CARING & CODING FOR MALNUTRITION

Sandy Routhier RHIA, CCS, CDIP, AHIMA
Approved ICD-10CM/PCS Trainer
CloudMed Solutions

Michelle Mathura, RDN, LRD, CDE
Director, Nutrition Division DM&A

Our Presenters

Sandra Routhier, RHIA, CCS, CDIP
AHIMA-Approved ICD-10-CM/PCS
Trainer & Ambassador

Michelle Mathura, RDN, LRD, CDE
Director, Nutrition Division – DM&A
DM&A Nutrition Division Services

Professional Coaching, Education, and Training:

- Inpatient Nutrition Services
- Outpatient Nutrition Services
- Diabetes Self Management
- Tele-nutrition Support

More information:
www.destination10.com/nutrition-division
DM&A Nutrition Division

Malnutrition Education and Training Program

• Onsite Nutrition Focused Physical Assessment Hands On Training

• Dietitian Driven Program

• **Education, Training and Coaching:**
  Dietitians, Providers & Physicians, Coding, CDI, Revenue Integrity, Decision Support, Food Service, Social Work, Case Management, Nursing and many more....

The Value & Purpose of a Malnutrition Program

• Improves quality of patient care

• Provides training and tools to effectively implement evidenced based guidelines

• Elevates the role and function of the RDN in the healthcare setting

• Promotes collaboration and integration
  - CDI/Coding, Physicians, RN/PCT’s, Administration, Information Systems, and more

• Demonstrates the value of the RDN to the healthcare organization

• Improves the financial health of the hospital
Global Prevalence of Malnutrition

• 25 - 50% of patients admitted to hospitals each year are **malnourished** in emerging and developed nations.

• An estimated **20 million children** under the age of 5 worldwide are severely undernourished.


Malnutrition Global Consensus

• Malnutrition is common worldwide.

• Malnourished patients have poorer health related outcomes than non-malnourished counterparts.

• Nutrition intervention can make a difference.

Best Practices

- Nutrition Screening
- Nutrition Assessment
- Nutrition Focused Physical Assessment / Exam
- Intervention – inpatient / outpatient
- Care plan / discharge

CODING FOR MALNUTRITION
### Malnutrition Codes

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>Code</th>
<th>Status</th>
<th>SOI/ROM</th>
</tr>
</thead>
<tbody>
<tr>
<td>Malnutrition – Unspecified</td>
<td>E46</td>
<td>CC</td>
<td>3/2</td>
</tr>
<tr>
<td>Malnutrition – Mild</td>
<td>E44.1</td>
<td>CC</td>
<td>2/1</td>
</tr>
<tr>
<td>Malnutrition – Moderate</td>
<td>E44.0</td>
<td>CC</td>
<td>3/2</td>
</tr>
<tr>
<td>Malnutrition – Severe</td>
<td>E43</td>
<td>MCC</td>
<td>4/3</td>
</tr>
<tr>
<td>Nutritional Marasmus</td>
<td>E41</td>
<td>MCC</td>
<td>4/3</td>
</tr>
<tr>
<td>Emaciation (due to Malnutrition)</td>
<td>E41</td>
<td>MCC</td>
<td>4/3</td>
</tr>
<tr>
<td>Malnutrition – Severe Protein-Calorie Intermediate Form (codes to Marasmic Kwashiorkor)</td>
<td>E42</td>
<td>MCC</td>
<td>4/3</td>
</tr>
<tr>
<td>Kwashiorkor</td>
<td>E40</td>
<td>MCC</td>
<td>4/3</td>
</tr>
<tr>
<td>Malignant Malnutrition</td>
<td>E40</td>
<td>MCC</td>
<td>4/3</td>
</tr>
</tbody>
</table>

### Impact on Reimbursement

**MS-DRGs**
- Complication or Comorbidity (CC)
- Major Complication or Comorbidity (MCC)

**APR-DRGs**
- Severity of Illness (SOI)
- Risk of Mortality (ROM)
### MS-DRG Impact: CC/MCC

#### NUTRITION DIVISION

**Respiratory Neoplasms**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Affect</th>
<th>MCC</th>
<th>CC</th>
<th>SOI</th>
<th>ROM</th>
</tr>
</thead>
<tbody>
<tr>
<td>C3412</td>
<td>Malignant neoplasm of upper lobe, left bronchus or lung</td>
<td>✔</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

\[
0.8449 \times \$7000 = \$5,914
\]

