Section K

Swallowing/ Nutritional Status

Objectives

- State the intent of Section K Swallowing/ Nutritional Status.
- Describe how to conduct an assessment of a resident's nutritional status.
- Calculate resident weight change (gain or loss) accurately.
- Code Section K correctly and accurately.

Intent of Section K

- Assess conditions that affect ability to maintain adequate nutrition and hydration.
- Includes:
  - Swallowing disorders
  - Height and weight
  - Weight change
  - Nutritional approaches
- Collaborate with dietician and dietary staff.

Item K0100

Swallowing Disorder

K0100 Importance

- Ability to swallow safely can be affected by many disease processes and functional decline.
- Alterations in the ability to swallow can result in choking and aspiration.
- Can increase the resident's risk:
  - Malnutrition
  - Dehydration
  - Aspiration pneumonia

K0100 Conduct the Assessment[1]

- Ask resident about any difficulty swallowing during the look-back period.
- Ask about each symptom.
- Observe resident to identify any symptoms.
  - During meals
  - At times resident is eating, drinking, or swallowing
- Interview staff members across all shifts.

K0100 Conduct the Assessment$_2$

- Review medical record
  - Nursing notes
  - Physician notes
  - Dietician notes
  - Speech language pathologist notes
  - Dental history or problems
- Dental problems may include:
  - Poor fitting dentures
  - Dental caries
  - Edentulous
  - Mouth sores
  - Tumors
  - Pain with food consumption

K0100 Assessment Guidelines

- Code a symptom even if it occurred only once in the look-back period.
- Do **not** code a swallowing problem if interventions have been successful in treating the problem.

K0100 Coding Instructions

- Check all items that apply during the look-back period.

K0100. Swallowing Disorder Signs and symptoms of possible swallowing disorder	
↓ Check all that apply	
☐	A. Loss of liquids/solids from mouth when eating or drinking
☑	B. Holding food in mouth/cheeks or residual food in mouth after meals
☐	C. Coughing or choking during meals or when swallowing medications
☑	D. Complaints of difficulty or pain with swallowing
☐	Z. None of the above

Item K0200

Height and Weight

K0200 Importance

- Diminished nutritional and hydration status can lead to debility that can adversely affect:
  - Health and safety
  - Quality of life

- Measuring weight is one guide for determining nutritional status.
- Significant weight gain is as important to monitor as weight loss.

K0200A Height
Conduct the Assessment

- Measure and record height in inches on admission.
- Measure height consistently over time in accordance with facility policy and procedure.
- Check the medical record for subsequent assessments.
- Measure and record height again if last measurement is more than one year old.

K0200A Height
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.

K0200B Weight
Conduct the Assessment

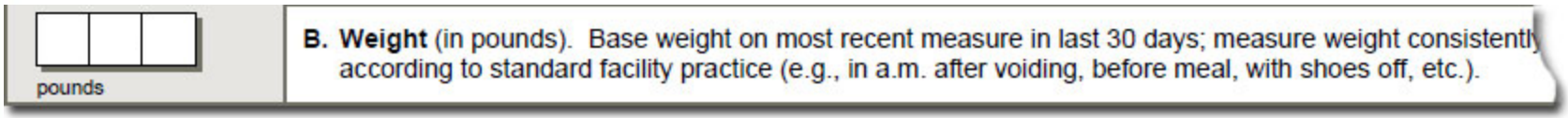
- Weigh resident on admission.
- For subsequent assessments:
  - Check the medical record.
  - Enter the weight taken within 30 days of the ARD.
- Weigh resident again if:
  - Last recorded weight was taken more than 30 days prior to the ARD.
  - Previous weight is not available.

K0200B Weight Assessment Guidelines

- Record the most recent weight if the resident's weight was taken more than once during the preceding month.
- Measure weight consistently over time in accordance with the facility policy and procedure, which should reflect current standards of practice.

K0200B Weight
Coding Instructions

- 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 no-information code (**-**) if the resident cannot be weighed.



