

SECTION K: SWALLOWING/NUTRITIONAL STATUS

Intent: This section covers height and weight, and nutritional approaches.

K0200. Height and Weight

K0200. Height and Weight - While measuring, if the number is X.1 - X.4 round down; X.5 or greater round up	
inches	A. Height (in inches). Record most recent height measure since admission.
pounds	B. Weight (in pounds). Base weight on most recent measure in last 4 days; measure weight consistently, according to standard facility practice (e.g., in a.m. after voiding, before meal, with shoes off).

Item Rationale

- Diminished nutritional and hydration status can lead to debility that can adversely affect wound healing and increase risk for the development of pressure ulcers.
- Height and weight measurements (and body mass index [BMI] calculation) assist staff in assessing the patient's nutrition and hydration status by providing a mechanism for monitoring stability of weight and BMI over a period of time. The measurement of height and weight for the calculation of BMI is one guide for determining nutritional status.

K0200A, Height

Steps for Assessment

1. Measure height in accordance with the facility's policies and procedures, which should reflect current standards of practice (shoes off, etc.).
2. Measure and record height in inches.

Coding Instructions

Complete only if A0250 = 01 Admission.

- Record the patient's height to the nearest whole inch.
- Only enter a height that has been directly measured by your facility staff. Do not enter a height that is self-reported or derived from documentation from another provider setting.
- Use mathematical rounding (i.e., if height measurement is X.5 inches or greater, round height upward to the nearest whole inch. If height measurement number is X.1 to X.4 inches, round down to the nearest whole inch). For example, a height of 62.5 inches would be rounded to 63 inches, and a height of 62.4 inches would be rounded to 62 inches.
- When reporting height for a patient with bilateral lower extremity amputations, measure and record the patient's current height (i.e., height after bilateral amputations).

K0200B, Weight**Steps for Assessment**

1. Weight should be measured in accordance with the hospital's policies and procedures, which should reflect current standards of practice (e.g., in a.m. after voiding, with shoes off, etc.).
2. Measure and record the patient's weight in pounds.

Coding Instructions

Complete only if A0250 = 01 Admission.

- Only enter a weight that has been directly measured by your facility staff. Do not enter a weight that is self-reported or derived from documentation from another provider setting.
- If a patient is weighed multiple times during the assessment period, the first weight should be used.
- Use mathematical rounding (i.e., if weight is X.5 pounds [lbs.] or more, round weight upward to the nearest whole pound. If weight is X.1 to X.4 lbs., round down to the nearest whole pound). For example, a weight of 152.5 lbs. would be rounded to 153 lbs., and a weight of 152.4 lbs. would be rounded to 152 lbs.
- If a patient cannot be weighed, for example, because of extreme pain, immobility, or risk of pathological fractures, the use of a dash (-) is appropriate. Document the rationale on the patient's medical record or available documentation.

K0520. Nutritional Approaches

Admission

K0520. Nutritional Approaches	
Check all of the following nutritional approaches that apply on admission.	
	1. On Admission Check all that apply ↓
A. Parenteral/IV feeding	<input type="checkbox"/>
B. Feeding tube (e.g., nasogastric or abdominal (PEG))	<input type="checkbox"/>
C. Mechanically altered diet - require change in texture of food or liquids (e.g., pureed food, thickened liquids)	<input type="checkbox"/>
D. Therapeutic diet (e.g., low salt, diabetic, low cholesterol)	<input type="checkbox"/>
Z. None of the above	<input type="checkbox"/>

Planned/Unplanned Discharge

K0520. Nutritional Approaches		
	4. Last 7 Days Check all that apply ↓	5. At Discharge Check all that apply ↓
4. Last 7 Days Check all of the nutritional approaches that were received in the last 7 days		
5. At Discharge Check all of the nutritional approaches that were being received at discharge		
A. Parenteral/IV feeding	<input type="checkbox"/>	<input type="checkbox"/>
B. Feeding tube (e.g., nasogastric or abdominal (PEG))	<input type="checkbox"/>	<input type="checkbox"/>
C. Mechanically altered diet - require change in texture of food or liquids (e.g., pureed food, thickened liquids)	<input type="checkbox"/>	<input type="checkbox"/>
D. Therapeutic diet (e.g., low salt, diabetic, low cholesterol)	<input type="checkbox"/>	<input type="checkbox"/>
Z. None of the above	<input type="checkbox"/>	<input type="checkbox"/>

Item Rationale

- Nutritional approaches such as mechanically altered food or those that rely on alternative methods (e.g., parenteral/IV or feeding tubes) can diminish an individual's sense of dignity and self-worth as well as diminish pleasure from eating.
- The patient's clinical condition may potentially benefit from the various nutritional approaches included here.

