OIG Malnutrition Audits Time To Up Our Game

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Speaker
James S. Kennedy MD

- **Education**
  - Medical school – University of Tennessee, Memphis – 1976 - 1979
  - Internal Medicine Residency, UT Memphis – 1980 – 1982
- **Clinical Experience**
  - Primary Care Internal Medicine – Franklin, TN – 1983 – 1998
  - Part of Vanderbilt faculty
  - Medical Examiner of Williamson County
- **Current Activities**
  - CDI Consulting – 1999 – present
  - ICD-10-CM/PCS Analytics - CDIMDTracker
  - Medical Informatics – Epic/Cerner/Meditech support
  - Physician Advisor/CDI education
  - Inpatient MS-DRG/APR-DRG Compliance

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Speaker
Paul R. Belton, RHIA, MHA, MBA, JD, LLM

- **Experience**
  - Compliance Officer – Sharp Healthcare in California (1998-2020)
  - Manager, Healthcare Regulatory Division - PwC (1997-1998)
  - Legal Consultant – AHA – (1996-1997)
- **Education**
  - University of Illinois at Chicago – RHIA
  - Arizona State – MHA
  - University of Akron – JD
  - Arizona State – MBA
  - Loyola University – Masters of Law – Health
- Currently available for consulting applicable to today's topic

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Article Discussing Today's Topic

- Available at https://tinyurl.com/AHLAConnections202010 - page 18
- Published October 1, 2020

Goals

At the conclusion of this lecture, the audience should be able to:

- Understand the OIG's approach to the clinical and coding validation of severe malnutrition
- Embrace official ICD-10-CM conventions, guidelines, and advice applicable to severe malnutrition
- Begin to develop and implement a strategy toward CDI and coding compliance with severe malnutrition

This lecture is the sole opinion of Dr. James S. Kennedy MD and Paul Belton, RHIA, JD
While every effort is made to be accurate, what is stated may not necessarily adhere to official policy.
In all circumstances, please ascertain with leadership the correct protocols for ICD-10-CM/PCS query and code assignment.

CDI Foundations
What Is CDI (CDCI)?

- Clinical documentation (and coding) **integrity** (CDI or CDCI) is the **policies, procedures, technology, people, and effort** that promotes legible, clear, consistent, complete, precise, non-conflicting, and reliable provider documentation essential to the ***final*** assignment of ***accurate*** and ***clinically congruent*** HIPAA-associated transaction set codes (e.g., CPT, ICD-10-CM, ICD-10-PCS) and their submission to intermediaries for adjudication.
- CDI is emphasized in the ICD-10-CM Official Guidelines for Coding and Reporting, which states:
  - A ***joint effort*** between the healthcare provider and the coder is essential to achieve complete and accurate documentation, code assignment, and reporting of diagnoses and procedures.
  - The importance of ***consistent, complete documentation*** in the medical record cannot be overemphasized. Without such documentation accurate coding cannot be achieved.

CDI Foundations Responsibilities

- **Physician/provider (Medical staff)**
  - **Definition(s)** of diagnostic or therapeutic terminologies
  - **Diagnosis** or **description** of patient conditions or treatments
  - **Documentation** in the medical record

- **Everyone**
  - **Defense** when held accountable by outside entities

- **Clinical documentation, ancillary, and coding staff (Facility)**
  - **Deciphering** unclear, inconsistent, incomplete, imprecise, unreliable, conflicting, or illegible documentation in light of the clinical circumstances
  - **Delineation** of documented diagnoses or treatments in the context of their actual occurrence and within the limitations of HIPAA-associated transaction sets
  - **Deployment** of ICD-10 and CPT/HCPCS codes based upon the actual and vetted provider documentation

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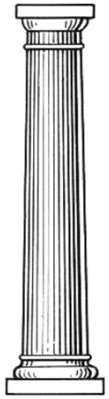
CDI Foundations
Team Composition

- **Providers**
  - Primary agents for condition or treatment definition, diagnosis, description and documentation

CDI

- **Coders**
  - ICD-10-CM/PCS content experts and final arbiters on what codes are submitted
  - Usually tasked with post-discharge (retrospective) query



- **Concurrent/Clinical Documentation Specialists (CDS)**
  - Nurses, coders or others who negotiate CDI principles with physicians, usually during an active patient encounter ("concurrent review")
  - Managers of the whole CDI process
- **Compliance officer**
  - Ensures that the process withstands retrospective scrutiny
- **Medical informatics**
  - **Incorporates ICD-10-CM/PCS or CPT terminology into paper or electronic health record (EHR)**

- **Service line directors (e.g., CV, orthopaedic, trauma, obstetrics)**
  - Negotiates terminology and documentation structure that systemizes clinical information capture with providers, coders, and CDI team
- **Ancillaries, such as**
  - **Dietitians**
  - Wound care
  - Respiratory therapy
  - Physical therapy
  - Antibiotic stewardship/clinical pharmacy
- **Others (e.g. subject matter experts)**