Item K0300

Weight Loss

K0300 Importance

- Weight loss can result in debility.
- Can adversely affect:
  - Health
  - Safety
  - Quality of life
- Controlled and careful weight loss can improve mobility and health status for persons with morbid obesity.
- Controlled and careful diuresis can improve health status for persons with a large volume (fluid) overload.

K0300 Conduct the Assessment New Admission

- Ask the resident, family, or significant other.
- Compare admission weight to previous weight.
  - Consult the resident's physician.
  - Review transfer documentation.
- Calculate the percentage of weight loss if admission weight is less than previous weight.
  - Compare to weight 30 days ago.
  - Compare to weight 180 days ago.

K0300 Conduct the Assessment Subsequent Assessments

- Compare current weight to weight 30 days ago.
- Calculate the percentage of weight loss if current weight is less.
- Compare current weight to weight 180 days ago.
- Calculate the percentage of weight loss if current weight is less.

K0300 Assessment Guidelines

- Does not consider weight fluctuation outside of these two time points
- Should not wait for the 30-day or 180-day timeframe if resident is losing or gaining significant amounts of weight
  - 5% in one month
  - 7.5% in three months
  - 10% in six months
- Code weight loss based on whether it was planned/ managed or unplanned/ unmanaged.

K0300 Calculate Percentage (5%)

- Use mathematical rounding before calculation.
- Multiply previous weight by 0.95 to determine resident weight after 5% weight loss.
- Example: 160 pounds x 0.95 = 152 pounds
  - A resident whose weight drops from 160 to 152 lbs or less has experienced 5% or more weight loss.
- Example: 200 pounds x 0.95 = 190 pounds
  - A resident whose weight drops from 200 to 190 lbs or less has experienced 5% or more weight loss.

K0300 Calculate Percentage (10%)

- Use mathematical rounding before calculation.
- Multiply previous weight by 0.90 to determine resident weight after 10% weight loss.
- Example: 160 pounds x 0.90 = 144 pounds
  - A resident whose weight drops from 160 to 144 lbs or less has experienced 10% or more weight loss.
- Example: 200 pounds x 0.90 = 180 pounds
  - A resident whose weight drops from 200 to 180 lbs or less has experienced 10% or more weight loss.

K0300 Calculation Practice #1

- Mrs. J has been on a physician-ordered, calorie-restricted diet for the past year.
- Her current weight is 169 lbs.
- Her weight 30 days ago was 172 lbs.
- Her weight 180 days ago was 192 lbs.

Does Mrs. J have weight loss of 5% or more over the last 30 days?

A. Yes, Mrs. J had weight loss of 5% or more.

B. No, Mrs. J did not have weight loss of 5% or more.

C. Resident did not have weight loss over this time period.

K0300 Coding Sample #1
30-Day Weight Loss

- Mrs. J's current weight is 169 lbs.
- Her weight 30 days ago was 172 lbs.
- 30-day 5% calculation = 172 lbs x .95
- 5% weight loss point is 163.4 lbs.
- Mrs. J does not weigh less than 163.4 lbs.
- Mrs. J does not have 5% weight loss over the last 30 days.

Does Mrs. J have weight loss of 10% or more over the last 180 days?