Steps for Assessment for Admission

1. Review the medical record to determine if any of the listed nutritional approaches apply on admission.

Coding Instructions for Admission

*Check all that are part of the patient's current care/treatment plan during the 4-day admission assessment time period, even if not used during the 4-day admission assessment time period. If none apply, check **K0520Z**, None of the above.*

Complete only if A0250 = 01 Admission.

- **K0520A**, Parenteral/IV feeding
- **K0520B**, Feeding tube (e.g., nasogastric or abdominal [PEG])
- **K0520C**, Mechanically altered diet – require change in texture of food or liquids (e.g., pureed food, thickened liquids)
- **K0520D**, Therapeutic diet (e.g., low salt, diabetic, low cholesterol)
- **K0520Z**, None of the above

Steps for Assessment for Discharge

1. Review the medical record to determine if any of the listed nutritional approaches were part of the current care/treatment plan in the last 7 days (Column 4) and at discharge (Column 5).

Coding Instructions for Discharge

Check all of nutritional approaches that were part of the patient's current care/treatment plan during the last 7 days, even if not used in the last 7 days, and check all of the nutritional approaches that are part of the patient's current care/treatment plan during the 3-day discharge

DEFINITIONS

MECHANICALLY ALTERED DIET

A diet specifically prepared to alter the texture or consistency of food to facilitate oral intake. Examples include soft solids, pureed foods, ground meat, and thickened liquids. A mechanically altered diet should not automatically be considered a therapeutic diet.

THERAPEUTIC DIET

A diet intervention prescribed by a physician or other authorized non-physician practitioner that provides food or nutrients via oral, enteral, and parenteral routes as part of treatment of disease or clinical condition to modify, eliminate, decrease, or increase identified micro- and macro-nutrients in the diet (Academy of Nutrition and Dietetics, 2021).

PARENTERAL/IV FEEDING

Introduction of a nutritive substance into the body by means other than the intestinal tract (e.g., subcutaneous, intravenous).

FEEDING TUBE

Presence of any type of tube that can deliver food/nutritional substances/fluids directly into the gastrointestinal system. Examples include, but are not limited to, nasogastric tubes, gastrostomy tubes, jejunostomy tubes, and percutaneous endoscopic gastrostomy (PEG) tubes.

*assessment time period, even if not used during the 3-day discharge assessment time period. If none apply, check **K0520Z**, None of the above.*

Complete only if A0250 = 10 Planned Discharge or A0250 = 11 Unplanned Discharge.

- **K0520A**, Parenteral/IV feeding
- **K0520B**, Feeding tube (e.g., nasogastric or abdominal [PEG])
- **K0520C**, Mechanically altered diet – require change in texture of food or liquids (e.g., pureed food, thickened liquids)
- **K0520D**, Therapeutic diet (e.g., low salt, diabetic, low cholesterol)
- **K0520Z**, None of the above

Coding Tips for Discharge

- At discharge, K0520 does not report on nutritional approaches that are expected to occur after discharge.

K0520A, Parenteral/IV Feeding

Coding Tips

- Parenteral/IV feeding—The following fluids may be included **when there is supporting documentation that reflects the need for additional fluid intake specifically addressing a nutrition or hydration need. This supporting documentation should be noted in the patient’s medical record as defined by facility policy and in accordance with State and Federal regulations:**
 - IV fluids or hyperalimentation, including total parenteral nutrition (TPN), administered continuously or intermittently.
 - Hypodermoclysis and subcutaneous ports in hydration therapy.
 - IV fluids can be coded in K0520A if needed to prevent dehydration if the additional fluid intake is specifically needed for nutrition and/or hydration.
- **The following items are NOT to be coded in K0520A:**
 - IV medications – **Code these when appropriate in O0110H, IV Medications.**
 - IV fluids used to reconstitute and/or dilute medications for IV administration.
 - IV fluids administered as a routine part of an operative or diagnostic procedure or recovery room stay.
 - IV fluids administered to flush the IV line.
 - Parenteral/IV fluids administered in conjunction with chemotherapy or dialysis.
- Enteral feeding formulas:
 - Should not be coded as a mechanically altered diet.