Physician advisors and C-suite are active supporters and champions

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CDI Essentials

REACTIVE CDI

- Occurs ***after*** the provider finishes documenting an encounter
- Involves labor-intensive direct physician queries by expensive CDI specialists or coders
  - While AI technologies like Iodine help, no one individual can master all 30-35 methodologies
- Queries often cannot directly suggest a new diagnosis or documentation style
  - CDS or coder cannot "lead" the provider
- Inhibited by manpower requirements and "query fatigue", resulting in some risk-models not receiving due attention
- Confounded by non-intuitive ICD-10-CM/PCS documentation and coding requirements

PROACTIVE CDI

- Promotes complete, precise, and clinically valid critical thinking and documentation ***prior to*** the provider's completion of their record, inhibiting the need for provider query.
- Involves EHR-imbedded templates, structure, and processes that not only promotes correct documentation for ALL risk models at the time of the encounter but also allows for the documentation to be "reused" by others
- Supplemented by AI (e.g. M*Modal, Nuance) or EHR (e.g. Epic Best Practice Advisories) technologies that encourage correct documentation upfront
- Monitored by CDI staff whereby the query is the exception, rather than the rule

All supplemented by data analytics, education, and training as to focus the work effort

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Reactive CDI Requiring Proactive Approach OIG Severe Malnutrition Audits

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

July 23, 2020

HOSPITALS OVERBILLED MEDICARE $1 BILLION BY INCORRECTLY ASSIGNING SEVERE MALNUTRITION DIAGNOSIS CODES TO INPATIENT HOSPITAL CLAIMS

https://oig.hhs.gov/oas/reports/region3/31700010.pdf

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OIG's Declaration

- **According to the OIG:**
  - ***173 of 200 (86.5%)*** inpatient encounters reporting ICD-10-CM codes E41, Nutritional marasmus, or E43, Unspecified severe protein-calorie malnutrition, serving as the only MS-DRG MCC were reported in error.
  - ***31% payment error rate***, much higher than the 5% benchmark the OIG uses in discovery audits, incurred that, upon extrapolation, represents a $1 billion two-year impact on the traditional Medicare program.

APPENDIX E: CMS COMMENTS

DEPARTMENT OF HEALTH & HUMAN SERVICES — Centers for Medicare & Medi

Administrator
Washington, DC 20201

DATE: May 15, 2020

TO: Christi Grimm
Principal Deputy Inspector General
Office of Inspector General

FROM: Seema Verma
Administrator
Centers for Medicare & Medicaid Services

SUBJECT: Office of Inspector General (OIG) Draft Report: Hospitals Overbilled Medicare $1 Billion by Incorrectly Assigning Severe Malnutrition Diagnosis Codes to Inpatient Hospital Claims (A-03-17-00010)

"Centers for Medicare & Medicaid Services [will] review how hospitals are using diagnosis code E41 for nutritional marasmus and diagnosis code E43 for unspecified severe protein-calorie malnutrition and work with hospitals to ensure that they correctly bill Medicare when using severe malnutrition diagnosis codes."

ASPEN – AND – ASN – ACDIS Joint Statement

https://tinyurl.com/yxjhwazg

Two Consensus Driven Criteria ASPEN/AND and GLIM

Consensus Statement | Free Access

Consensus Statement: Academy of Nutrition and Dietetics and American Society for Parenteral and Enteral Nutrition

Characteristics Recommended for the Identification and Documentation of Adult Malnutrition (Undernutrition)

https://onlinelibrary.wiley.com/doi/full/10.1177/0148607112440285

GLIM Criteria for the Diagnosis of Malnutrition: A Consensus Report From the Global Clinical Nutrition Community

https://onlinelibrary.wiley.com/doi/full/10.1002/jpen.1440

- Others exist, such as the Subjective Global Assessment (SGA), the Nestle Nutritional Assessment, or World Health Organization
- Requires negotiation with invested entities

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Estimated Incidence Of Inpatient Non-Severe/Severe Malnutrition

- Applicable to GLIM criteria

	Total	Ages 40-69	Ages ≥ 70	Mortality
None	71.9%	85.5%	58.1%	
"At-Risk"	28.1%	14.5%	41.9%	1.9%
GLIM-defined malnutrition	18.0%	10.6%	25.7%	
Stage 1 – Nonsevere	9.0%	5.0%	13.0%	5.7%
Stage 2 – severe	9.0%	5.5%	12.6%	9.6%
Adapted from Maeda K, Ishida Y, et. al. Reference body mass index values and the prevalence of malnutrition according to the Global Leadership Initiative on Malnutrition criteria. Clinical Nutrition 2020:39 (1), pp 180-184.				