A. Yes, Mrs. J had weight loss of 10% or more.

B. No, Mrs. J did not have weight loss of 10% or more.

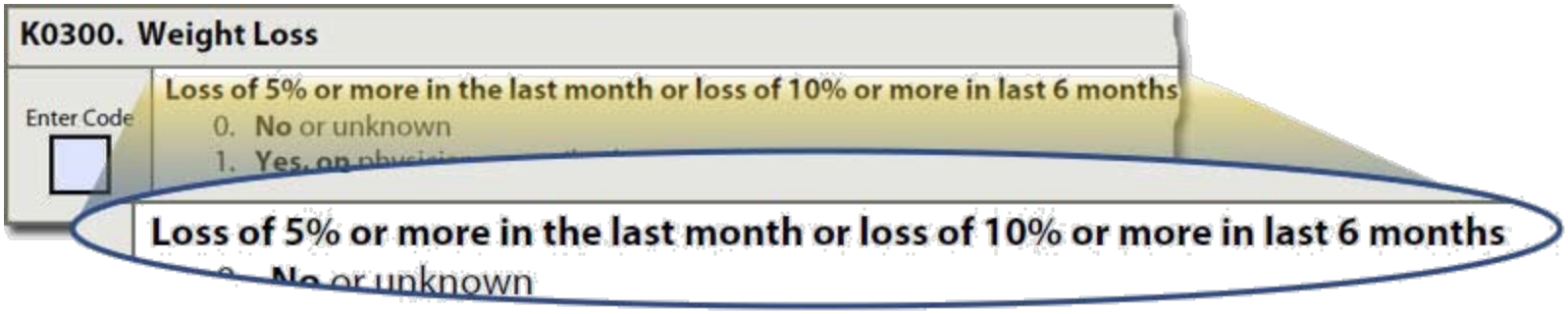
C. Resident did not have weight loss over this time period.

K0300 Coding Sample #1
180-Day Weight Loss

- Mrs. J's current weight is 169 lbs.
- Her weight 180 days ago was 192 lbs.
- 180-day 10% calculation = 192 lbs x .90%
- 10% weight loss point is 172.8 lbs.
- Mrs. J weighs less than 172.8 lbs.
- Mrs. J does have 10% or more weight loss over the last 180 days.

K0300 Coding Instructions$_1$

- Coding determined by percentage of weight loss over the 30-day and 180-day snapshot period.
  - Loss of 5% or more in last month
  - Loss of 10% or more in last six months
  - Does not have to meet both criteria



K0300 Coding Instructions$_2$

- **Code 0. No or unknown**
  - Resident did not experience defined weight loss.
  - Prior weight is not available.
- **Code 1. Yes, on physician-prescribed weight loss regimen**
  - Weight loss planned and pursuant to physician's order.
  - Expressed goal of the diet must be inducing weight loss.
- **Code 2. Yes, not on physician-prescribed weight loss regimen**
  - Weight loss not planned and prescribed by a physician.

Item K0500

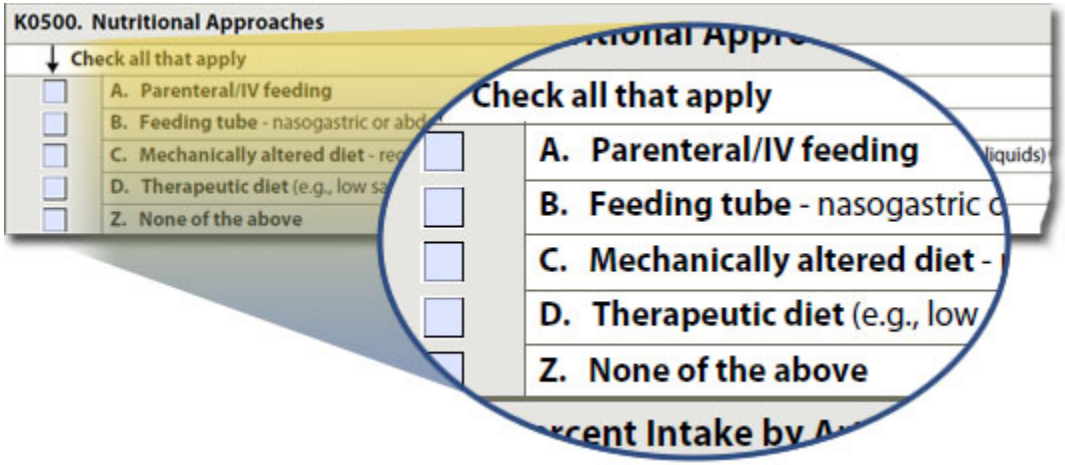
Nutritional Approaches

K0500 Importance

- The resident's clinical condition may potentially benefit from various nutritional approaches.
- It is important for the facility to work with the resident and family members to establish nutritional support goals that integrate the resident's preferences with the overall clinical goals.

