage 2 pressure ulcer, osteomyelitis and severe malnutrition.
- He uses an air-fluidized bed, so the therapists and nurses are unable to assess his bed mobility skills, including his ability to roll onto his left side and his ability to roll onto his right side.

How Should GG0160A Roll Left and Right be Coded?

06. Independent

05. Setup or clean-up assistance

04. Supervision or touching assistance

03. Partial/ moderate assistance

02. Substantial/ maximal assistance

01. Dependent

07. Patient refused

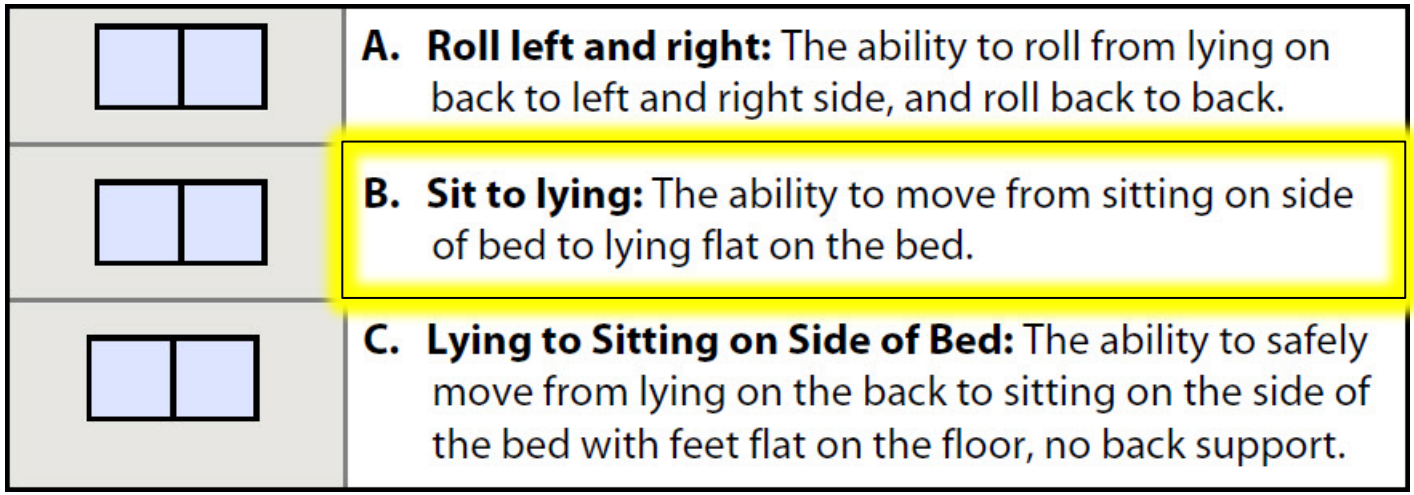
09. Not applicable (not attempted)

88. Not attempted due to medical condition/safety concerns

GG0160A Scenario #2 Coding

- The correct code is **88 – Not attempted due to medical condition/ safety concerns.**
- Rationale: Staff are unable to assess Mr. L.'s ability to roll left and right due to his need for a specialized bed.

Functional Mobility: Sit to Lying



A. Roll left and right: The ability to roll from lying on back to left and right side, and roll back to back.

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 safely move from lying on the back to sitting on the side of the bed with feet flat on the floor, no back support.

GG0160 Scenario #3

- Mr. S.'s admitting diagnoses include incomplete tetraplegia and brain injury.
- To move Mr. S. from a sitting to lying position, the assistance of 2 staff members is required. One therapist provides lifting assistance as the nurse provides steadying assistance.

How Should GG0160B Sit to Lying be Coded?

06. Independent

05. Setup or clean-up assistance

04. Supervision or touching assistance

03. Partial/ moderate assistance

02. Substantial/ maximal assistance

01. Dependent

GG0160B Scenario #3 Coding

- The correct code is **01 – Dependent**.
- Rationale: The assistance of 2 staff members is needed.

Functional Mobility: Lying to Sitting on Side of Bed

	**A. Roll left and right:** The ability to roll from lying on back to left and right side, and roll back to back.
	**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 safely move from lying on the back to sitting on the side of the bed with feet flat on the floor, no back support.

GG0160 Scenario #4

- Mr. B. was admitted with a diagnosis of acute respiratory failure, protein calorie malnutrition and chronic kidney disease. By discharge, Mr. B. has been weaned from the ventilator but continues to have generalized weakness.
- Mr. B. pushes up on the bed to get himself from a lying to a seated position.
- The helper provides steadying (touching) assistance as Mr. B. scoots himself to the edge of the bed and lowers his feet to the floor.

How Should GG0160C Lying to Sitting on Side of Bed be Coded?