- Unable to find similar data in the literature for ASPEN

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ASPEN – AND – ASN – ACDIS Statement

- Despite efforts, CMS still has been unable to provide us with written policies and procedures for what they consider to be correct criteria for diagnosis and coding of severe malnutrition.
  - Anecdotal reports from our members and review of some CMS auditor reports raise concerns about inappropriate use of criteria such as serum albumin.
- This task force has been actively collaborating for several years on efforts to help the U.S. Department of Health and Human Services, the OIG, and CMS understand the best practices for diagnosing, documenting, and coding for malnutrition.
  - As characterized by experts in the field, these criteria have evolved appreciably over the past two decades, such that some historic indicators of malnutrition are now considered to lack validity.
  - The task force intends to continue these efforts including providing a response to CMS about the OIG report.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

OFFICE OF INSPECTOR GENERAL

WASHINGTON, DC 20201

FOIA Request 2020-2232

Freedom of Information Act Office
Cohen Bldg., Suite 5541
330 Independence Ave., SW
Washington DC 20201

September 21, 2020

James Kennedy
110 Francis King Drive
Smyrna, TN 37167

Dear Mr. Kennedy:

This is in response to the July 16, 2020, Freedom of Information Act (FOIA) request you originally submitted to the Department of Interior and received in the Department of Health and Human Services (HHS), Office of Inspector General (OIG), on August 24, 2020, seeking Review Sheets for A-03-17-00010 and Clinical Criteria for Severe Malnutrition and Marasmus.

ASPEN Criteria Used
Actual Article Sent With FOIA Request

Consensus Statement

aspen | LEADING THE SCIENCE AND PRACTICE OF CLINICAL NUTRITION
American Society for Parenteral and Enteral Nutrition

Consensus Statement: Academy of Nutrition and Dietetics and American Society for Parenteral and Enteral Nutrition: Characteristics Recommended for the Identification and Documentation of Adult Malnutrition (Undernutrition)

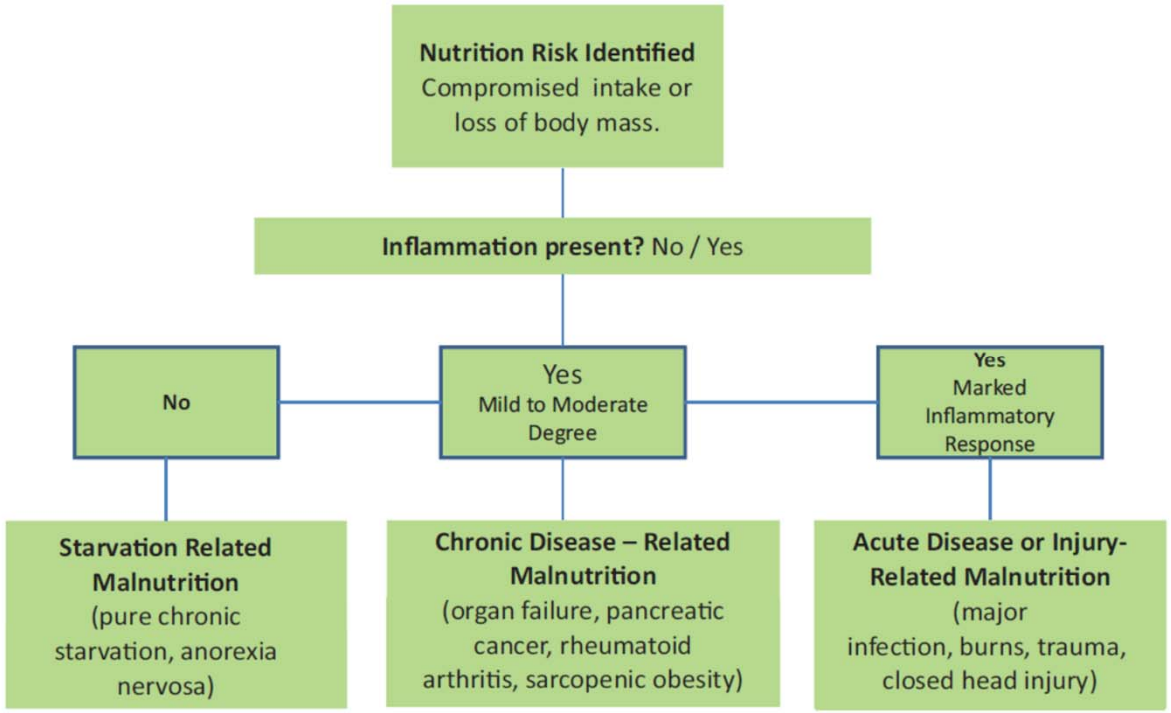
Jane V. White, PhD, RD, FADA[1]; Peggi Guenter, PhD, RN[2]; Gordon Jensen, MD, PhD, FASPEN[3]; Ainsley Malone, MS, RD, CNSC[4]; Marsha Schofield, MS, RD[5]; the Academy Malnutrition Work Group; the A.S.P.E.N. Malnutrition Task Force; and the A.S.P.E.N. Board of Directors

Journal of Parenteral and Enteral Nutrition
Volume 36 Number 3
May 2012 275-283

DOI: 10.1177/0148607112440285
http://jpen.sagepub.com
hosted at
http://online.sagepub.com
SAGE

http://www.tinyurl.com/malnutrition2012

3 Different Criteria
Based On Patient's Inflammatory State



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Guiding Principles

- Malnutrition was classified as nonsevere (moderate) or severe
  - There is insufficient evidence regarding their application in clinical settings to allow for further distinction to be made between mild and moderate forms of malnutrition at this time.
- Serum proteins such as serum albumin and prealbumin are not included as defining characteristics of malnutrition because recent evidence analysis shows that serum levels of these proteins do not change in response to changes in nutrient intake.
- The National Center for Health Statistics defines chronic as a disease/condition lasting 3 months or longer.