K0500 Conduct the Assessment

- Review the medical record.
- Determine if any of the listed nutritional approaches were received by the resident during the look-back period.



K0500 Assessment Guidelines$_1$

- Nutritional approaches include:
  - Any and all nutrition and hydration received by the nursing home resident
  - At the nursing home or at a hospital as an outpatient or as an inpatient
  - **Provided it was administered for nutrition or hydration**

K0500 Assessment Guidelines$_2$

- Enteral feeding formulas:
  - Should not be coded as a mechanically altered diet.
  - Should be coded as a therapeutic diet only if used to manage problematic health conditions (for example, enteral formulas for diabetics).

K0500 Assessment Guidelines$_3$

- Parenteral/ IV feeding can include the following when there is **supporting documentation that reflects the need for additional fluid intake specifically for nutrition or hydration**:
  - IV fluids or hyperalimentation, including total parenteral nutrition (TPN), administered continuously or intermittently
  - IV fluids running at KVO (Keep Vein Open)
  - IV fluids contained in IV Piggybacks
  - Hypodermoclysis and subcutaneous ports in hydration therapy

K0500 Assessment Guidelines$_4$

- The following items are **NOT** coded in K0500A:
  - IV medications
  - IV fluids administered as a routine part of an operative or diagnostic procedure or recovery room stay
  - IV fluids administered solely as flushes
  - Parenteral/ IV fluids administered in conjunction with chemotherapy or dialysis

K0500 Assessment Guidelines$_5$

- IV fluids can be coded in K0500 if needed to prevent dehydration.
- Additional fluid intake specifically for nutrition or hydration and preventing dehydration should be clinically indicated.
- Supporting documentation should be provided in the medical record.

K0500 Coding Instructions

- Check all that apply.
- Check option **Z** if none apply.

K0500. Nutritional Approaches	
↓ Check all that apply	
☑	A. **Parenteral/IV feeding**
☐	B. **Feeding tube** - nasogastric or abdominal (PEG)
☑	C. **Mechanically altered diet** - require change in texture of food or liquids (e.g., pureed food, thickened liquids)
☐	D. **Therapeutic diet** (e.g., low salt, diabetic, low cholesterol)
☐	Z. **None of the above**

K0500 Practice #1$_1$

- Mrs. H is receiving an antibiotic in 100 cc of normal saline via IV.
- She has:
  - Urinary tract infection (UTI)
  - Fever
  - Abnormal lab results (e.g. new pyuria, microscopic hematuria, urine culture with growth >100,000 colony forming units of a urinary pathogen)
  - Documented inadequate fluid intake (i.e. output of fluids far exceeds fluid intake) with signs and symptoms of dehydration

K0500 Practice #1$_2$

- She is placed on the nursing home's hydration plan to ensure adequate hydration.
- Documentation shows IV fluids are being administered as part of the already identified need for additional hydration.

How should K0500 be coded?

A. Check K0500A Parenteral/ IV feeding.

B. Check K0500B Feeding tube.

C. Check K0500C Mechanically altered diet.

D. Check K0500D Therapeutic diet.

E. Check K0500Z None of the above.

K0500 Practice #1 Coding

- Check K0500A Parenteral/ IV feeding.
- The resident received 100 cc of IV fluid.
- There is supporting documentation that reflected an identified need for additional fluid intake for hydration.

K0500 Practice #2

- Mr. J is receiving an antibiotic in 100 cc of normal saline via IV.
- He has a UTI, no fever, and documented adequate fluid intake.
- He is placed on the nursing home's hydration plan to ensure adequate hydration.

How should K0500 be coded?

