Centers for Medicare & Medicaid Services

MDS 2.0 Tip Sheet: ITEMS K2a/K2b

Height and Weight

JUNE 2008

INTRODUCTION

In response to questions related to MDS coding for items K2a and K2b, Height and Weight, the following tip sheet has been developed. Use this MDS 2.0 Tip Sheet to better understand MDS coding rationale for this item.

DEFINITION

This item directs you to record a current height and weight in order to monitor nutrition and hydration status over time, and provides a mechanism for monitoring the stability of weight over time.

CLARIFICATIONS

HEIGHT

- **New Admissions** – Measure height in inches.
- **Current Admissions** – Check the clinical records. If the last height recorded was more than one year ago, measure the resident's height again.

WEIGHT

- **Process** – Check the clinical records. If the last recorded weight was taken more than one month ago or **previous** weight is not available, weigh the resident again. If the resident has experienced a decline in intake at meals or snacks, or a decline in fluid intake, weigh the resident again. If the resident's weight was obtained more than once during the preceding month, record the most recent weight.

CODING TIPS

HEIGHT

Round height upward to the nearest whole inch. Measure height consistently over time in accordance with standard facility policy and procedure (e.g., shoes off). If a resident cannot stand to obtain a current height or is missing limbs, use another means of determining height in accordance with facility policy and current standards of clinical practice. **If a resident refuses to be measured, use the standard no-information code, the dash (–)**.Document your rationale in the resident's record.

WEIGHT

Round weight upward to the nearest whole pound. Measure weight consistently over time in accordance with standard facility policy and procedure (e.g., after voiding, before meal). There may be circumstances when a resident cannot be weighed (e.g., extreme pain, immobility, risk of pathological fractures) or refuses to be weighed**. If, as a matter of professional judgment, a resident cannot be weighed or refuses to be weighed, use the standard no-information code, the dash (–)**. Document your rationale in the resident's record.

CODING EXAMPLES

1) Mr. B was admitted to Glen Falls Nursing Home today. Per nursing home policy, the nursing staff measured Mr. B's height with his shoes off, to find that he was 5 feet 7¼ inches tall. The height in Mr. B's chart was documented as such. However, on the MDS, the RAI Coordinator correctly documented his height as 5 feet 8 inches.

2) Mrs. R. has been at Heather Gardens Nursing Home for 5 years. As per nursing home policy, Mrs. R has her weight documented every month. When the nursing home staff weighed her, it was determined that she was exactly 115.3 pounds. The nursing staff documented her weight as 115.3 pounds in her medical record. However, on the MDS, the RAI Coordinator correctly documented her weight as 116 pounds.

FOR MORE HELP

The RAI User's Manual for MDS coding is available on the Centers for Medicare & Medicaid Services website: http://www.cms.hhs.gov/NursingHomeQualityInits/20_NHQIMDS20.asp.
If you need help interpreting MDS coding instructions, contact your State RAI Coordinator listed in Appendix B of the User's Manual. If you require further assistance, you may submit your question to mdsquestions@cms.hhs.gov.