- Should only be coded as K0520D, Therapeutic diet when the enteral formula is altered to manage problematic health conditions, e.g., enteral formulas specific to diabetes.

K0520B, Feeding Tube (e.g., nasogastric or abdominal [PEG])

Coding Tips

- If a feeding tube is in place but there are no scheduled or PRN (as needed) orders to provide nutrition or hydration via the feeding tube on the current care/treatment plan, do not code K0520B, Feeding tube.

K0520D, Therapeutic Diet (e.g., low salt, diabetic, low cholesterol)

Coding Tips

- Therapeutic diets provide the corresponding treatment that addresses a particular disease or clinical condition which is manifesting an altered nutritional status by providing the specific nutritional requirements to remedy the alteration.
- A nutritional supplement given as part of the treatment for a disease or clinical condition manifesting an altered nutrition status does not constitute a therapeutic diet, but may be part of a therapeutic diet. Therefore, supplements (whether taken with, in-between, or instead of meals) are only coded in K0520D, Therapeutic diet when they are being taken as part of a therapeutic diet to manage problematic health conditions (e.g., supplement for protein-calorie malnutrition).
- Food elimination diets related to food allergies (e.g., peanut allergy) can be coded as a therapeutic diet.

Examples for Admission

1. The patient is admitted and receiving an antibiotic in 100 cc of normal saline via IV for symptoms of a urinary tract infection (UTI), fever, abnormal lab results (e.g., new pyuria, microscopic hematuria, urine culture with growth $>10^5$ colony forming units of a urinary pathogen), and documented inadequate fluid intake (i.e., output of fluids far exceeds fluid intake) with signs and symptoms of dehydration. The patient's documentation is updated to include a hydration intervention to ensure adequate hydration. Documentation shows IV fluids are being administered as part of the already identified need for additional hydration.

Coding: K0520A, Parenteral/IV feeding would **be checked**. The IV medication would be coded at the **IV Medications** item (O0110H).

Rationale: The patient received 100 cc of IV fluid **and** there is supporting documentation that reflected an identified need for additional fluid intake for hydration.

2. The patient is admitted and receiving an antibiotic in 100 cc of normal saline via IV. The patient has a UTI, no fever, and documented adequate fluid intake. The patient is placed on an oral hydration plan to maintain adequate hydration.

Coding: K0520A, Parenteral/IV feeding would **NOT be checked**. The IV medication would be coded at the **IV Medications** item (O0110H).

Rationale: Although the patient received the additional IV fluids, there is no documentation to support a need for additional fluid intake.

Examples for Discharge

1. The patient will be discharged today. The patient was receiving rehabilitation services for a stroke. The patient has longstanding celiac disease and therefore was placed on a gluten-free diet while in the LTCH. Because of the patient's recent stroke, they also have documented dysphagia and have required a mechanical soft diet and honey-thick liquids to prevent aspiration and will be discharged on this same diet.

Coding: K0520C4, Mechanically altered diet – Last 7 Days and K0520C5, Mechanically altered diet – At Discharge as well as K0520D4, Therapeutic diet – Last 7 Days and K0520D5, Therapeutic diet – At Discharge would **be checked**.

Rationale: The patient requires both a mechanically altered diet (i.e., mechanical soft diet and honey-thick liquids) and a therapeutic diet (i.e., gluten free) for the patient's celiac disease in the last 7 days as well as at discharge.

2. Prior to their admission to the LTCH, the patient had been on a chopped diet due to facial trauma. The patient will be discharged today after rehabilitation services for multiple fractures after a car accident. The patient has been on a regular diet during their entire stay and has not required any parenteral or enteral nutrition.

Coding: K0520Z4, None of the above – Last 7 Days and K0520Z5, None of the above – At Discharge would **be checked**.

Rationale: The patient had a regular diet their entire stay and did not require any nutritional modifications.