Criteria
2 or more of the Following 6 Characteristics

- Because no single parameter is definitive for adult malnutrition, the identification of 2 or more of the following 6 characteristics is recommended for diagnosis:
  - Insufficient energy intake
  - Weight loss
  - Loss of muscle mass
  - Loss of subcutaneous fat
  - Localized or generalized fluid accumulation that may sometimes mask weight loss
  - Diminished functional status as measured by handgrip strength

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Clinical Characteristic	Malnutrition in the Context of Acute Illness or Injury		Malnutrition in the Context of Chronic Illness		Malnutrition in the Context of Social or Environmental Circumstances	
	Nonsevere (Moderate) Malnutrition	Severe Malnutrition	Nonsevere (Moderate) Malnutrition	Severe Malnutrition	Nonsevere (Moderate) Malnutrition	Severe Malnutrition
(1) Energy intake[1] Malnutrition is the result of inadequate food and nutrient intake or assimilation; thus, recent intake compared with estimated requirements is a primary criterion defining malnutrition. The clinician may obtain or review the food and nutrition history, estimate optimum energy needs, compare them with estimates of energy consumed, and report inadequate intake as a percentage of estimated energy requirements over time.	<75% of estimated energy requirement for >7 days	≤50% of estimated energy requirement for ≥5 days	<75% of estimated energy requirement for ≥1 month	≤75% of estimated energy requirement for ≥1 month	<75% of estimated energy requirement for ≥3 months	≤50% of estimated energy requirement for ≥1 month

(2) Interpretation of weight loss[2-5] The clinician may evaluate weight in light of other clinical findings, including the presence of under- or overhydration. The clinician may assess weight change over time reported as a percentage of weight lost from baseline.	%	Time	%	Time	%	Time	%	Time	%	Time	%	Time
	1–2	1 wk	>2	1 wk	5	1 mo	>5	1 mo	5	1 mo	>5	1 mo
	5	1 mo	>5	1 mo	7.5	3 mo	>7.5	3 mo	7.5	3 mo	>7.5	3 mo
	7.5	3 mo	>7.5	3 mo	10	6 mo	>10	6 mo	10	6 mo	>10	6 mo
					20	1 y	>20	1 y	20	1 y	>20	1 y

Clinical Characteristic	Malnutrition in the Context of Acute Illness or Injury		Malnutrition in the Context of Chronic Illness		Malnutrition in the Context of Social or Environmental Circumstances	
	Nonsevere (Moderate) Malnutrition	Severe Malnutrition	Nonsevere (Moderate) Malnutrition	Severe Malnutrition	Nonsevere (Moderate) Malnutrition	Severe Malnutrition
Physical Findings[5,6] Malnutrition typically results in changes to the physical exam. The clinician may perform a physical exam and document any one of the physical exam findings below as an indicator of malnutrition.						
(3) Body fat Loss of subcutaneous fat (eg, orbital, triceps, fat overlying the ribs)	Mild	Moderate	Mild	Severe	Mild	Severe
(4) Muscle mass Muscle loss (eg, wasting of the temples [temporalis muscle], clavicles [pectoralis and deltoids], shoulders [deltoids], interosseous muscles, scapula [latissimus dorsi, trapezious, deltoids], thigh [quadriceps], and calf [gastrocnemius])	Mild	Moderate	Mild	Severe	Mild	Severe

Clinical Characteristic	Malnutrition in the Context of Acute Illness or Injury		Malnutrition in the Context of Chronic Illness		Malnutrition in the Context of Social or Environmental Circumstances	
	Nonsevere (Moderate) Malnutrition	Severe Malnutrition	Nonsevere (Moderate) Malnutrition	Severe Malnutrition	Nonsevere (Moderate) Malnutrition	Severe Malnutrition
(5) Fluid accumulation The clinician may evaluate generalized or localized fluid accumulation evident on exam (extremities, vulvar/scrotal edema, or ascites). Weight loss is often masked by generalized fluid retention (edema), and weight gain may be observed.	Mild	Moderate to severe	Mild	Severe	Mild	Severe
(6) Reduced grip strength[7] Consult normative standards supplied by the manufacturer of the measurement device	NA	Measurably reduced	NA	Measurably reduced	NA	Measurably reduced

- These are the criteria as published by ASPEN/AND serving as a foundation of what the OIG's contracted auditor was looking for

Report Outline

- Provider – shielded from view
- Date of service
- Determination – Compliant or noncompliant
- Biography of Reviewers
  - Involved a physician and a coder
- Issue – whether the documentation/coding meet definition of E41 or E43
- Facts – A case synopsis
- Coverage Elements – the reviewers' medical decision making

All Cases Start Off With This

Provider: (b)(4)

Date of Service: 9/30/2016-10/3/2016

or did

Determination: The hospital care on 9/30/2016-10/3/2016 did not meet Medicare coverage criteria as billed.