06. Independent

05. Setup or clean-up assistance

04. Supervision or touching assistance

03. Partial/ moderate assistance

02. Substantial/ maximal assistance

01. Dependent

GG0160C Scenario #4 Coding

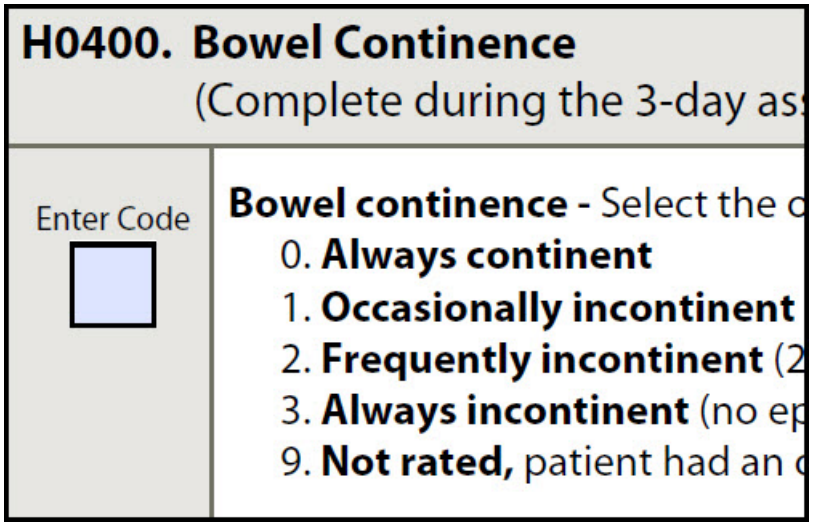
- The correct code is **04 Supervision or Touching Assistance**.
- The helper provides touching assistance as Mr. B. moves from a lying to sitting position.

Section H

Bladder & Bowel

H0400 Bowel Continence

- Gathers information about the patient's bowel continence.
- Included only on the Admission, Planned Discharge, and Unplanned Discharge data sets.



Importance of Bowel Continence

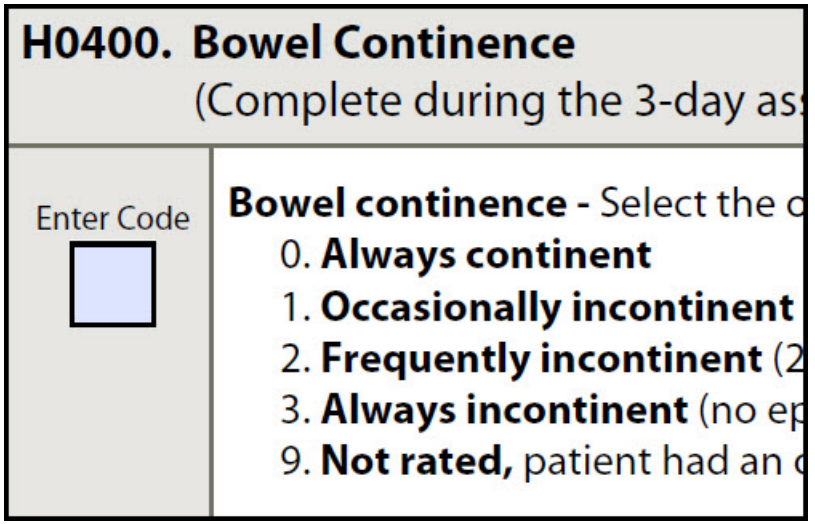
- Leads to many complications:
  - Interferes with participation in activities
  - Is socially embarrassing and can lead to increased feelings of dependency
  - Increases risk of long-term institutionalization
  - Increases risk of skin rashes and breakdown
  - Increases the risk of falls and injuries resulting from attempts to reach a toilet unassisted

Assessing Bowel Continence

- Review the medical record.
- Interview the patient (if capable of reporting).
- Speak with family members or significant others if patient is not able to report.
- Ask direct care staff on all shifts about incontinence episodes.

H0400 Coding Instructions

- Bowel incontinence precipitated by loose stools or diarrhea from any cause (including laxatives) counts as incontinence.
- Code according to the number of episodes of bowel incontinence that occur during the 3-day assessment period.



Section I

Active Diagnoses

I0900, I2900 & I5600 Active Diagnoses

- Identifies active diseases associated with the risk of developing a pressure ulcer.
- Intended to be coded only for **active diseases**.
- Included only on the Admission, Planned Discharge, and Unplanned Discharge data sets.