A. Check K0500A Parenteral/ IV feeding.

B. Check K0500B Feeding tube.

C. Check K0500C Mechanically altered diet.

D. Check K0500D Therapeutic diet.

E. Check K0500Z None of the above.

K0500 Practice #2 Coding

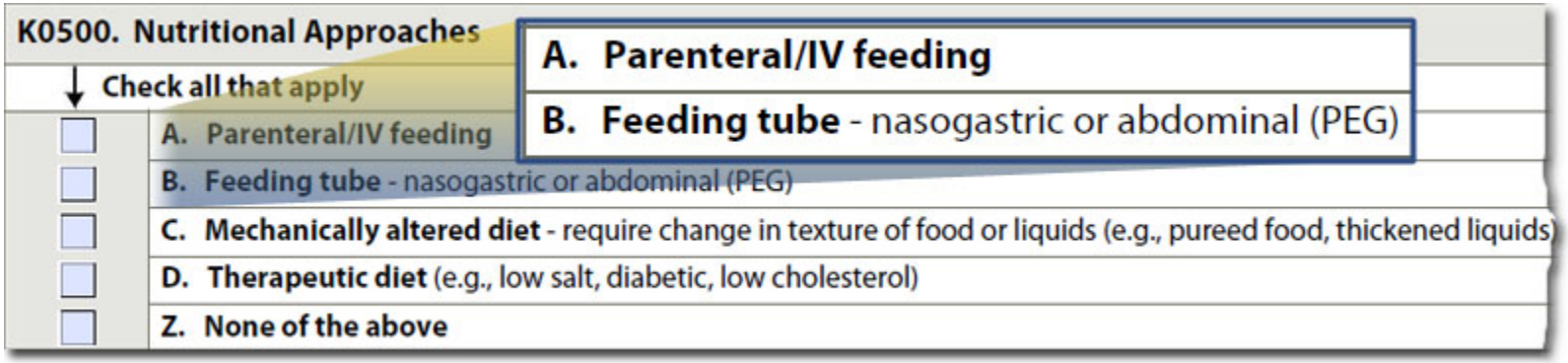
- Check K0500Z None of the above.
- Although the resident received the additional fluid, there is no documentation to support a need for additional fluid intake.

Item K0700

Percent Intake by Artificial Route

K0700 Percent Intake by Artificial Route

- Complete this item only if K0500A or K0500B is checked.



K0700A Parenteral/ IV Feeding Conduct the Assessment

- Review intake records to determine actual intake through parenteral or tube feeding routes.
- Calculate the proportion of total calories received through these routes.
- If the resident took no food or fluids by mouth or took just sips of fluid, stop here**.**
- If the resident had more substantial oral intake than this, consult with the dietician.

K0700A Calculate Proportion$_1$

- Dietician report of total calories:

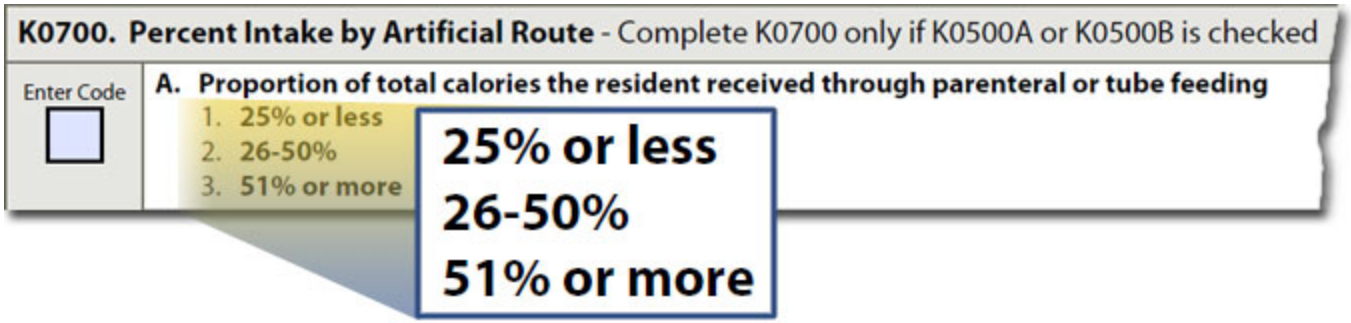
	Oral	Tube
Sun.	500	2,000
Mon.	250	2,250
Tues.	250	2,250
Wed.	350	2,250
Thurs.	500	2,000
Fri.	250	2,250
Sat.	350	2,000
Total	2,450	15,000

K0700A Calculate Proportion$_2$

- Total oral intake = 2,450 calories
- Total tube intake = 15,000 calories
- Total calories = 2,450 + 15,000 = 17,450
- Percentage of calories by tube feeding
  - 15,000 / 17,450 = 0.859
  - 0.859 x 100 = 85.9%

K0700A Coding Instructions

- Select the best response.
- Code **3** if the resident took no food or fluids by mouth or took just sips of fluid.