Biography:

I am a physician who is duly licensed to practice medicine. I am knowledgeable in the treatment of the enrollee's medical condition, and I am familiar with guidelines and protocols in the area of treatment under review. In addition, I hold a current certification by a recognized American medical specialty board in an area appropriate to the treatment under review. I have no history of disciplinary action or sanctions against my license.

I am a certified coding specialist and a registered health information technician. I am skilled in classifying clinical data from medical records and assigning numeric codes for each diagnosis and procedure. I have expertise in the ICD-9, ICD-10, HCPCS and CPT coding systems and I am knowledgeable in medical terminology, disease processes, and pharmacology.

Case #1 - Facts

- A review of the record indicates that the patient is a female Medicare enrollee with a medical history including *chronic obstructive pulmonary disease (COPD) and oxygen-dependence, hypertension, and non-Hodgkin's lymphoma*. The patient presented to the hospital on 12/18/2016 for increasing shortness of breath and brown phlegm. The patient was treated as an inpatient over the period 12/18/2016-1/3/2017.
- The patient's History and Physical (H&P) by the *emergency physician documented the patient's appearance as well-developed and well-nourished*, with moist oropharynx. The patient was in respiratory distress with diffuse wheezes but was afebrile and alert and oriented. Her abdomen was soft.
- A chest x-ray showed no acute findings. The patient's lab results showed elevated white blood cells (WBC), glucose level, and blood urea nitrogen (BUN) and low hemoglobin and hematocrit. The patient was admitted for medical management and was started on a cardiac diet.
- *Active problems included obesity, with BMI 30-34.9kg/m^2*

Case #1 - Facts

- A nutrition assessment on 12/23/2016 documented that the patient's weight was 82.4kg and body mass index (BMI) 35.5kg/m2.
- *The assessment noted that, per chart review, the patient had not had recent weight loss.* Inadequate oral intake related to decreased appetite, and illness as evidenced by patient eating 25%-75% of meals, was documented.
- *The intervention was to trial Carnation Instant Breakfast (CIB) with lunch and monitor meal and supplement intakes*; follow up was planned in 3-4 days due to the holiday. The goal was for oral intake >/= 50% of meals and consumption of nutrition supplement.
  - On 12/24/2016, the nurse documented encouraging adequate intake. *Albumin level was low (2.9) on 12/27/2016.* Ensure pudding was added with lunch and dinner in place of CIB due to fluid restriction, per dietitian note on 12/27/2016; the patient was eating 75% of meals. By 1/2/2017, the patient was consuming 50-75% of meals and 100% of CIB at breakfast.

Clinical Factors for Review	Support in Record
Nutritional Marasmus or Other Severe Protein-Calorie Malnutrition Hospital Claims:	
Did the patient medically have Nutritional Marasmus or suffer from severe malnutrition of any type? SSA §1862, 42 CFR § 424.5(a)(6)	No
Was the assignment of diagnosis code E41 (Nutritional Marasmus) and/or E43 (Unspecified Severe Protein-Calorie Malnutrition) adequately supported by the documentation contained in the medical record? If not, what malnutrition diagnosis code, if any, was supported by the medical records? CMS Publication 100-02. Benefit Policy Manual. Chapter 1, §10 Covered Inpatient Hospital Services; *Journal of the Academy of Nutrition and Dietetics*. May 2012; Volume 112, Issue 5: Pages 730–738. Consensus Statement of the Academy of Nutrition and Dietetics/American Society for Parenteral and Enteral Nutrition: Characteristics Recommended for the Identification and Documentation of Adult Malnutrition (Undernutrition).	No None
Is the DRG assignment substantiated by the patient's diagnoses and procedures? CMS Publication 100-08. Program Integrity Manual. Chapter 3, §6.5.3 DRG Validation CMS Publication 100-04. Claims Processing Manual. Chapter 1, §80.3.2.2.	No

Rationale

- Review of the medical records found that there was no weight loss documented.
- The patient was obese. It is difficult to establish malnutrition with modest weight loss in an obese person. Patients whose BMIs are in the obese or very obese range can be deficient in micronutrients. However, no documentation of micronutrient deficiency was provided in this patient's record.
- The patient was eating; there is no evidence of inadequate intake.
- This patient's serum albumin was noted to be 2.9, below the normal range. However, this patient was given prednisone to treat an acute COPD exacerbation. Prednisone is known to depress serum albumin levels in proportion to dosage level. In the setting of steroid dosing, serum albumin is not a reliable measure for determining malnutrition risk.
- The dietary interventions were more consistent with prevention of malnutrition. There was no specific medical management of malnutrition, the dietary interventions were nonspecific; there were no complications from malnutrition and malnutrition did not complicate the clinical course. *No specific malnutrition diagnosis is evident.*

