



Long-Term Care Hospital (LTCH) Quality Reporting Program (QRP) Provider Training



*Section K:
Swallowing/Nutritional Status*

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Section K: Objectives

- Define Section K: Swallowing/Nutritional Status.
- Explain new items and/or changes between LTCH CARE Data Set v2.01 and v3.00.
- Explain the intent of Section K.
- Discuss coding instructions and needed information for items.
- Accurately code scenario(s).

Section K: New Items and Changes

No new items or changes made to Section K in the LTCH CARE Data Set v3.00.

Section K: Intent and Item Rationale

INTENT: Assess the patient's body mass index (BMI) using the patient's height and weight.

ITEM RATIONALE:

- 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.

Section K: 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				
<table border="1"><tr><td><input type="text"/></td><td><input type="text"/></td></tr></table> inches	<input type="text"/>	<input type="text"/>	A. Height (in inches). Record most recent height measure since admission.	
<input type="text"/>	<input type="text"/>			
<table border="1"><tr><td><input type="text"/></td><td><input type="text"/></td><td><input type="text"/></td></tr></table> pounds	<input type="text"/>	<input type="text"/>	<input type="text"/>	B. Weight (in pounds). Base weight on most recent measure in last 3 days; measure weight consistently, according to standard facility practice (e.g., in a.m. after voiding, before meal, with shoes off).
<input type="text"/>	<input type="text"/>	<input type="text"/>		

Applies only to the Admission Assessment.

Section K: K0200A. Height

STEPS FOR ASSESSMENT:

- Measure height in accordance with the LTCH's policies and procedures (shoes off, etc.).
- Measure and record height in inches.

Section K: K0200A. Height (cont.)

K0200. Height and Weight - While measuring, if the number is X.1 - X.4 round down; X.5 or greater round up	
<input type="text"/> <input type="text"/> inches	A. Height (in inches). Record most recent height measure since admission.
<input type="text"/> <input type="text"/> <input type="text"/> pounds	B. Weight (in pounds). Base weight on most recent measure in last 3 days; measure weight consistently, according to standard facility practice (e.g., in a.m. after voiding, before meal, with shoes off).

Applies only to the Admission Assessment.

CODING INSTRUCTIONS:

- Complete only if A0250 = 01 Admission.
- Record the patient's 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.

Section K: K0200B. Weight

STEPS FOR ASSESSMENT:

- Measure weight in accordance with LTCH's policies and procedures (shoes off, etc.).
- Measure and record the patient's weight in pounds.
- If patient has been weighed multiple times during the assessment period, use first weight.

Section K: K0200B. Weight (cont.)

<table border="1"><tr><td></td><td></td><td></td></tr></table> <p>pounds</p>				<p>B. Weight (in pounds). Base weight on most recent measure in last 3 days; measure weight consistently, according to standard facility practice (e.g., in a.m. after voiding, before meal, with shoes off).</p>

Applies only to the Admission Assessment.

CODING INSTRUCTIONS:

- Complete only if A0250 = 01 Admission.
- Use mathematical rounding.
 - Record a weight of 152.5 pounds as 153 pounds.
 - Record a weight of 152.4 pounds as 152 pounds.
- Use the default response of a dash (-) if the patient cannot be weighed.

Section K: K0200B Coding Scenario

Mrs. G has terminal breast cancer and is receiving palliative care. She is at risk for pathological fractures due to metastatic bone disease. She is pain free at rest but experiences discomfort when she moves. Daily weights are not part of her prescribed medical care and they do not affect her end of life (EOL) care.

How would you code K0200B?

What is your rationale?

Section K: K0200B Coding Scenario

CODING: K0200B would be coded (-)

RATIONALE: If a patient cannot be weighed, for example, because of extreme pain, immobility, or risk of pathological fractures, use the default response of a dash (-) and document the rationale on the patient's medical record.

Section K: Summary

- Record height in inches and use mathematical rounding.
- Record weight in pounds and use mathematical rounding.
- Record most recent weight.
- Use the default response of a dash (-) when unable to weigh patient.
- Record height of bilateral amputee patient after bilateral amputation.

Section K: Action Plan

- Review the importance and rationale of obtaining and documenting the patient's height and weight.
- Review coding instructions for completing the LTCH CARE Data Set height and weight items, including mathematical rounding.
- Review the default response of a dash (-) when a patient cannot be weighed.
 - Emphasize documentation of the rationale for not weighing a patient in the medical record.
- Practice coding a variety of scenarios with staff.