K0700B Feeding Tube
Conduct the Assessment

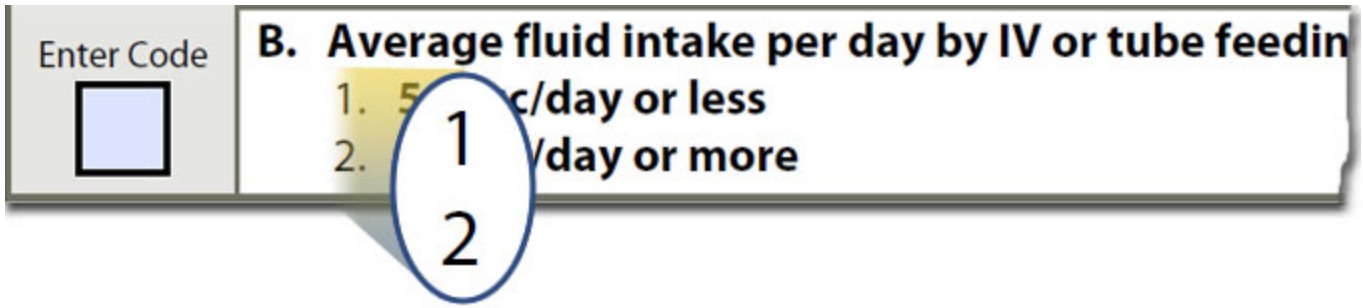
- Add up the total amount of fluid received each day by IV and/ or tube feedings only.
- Divide the week's total fluid intake by 7 to calculate the average of fluid intake per day.
- Divide by 7 even if the resident did not receive IV fluids and/ or tube feeding on each of the 7 days.

K0700B Assessment Guidelines

- Code the average number of cc's of fluid the resident received per day by IV or tube feeding.
- Record what was **actually received** by the resident.
- Do not code what was ordered.

K0700B Coding Instructions

- **Code 1.** 500 cc/ day or less
- **Code 2.** 501 cc/ day or more



K0700B Scenario #1$_1$

- Ms. A has swallowing difficulties secondary to Huntington's disease.
- She is able to take oral fluids by mouth with supervision, but not enough to maintain hydration.
- She received daily fluid by supplemental tube feedings (including water, prepared nutritional supplements, juices) during the last 7 days.

K0700B Scenario #1$_2$

Sun	1250 cc	Thurs	1200 cc
Mon	775 cc	Fri	500 cc
Tues	925 cc	Sat	450 cc
Wed	1200 cc	Total	6,300 cc

- Daily average = 6,300 cc/ 7 days
- Daily average = 900 cc/ day
- Code option **2. 501 cc/ day or more**

K0700B Scenario #2$_1$

- Mrs. G received 1 liter of IV fluids during the 7-day assessment period.
- She received no other intake via IV or tube feeding during the assessment period.

K0700B Scenario #2$_2$

Sun	00 cc	Thurs	00 cc
Mon	00 cc	Fri	00 cc
Tues	1000 cc	Sat	00 cc
Wed	00 cc	Total	1,000 cc

- Daily average = 1,000 cc/ 7 days
- Daily average = 142.9 cc/ day
- Code option **1. 500 cc/ day or less**

Section K

Summary

Section K Summary

- Intent is to assess conditions that could affect a resident's ability to maintain adequate nutrition and hydration.
- Addresses multiple factors reflecting nutritional status:
  - Difficulties swallowing
  - Weight loss
  - Nutritional approaches required
  - Intake of calories or fluid by parenteral or tube feeding