Case #2

- The patient is a male with a history including non-small cell lung cancer with lobectomy of the right lower lobe and pneumothorax The patient with complaints of worsening shortness of breath and decreased appetite.
- In the adult nutrition initial assessment/plan:
  - The admission height was 69 inches, weight was 62.2 kg, and **BMI was 21 kg/m2.**
  - The nutritional intake history stated that the patient was **consuming less than 75% of meals and had a decreased appetite with unintentional weight loss of 26 pounds (>7.5%) in three months**.
  - A general diet was ordered for the patient.
  - **The assessment stated the patient met criteria for severe malnutrition for decreased appetite, decreased oral intake, moderate deficit related to acute illness, and measurable reduced grip strength. The assessment showed moderate muscle loss, mild fat loss and weak hand strength.**
  - The patient reported that he drank one bottle of Boost per day at home; the patient refused the Ensure options the hospital offered and preferred to bring in his own Boost. The record indicated that the patient had been snacking on chocolates and chips. **Nutritional interventions included encouraging oral intake, especially of high protein foods including Boost, and monitoring oral intake and weight, with a goal of the patient consuming >/= 50% of meals three times a day.**

Case #2

Clinical Factors for Review	Support in Record
Nutritional Marasmus or Other Severe Protein-Calorie Malnutrition Hospital Claims:	
Did the patient medically have Nutritional Marasmus or suffer from severe malnutrition of any type? SSA §1862, 42 CFR § 424.5(a)(6)	Yes
Was the assignment of diagnosis code E41 (Nutritional Marasmus) and/or E43 (Unspecified Severe Protein-Calorie Malnutrition) adequately supported by the documentation contained in the medical record? If not, what malnutrition diagnosis code, if any, was supported by the medical records? CMS Publication 100-02. Benefit Policy Manual. Chapter 1, §10 Covered Inpatient Hospital Services; *Journal of the Academy of Nutrition and Dietetics*. May 2012; Volume 112, Issue 5: Pages 730–738. Consensus Statement of the Academy of Nutrition and Dietetics/American Society for Parenteral and Enteral Nutrition: Characteristics Recommended for the Identification and Documentation of Adult Malnutrition (Undernutrition).	No None
Is the DRG assignment substantiated by the patient's diagnoses and procedures?	No

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Case #2 Rationale

- Review of the medical records found that documentation **does not** support the diagnosis of severe protein-calorie malnutrition.
  - The patient medically had severe protein-calorie malnutrition, with a weight loss of greater than 7.5% over the previous three months and less than 75% of total estimated energy requirements over the same period.
- **However, while a diagnosis of severe protein-calorie malnutrition can be supported by the medical record, the nutritional intervention was not complex and consisted of a high protein diet with oral supplements.**
  - Neither the length of stay nor treatment plan were affected by the nutritional diagnosis. The Medicare coverage criteria were not met for the secondary diagnosis of severe protein-calorie malnutrition.

Case # 3

- The patient's History and Physical (H&P) documented that the patient was alert, but not oriented on examination. A complete review of systems was unobtainable secondary to the patient's mental condition. The patient had dry mucous membranes and the abdomen was noted to be soft and nontender, with normal bowel sounds.
- **The record indicated that the patient had little oral intake and had severe protein-calorie malnutrition present on admission.**
  - Functionally, the patient required assistance and had very limited mobility.
- **There was no obvious comprehensive nutritional assessment found in the record provided, and none was provided on request.**
  - The record contained an admission high risk nutrition score completed on 10/2/2016, which the patient was rated a two and a daily nutritional risk score was documented as three (eight or higher prompted a registered dietitian assessment within 48 hours)

Case #3

Clinical Factors for Review	Support in Record
Nutritional Marasmus or Other Severe Protein-Calorie Malnutrition Hospital Claims:	
Did the patient medically have Nutritional Marasmus or suffer from severe malnutrition of any type? SSA §1862, 42 CFR § 424.5(a)(6)	Yes
Was the assignment of diagnosis code E41 (Nutritional Marasmus) and/or E43 (Unspecified Severe Protein-Calorie Malnutrition) adequately supported by the documentation contained in the medical record? If not, what malnutrition diagnosis code, if any, was supported by the medical records? CMS Publication 100-02. Benefit Policy Manual. Chapter 1, §10 Covered Inpatient Hospital Services; *Journal of the Academy of Nutrition and Dietetics*. May 2012; Volume 112, Issue 5: Pages 730–738. Consensus Statement of the Academy of Nutrition and Dietetics/American Society for Parenteral and Enteral Nutrition: Characteristics Recommended for the Identification and Documentation of Adult Malnutrition (Undernutrition).	No None
Is the DRG assignment substantiated by the patient's diagnoses and procedures? CMS Publication 100-08. Program Integrity Manual. Chapter 3, §6.5.3 DRG Validation CMS Publication 100-04. Claims Processing Manual. Chapter 1, §80.3.2.2.	No

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Case # 3 - Rationale

- Review of the medical records found that documentation does not support the diagnosis of severe protein-calorie malnutrition.
  - The patient medically had severe protein-calorie malnutrition, with a BMI of 15 kg/m2, in association with being a debilitated patient with limited mobility and advanced dementia, although there is no documentation of other criteria present in the record.
  - **However, while the patient was severely malnourished, the nutritional condition did not affect the length of stay or treatment plan, the nutritional interventions were not complex and consisted of offering an oral diet.**
- The Medicare criteria were not met to support the secondary diagnosis of severe protein-calorie malnutrition.