	Heart/Circulation
☐	**I0900. Peripheral Vascular Disease (PVD) or Peripheral Arterial Disease (PAD)**
	Metabolic
☐	**I2900. Diabetes Mellitus (DM)**
	Nutritional
☐	**I5600. Malnutrition** (protein or calorie) or at risk for malnutrition

Assessing Active Diagnoses

Step 1: Identify any of these diagnoses applicable to the patient.

- A diagnosis must be documented by a physician or other licensed, authorized staff as permitted by state law.
- Identify any diagnoses documented the last **3 days**.

Step 2: Determine if each diagnosis is active.

- Determine if the diagnosis is active or inactive over the **3-day** assessment period.

Step 1: Identify Diagnoses

- Identification requires documented diagnosis by authorized licensed staff as permitted by state law.
  - Physician
  - Physician Assistant
  - Nurse Practitioner
  - Clinical Nurse Specialist
- Include only diagnoses in the last 3 **days**.

Step 1: Identify Diagnoses$_2$

- Review medical record sources.
  - Progress notes
  - Most recent history and physical
  - Transfer documents
  - Discharge summaries
  - Diagnosis/ problem list
  - Other resources as available
- If a diagnosis/ problem list is used, enter only diagnoses confirmed by a physician or other authorized, licensed staff as permitted by state law.

Step 2: Determine If Diagnoses Are Active

- Assessment period for this step is **3 days**.
- Do not include conditions that have been resolved or no longer affect the patient's functioning or care.
- There must be specific **documentation** of an **active diagnosis** in the **medical record** made by a physician or authorized, licensed staff as permitted by state law.

Section I Coding Guidelines

- If there is specific documentation in the medical record by a physician or other licensed, authorized staff of an active diagnosis, code as active.
- No additional confirmation is required.
- In the absence of specific documentation:
  - Recent onset or acute exacerbation of the disease or condition in the last 3 days
  - Symptoms, abnormal signs indicating ongoing or decompensated disease in the last 3 days

Section I Coding Instructions

- Check off each active disease.
- Check all that apply for the patient.

	Heart/Circulation
☐	**I0900. Peripheral Vascular Disease (PVD) or Peripheral Arterial Disease (PAD)**
	Metabolic
☐	**I2900. Diabetes Mellitus (DM)**
	Nutritional
☐	**I5600. Malnutrition** (protein or calorie) or at risk for malnutrition

Section I Scenario

- A patient is prescribed insulin for diabetes mellitus.
- The patient requires regular blood glucose monitoring to determine whether blood glucose goals are achieved by the current regimen.
- Physician progress note documents diabetes mellitus.

How Should Section I be Coded?

A. Check I2900 Diabetes Mellitus.

B. Check I5600 Malnutrition.

C. Do not check any items in Section I.

Section I Scenario Coding

- Check I2900 Diabetes Mellitus.
- This would be considered an active diagnosis because:
  - Physician progress note documents the diabetes mellitus diagnosis.
  - There is ongoing glucose monitoring.

Section K

Swallowing/Nutrition

Item K0200 Height/ Weight

- Assesses a patient's body mass index using the patient's height and weight.
- Included only on the Admission, Planned Discharge, and Unplanned Discharge data sets.

K0200. Height and Weight - While measuring, if the number is X.1 - X.	
inches	**A. Height** (in inches). Record most recent height measure sin
pounds	**B. Weight** (in pounds). Base weight on most recent measure facility practice (e.g., in a.m. after voiding, before meal, with

Importance of Height/ Weight

- Diminished nutritional and hydration status can adversely affect wound healing and increase risk for pressure ulcers.
- Height and weight measurements help staff assess nutrition and hydration status over time.

Assessing Height

- Measure height in accordance with LTCH's policies and procedures (shoes off, etc.).
- Admission assessment: measure and record height in inches.
- Planned or Unplanned Discharge assessment: record the most recent height (in inches) measured since admission.

K0200A Coding Instructions

- Record height to the nearest whole inch.
- Use mathematical rounding.
  - Record a height of 62.5 inches as 63 inches.
  - Record a height of 62.4 inches as 62 inches.

K0200. Height and Weight – While measuring, if the number is X.1 – X.4, round down; X.5 or greater round up	
6 3 inches	**A. Height** (in inches). Record most recent height measure since admission.

K0200. Height and Weight – While measuring, if the number is X.1 – X.4, round down; X.5 or greater round up	
6 2 inches	**A. Height** (in inches). Record most recent height measure since admission.

Assessing Weight

- Measure weight in accordance with the LTCH's policies and procedures.
- Record the patient's weight in pounds.
- If the patient's weight was taken more than once, record the most recent weight.

K0200B Coding Instructions

- Use mathematical rounding.
  - Record weight of 152.5 pounds as 153 pounds.
  - Record weight of 152.4 pounds as 152 pounds.
- Use the no-information code (**-**) if the patient cannot be weighed.