

## Section K Coding Worksheet

SECTION	Nursing	Therapy
<b>K0100A</b>	Loss of Liquids/ solids from mouth when eating or drinking	<input type="checkbox"/> Anterior Spillage <input type="checkbox"/> Decreased oral containment on right or left side <input type="checkbox"/> Drooling <input type="checkbox"/> Labial/ bolus loss <input type="checkbox"/> Residue on lips or chin <input type="checkbox"/> Decreased ability to clear food from spoon <input type="checkbox"/> Poor saliva management <input type="checkbox"/> Perservative mastication with food expulsion/ loss
<b>K0100B</b>	Holding Food in mouth/cheeks or residual food in mouth after meals	<input type="checkbox"/> Reduced oral clearance with residue <input type="checkbox"/> Reduced bolus formation <input type="checkbox"/> Limited anterior-posterior propulsion of bolus or tongue movement <input type="checkbox"/> Tongue pumping <input type="checkbox"/> Reduced mastication <input type="checkbox"/> Increased time for meal consumption <input type="checkbox"/> Reduced tolerance to varied textures <input type="checkbox"/> Reduced tolerance to hot/ cold temperatures <input type="checkbox"/> Munched chewing
<b>K0100C</b>	Coughing or choking during meals or when swallowing medications	Signs of choking or coughing such as: <input type="checkbox"/> Watery eyes <input type="checkbox"/> Runny nose <input type="checkbox"/> Effortful swallow <input type="checkbox"/> Poor airway protection <input type="checkbox"/> Poor reflexive and volitional swallow <input type="checkbox"/> Wet vocal cords or change in vocal quality or breath sounds <input type="checkbox"/> Shortness of breath <input type="checkbox"/> Throat clearing <input type="checkbox"/> Recurring pneumonia
<b>K0100D</b>	Complaints of difficulty or pain with swallowing	<input type="checkbox"/> Odynophagia = pain with swallowing <input type="checkbox"/> Globus sensation = feeling of food stuck in throat at level of sternal notch <input type="checkbox"/> Premature feeling of fullness <input type="checkbox"/> Oral or nasal emesis during/ after intake <input type="checkbox"/> Heartburn sensation

Patient Name: \_\_\_\_\_

MRN: \_\_\_\_\_

 Therapist  
 Signature: \_\_\_\_\_

Date: \_\_\_\_\_