Case #4 - Rationale

- Review of the medical records found that documentation does not support the diagnosis of severe protein-calorie malnutrition. There was good documentation of a 38.5-pound weight loss (29%) over the past year with a cachectic appearance, temporal wasting, and frailty.
- There was severe protein-calorie malnutrition which was associated to neurologic deficits status post CVA and with dementia. However, there were no complex interventions associated with managing the malnutrition.
  - The record well-documented that no feeding tube was desired and nutritional care was supportive only.
  - The hospital treatment and length of stay were related to other medical diagnosis.
- The record does not support the secondary diagnosis of severe protein-calorie malnutrition.

Complex Decision Making

- Those with well documented criteria meeting ASPEN that was well documented in the record, AND that were or had
  - Treated with TPN with complex metabolic management
  - Monitored for the refeeding syndrome
  - Explicit documentation that the PEG was to treat the severe malnutrition
  - New enteral tube feedings that appear to have affected the length of stay

Refeeding Syndrome

- A potentially life-threatening condition induced by initiation of feeding after a period of starvation.
  - Although a uniform definition is lacking, most definitions comprise a complex constellation of laboratory markers (i.e. hypophosphatemia, hypokalemia, hypomagnesemia) or clinical symptoms, including cardiac and pulmonary failure.
  - Recent studies show that low caloric intake results in lower mortality rates in critically ill RFS patients compared with RFS patients on full nutritional support.
  - Therefore, standard monitoring of RFS-markers (especially serum phosphate) and caloric restriction when RFS is diagnosed should be considered.
  - Furthermore, standard therapy with thiamin and electrolyte supplementation is essential.

Boot R, Koekkoek KWAC, et. al. Refeeding syndrome: relevance for the critically ill patient. Current Opinion in Critical Care: August 2018 - Volume 24 - Issue 4 - p 235-240.

Overall Conclusions

- All of the elements of the ASPEN criteria supporting a diagnosis of nonsevere (moderate) or severe malnutrition clearly documented by a competent provider
- A provider MUST document that applicable term that is to be coded
  - Coding Clinic, 1st Quarter, 2014, pages 12-13
  - Coding Clinic, 4th Quarter, 2016, pages 147-149
- There must be some documentation in the record of how the documented diagnosis qualified as an additional diagnosis
- While not required by the Guidelines or Coding Clinic, it is suggested that the provider repeatedly document
  - Monitoring for the refeeding syndrome
  - The patient's progress with the dietary therapy
  - Discharge planning that addresses the social determinants causing the malnutrition in the first place
  - Inclusion of the nutritional diagnosis in the DC summary and its impact on the patient's stay

ICD-10-CM Guidelines
Additional Diagnoses

Section III. Reporting Additional Diagnoses

GENERAL RULES FOR OTHER (ADDITIONAL) DIAGNOSES

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. Diagnoses that relate to an earlier episode which have no bearing on the current hospital stay are to be excluded." UHDDS definitions apply to inpatients in acute care, short-term, long term care and psychiatric hospital setting. The UHDDS definitions are used by acute care short-

All Malnutrition - % of All Cases Tennessee

Hospital Name	City	ST	Cht	Metab - Malnutrition - All cases-Ratio
VANDERBILT UNIVERSITY MEDICAL CENTER	Nashville	TN	01	14.7%
TRISTAR SKYLINE MEDICAL CENTER	Nashville	TN	02	14.6%
FORT SANDERS REGIONAL MEDICAL CENTER	Knoxville	TN	02	13.4%
MEMORIAL HEALTHCARE SYSTEM, INC	Chattanooga	TN	02	10.8%
BAPTIST MEMORIAL HOSPITAL	Memphis	TN	02	10.8%
METHODIST HEALTHCARE MEMPHIS HOSPITALS	Memphis	TN	02	10.3%
COOKEVILLE REGIONAL MEDICAL CENTER	Cookeville	TN	02	9.7%
PARKRIDGE MEDICAL CENTER	Chattanooga	TN	02	9.6%
BRISTOL REGIONAL MEDICAL CENTER	Bristol	TN	02	8.7%
ERLANGER MEDICAL CENTER	Chattanooga	TN	01	6.8%
TRISTAR CENTENNIAL MEDICAL CENTER	Nashville	TN	02	6.6%
HOLSTON VALLEY MEDICAL CENTER	Kingsport	TN	02	6.0%
SAINT THOMAS RUTHERFORD HOSPITAL	Murfreesboro	TN	02	5.4%
JACKSON-MADISON COUNTY GENERAL HOSPITAL	Jackson	TN	02	5.0%
UNIVERSITY OF TN MEDICAL CENTER (THE)	Knoxville	TN	01	4.4%
SAINT THOMAS WEST HOSPITAL	Nashville	TN	02	4.4%
PARKWEST MEDICAL CENTER	Knoxville	TN	02	4.4%
REGIONAL ONE HEALTH	Memphis	TN	01	3.2%
JOHNSON CITY MEDICAL CENTER	Johnson City	TN	02	2.7%