### MS-DRG Impact: CC/MCC

#### NUTRITION DIVISION

**Respiratory Neoplasms**

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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>E441</td>
<td>Mild protein-calorie malnutrition</td>
<td>✔</td>
<td>✔</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

\[
0.8449 \times \$7000 = \$5,914 \\
1.1561 \times \$7000 = \$8,092
\]
MS-DRG Impact: CC/MCC

\[
\begin{align*}
0.8449 \times 7000 &= 5,914 \\
1.1561 \times 7000 &= 8,092 \\
1.6894 \times 7000 &= 11,825
\end{align*}
\]

APR-DRGs: Severity of Illness (SOI)

\[
0.8204 \times 7000 = 5,742
\]
**APR-DRGs: Severity of Illness (SOI)**

<table>
<thead>
<tr>
<th>Code</th>
<th>Diagnosis Code Detail</th>
<th>Description</th>
<th>Affect</th>
<th>MCC</th>
<th>CC</th>
<th>SOI</th>
<th>ROM</th>
</tr>
</thead>
<tbody>
<tr>
<td>C3412</td>
<td>Principal</td>
<td>Malignant neoplasm of upper lobe, left bronchus or lung</td>
<td>✓</td>
<td>P</td>
<td>P</td>
<td></td>
<td></td>
</tr>
<tr>
<td>E441</td>
<td></td>
<td>Mild protein-calorie malnutrition</td>
<td></td>
<td></td>
<td></td>
<td>2</td>
<td>1</td>
</tr>
</tbody>
</table>

- $0.8204 \times $7000 = $5,742
- $0.9167 \times $7000 = $6,417

**APR-DRGs: Severity of Illness (SOI)**

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<tr>
<th>Code</th>
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<td>P</td>
<td>P</td>
<td></td>
<td></td>
</tr>
<tr>
<td>E43</td>
<td></td>
<td>Unspecified severe protein-calorie malnutrition</td>
<td></td>
<td>4</td>
<td>3</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

- $0.8204 \times $7000 = $5,742
- $0.9167 \times $7000 = $6,417
- $1.3396 \times $7000 = $9,377
RECENT CODING ADVICE

AHA Coding Clinic – Severe Malnutrition

Question:
Can code E40, Kwashiorkor or code E42, Marasmus, kwashiorkor, be assigned to capture a diagnosis of severe malnutrition?

Answer:
No, do not assign code E40, Kwashiorkor or code E42, Marasmus, kwashiorkor, for severe malnutrition unless this condition is specifically documented. Assign code E43, Unspecified severe protein-calorie malnutrition. Code E43 can be found by looking up "Malnutrition, severe" in the Alphabetic Index as follows:

Malnutrition E46
degrees:
- first E44.1
- mild (moderate) E44.1
- moderate (severe) E44.0
- severe (protein-energy) E43
- intermediate form E42
  with
  kwashiorkor (and marasmus) E42
  marasmus E41

Kwashiorkor is a condition caused by severe protein deficiency that is usually seen in poor, underdeveloped countries. It is extremely rare in the United States.
AHA Coding Clinic – Emaciation

Question:
The ICD-10-CM Index for Diseases lists the following: Emaciation (due to malnutrition) E41. The Tabular List of Diseases lists E41 as Nutritional Marasmus. If a physician documents Emaciation, given that “due to malnutrition” is a nonessential modifier, the Index classifies the term “emaciation” as E41. Nutritional marasmus. If a physician documents “emaciation” without documenting malnutrition, would it be appropriate to assign code E41?

Answer:
First, it should be noted that marasmus by definition is a type of protein-energy malnutrition occurring in infants or young children, that is caused by a severe calcium deficiency. If that is not applicable for the case, then it is not correct to assign code E41. Nutritional marasmus, even if the physician only documents emaciated or emaciation without the documentation of malnutrition. Assign code R84, Cachexia, for a diagnosis of emaciation/marasmus. If the provider intended to describe malnutrition, then it should be documented as such. Emaciation is a descriptive term, meaning unusually thin due to wasting. Although the Index currently refers to code E41, a basic rule of coding is that further research is done if the title of the code suggested by the Index does not identify the condition correctly.
OIG Work Plan – Kwashiorkor

ICD-9 Diagnosis Code 260

OIG: “We determined that all of the providers should have used codes for other forms of malnutrition or no malnutrition code at all instead of diagnosis code 260. The ICD-9 coding classification contained a discrepancy between the tabular list and the alpha index on the use of diagnosis code 260. According to the alpha index, four other malnutrition diagnoses corresponded to diagnosis code 260. However, according to the ICD-9 tabular list, diagnosis code 260 was only for Kwashiorkor.”

Hospital: “determined that claims billed with the diagnosis code 260 (Kwashiorkor) were coded erroneously, facilitated by a decision path within our coding software, 3M Encoder.”

OIG Work Plan – Severe Malnutrition

DRG Validation vs. Clinical Validation

DRG Validation is the process of reviewing physician documentation and determining whether the correct codes, and sequencing were applied to the billing of the claim. This type of review shall be performed by a certified coder. For DRG Validations, certified coders shall ensure they are not looking beyond what is documented by the physician, and are not making determinations that are not consistent with the guidance in Coding Clinic.

Source: Recovery Audit Statement of Work 2013

DRG Validation vs. Clinical Validation

Clinical validation is an additional process that may be performed along with DRG validation. Clinical validation involves a clinical review of the case to see whether or not the patient truly possesses the conditions that were documented in the medical record. Recovery Auditor clinicians shall review any information necessary to make a prepayment or post-payment claim determination. Clinical validation is performed by a clinician (RN, CMD or therapist). Clinical validation is beyond the scope of DRG (coding) validation, and the skills of a certified coder. This type of review can only be performed by a clinician or may be performed by a clinician with approved coding credentials.

Source: Recovery Audit Statement of Work 2013
Clinical Validation – AHIMA Practice Brief

The goal of clinical validation is to ensure that the health record is not only coded accurately, but also accurately reflects the clinical scenario within the health record, which requires collaboration among providers, CDI professionals, and coding professionals.

The importance of accurately capturing the clinical scenario through the available code set continues to grow as CMS revises its payment methodologies, tying quality of care to reimbursement. Clinical validation is also a frequent reason for payment denials.
Clinical Validation - Denial

While it is recognized that this patient's underlying medical condition placed them at risk for malnutrition, the patient was not severely malnourished at the time of this hospitalization as judged by objective standards. In order to validate the diagnosis we require specific clinical data. According to consensus criteria, severe malnutrition is defined by Body Mass Index of less than 16, clinically significant weight loss and characteristic clinical signs.

In this case, the patient was diagnosed with urinary tract infection. Review acknowledged that the patient was noted with poor appetite due to Alzheimer's disease with 2.2% weight loss in one week, and evidence of severe muscle wasting and moderate subcutaneous fat loss warranting oral nutrition supplement with Ensure and Thrive. However, the patient's recorded weight was 126 pounds with a height of 4 feet 9 inches, a noted ideal body weight of 100 pounds, and body mass index of 23, which are not congruent with severe malnutrition. There was no recorded pre-albumin level found upon review. Although, severe malnutrition was documented, there was insufficient clinical evidence and supportive documentation in the records available for review to substantiate the coding of this condition.

References:

A final rule issued by CMS in May 2015 both concurs with the need for trained professionals to perform nutrition focused exams and to prescribe the appropriate diet to target the identified deficiencies.

In this rule CMS states: “We believe that RDs (clarified as qualified nutrition professionals) are the professionals who are best qualified to assess a patient’s nutritional status and to design and implement a nutritional treatment plan in consultation with the patient’s interdisciplinary care team. In order for the patient to receive timely nutritional care the RD must be viewed as an integral member of the hospital interdisciplinary care team, one who, as the team’s clinical nutrition expert, is responsible for the patient’s nutritional diagnosis and treatment in light of the patient’s medical diagnosis.

**Definition of Additional Diagnosis**

For reporting purposes the definition for “other diagnoses” is interpreted as additional conditions that affect patient care in terms of requiring:

- clinical evaluation; or
- therapeutic treatment; or
- diagnostic procedures; or
- extended length of hospital stay; or
- increased nursing care and/or monitoring.

The UHDDS item #11-b defines Other Diagnoses as “all conditions that coexist at the time of admission, that develop subsequently, or that affect the treatment received and/or the length of stay.

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**ICD-10-CM Coding Guideline I.A.19**

**Code assignment and Clinical Criteria**

The assignment of a diagnosis code is based on the provider’s diagnostic statement that the condition exists. The provider’s statement that the patient has a particular condition is sufficient. Code assignment is not based on clinical criteria used by the provider to establish the diagnosis.
Wrap Up

- Team Approach
- Communicate with CDI / Coding Malnutrition Diagnosis
- Constant communication / education with physicians
- Best Practice Nutrition, Competency, Confidence
- Follow up on denials
- Advocate for the best practice and patient care
- Collect Accurate Data
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