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PHYSICIAN CHAMPIONS

Severe Malnutrition - % of All Cases Tennessee

Hospital Name	City	ST	Cht	Malnutrition - Severe - All Cases-Ratio
FORT SANDERS REGIONAL MEDICAL CENTER	**Knoxville**	**TN**	**02**	**9.0%**
VANDERBILT UNIVERSITY MEDICAL CENTER	**Nashville**	**TN**	**01**	**8.2%**
COOKEVILLE REGIONAL MEDICAL CENTER	**Cookeville**	**TN**	**02**	**7.6%**
TRISTAR SKYLINE MEDICAL CENTER	**Nashville**	**TN**	**02**	**7.6%**
MEMORIAL HEALTHCARE SYSTEM, INC	**Chattanooga**	**TN**	**02**	**7.2%**
BAPTIST MEMORIAL HOSPITAL	Memphis	TN	02	5.0%
BRISTOL REGIONAL MEDICAL CENTER	Bristol	TN	02	4.3%
PARKRIDGE MEDICAL CENTER	Chattanooga	TN	02	4.2%
ERLANGER MEDICAL CENTER	Chattanooga	TN	01	3.8%
UNIVERSITY OF TN MEDICAL CENTER (THE)	**Knoxville**	**TN**	**01**	**3.3%**
PARKWEST MEDICAL CENTER	Knoxville	TN	02	2.8%
HOLSTON VALLEY MEDICAL CENTER	Kingsport	TN	02	2.5%
TRISTAR CENTENNIAL MEDICAL CENTER	Nashville	TN	02	2.5%
JACKSON-MADISON COUNTY GENERAL HOSPITAL	Jackson	TN	02	2.3%
SAINT THOMAS RUTHERFORD HOSPITAL	**Murfreesboro**	**TN**	**02**	**1.9%**
SAINT THOMAS WEST HOSPITAL	**Nashville**	**TN**	**02**	**1.4%**
METHODIST HEALTHCARE MEMPHIS HOSPITALS	**Memphis**	**TN**	**02**	**1.3%**
JOHNSON CITY MEDICAL CENTER	**Johnson City**	**TN**	**02**	**0.6%**
REGIONAL ONE HEALTH	**Memphis**	**TN**	**01**	**0.6%**

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Severe to Nonsevere Malnutrition Ratio Tennessee

Hospital Name	City	ST	Cht	Malnutrition - Severe to Nonsevere-Ratio
COOKEVILLE REGIONAL MEDICAL CENTER	**Cookeville**	**TN**	**02**	**78.7%**
UNIVERSITY OF TN MEDICAL CENTER (THE)	**Knoxville**	**TN**	**01**	**73.9%**
FORT SANDERS REGIONAL MEDICAL CENTER	**Knoxville**	**TN**	**02**	**67.6%**
MEMORIAL HEALTHCARE SYSTEM, INC	**Chattanooga**	**TN**	**02**	**66.8%**
PARKWEST MEDICAL CENTER	**Knoxville**	**TN**	**02**	**64.8%**
VANDERBILT UNIVERSITY MEDICAL CENTER	Nashville	TN	01	55.9%
ERLANGER MEDICAL CENTER	Chattanooga	TN	01	55.4%
TRISTAR SKYLINE MEDICAL CENTER	Nashville	TN	02	51.9%
BRISTOL REGIONAL MEDICAL CENTER	Bristol	TN	02	49.9%
BAPTIST MEMORIAL HOSPITAL	Memphis	TN	02	46.5%
JACKSON-MADISON COUNTY GENERAL HOSPITAL	Jackson	TN	02	45.6%
PARKRIDGE MEDICAL CENTER	Chattanooga	TN	02	43.4%
HOLSTON VALLEY MEDICAL CENTER	Kingsport	TN	02	42.7%
TRISTAR CENTENNIAL MEDICAL CENTER	Nashville	TN	02	37.4%
SAINT THOMAS RUTHERFORD HOSPITAL	Murfreesboro	TN	02	35.1%
SAINT THOMAS WEST HOSPITAL	**Nashville**	**TN**	**02**	**32.6%**
JOHNSON CITY MEDICAL CENTER	**Johnson City**	**TN**	**02**	**23.2%**
REGIONAL ONE HEALTH	**Memphis**	**TN**	**01**	**17.7%**
METHODIST HEALTHCARE MEMPHIS HOSPITALS	**Memphis**	**TN**	**02**	**12.3%**

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Proactive CDI - Action Steps Discussed in the AHLA Article

- Literature-based definitions of and the clinical indicators for the at-risk terminology involved, which in this case involves kwashiorkor, marasmus, other severe malnutrition, non-severe malnutrition, cachexia, and sarcopenia from provider and auditor perspectives.
- Physicians' medical decision making and documentation practices involving these terminologies, which may differ from those of their facilities or accountability agents.
- Official ICD-10-CM conventions, guidelines, and advice, especially those involving principal (first-listed) and additional (secondary) diagnoses, which are often unclear, imprecise, or conflicting and, in most providers' and facilities' view, often misinterpreted by accountability agents.
- Clinical validation practices whereby providers and facilities assure that a documented and coded diagnosis or treatment is clinically supported and how these differ from those of the auditors.

Proactive CDI - Action Steps Discussed in the AHLA Article

- CDI or coding clarification practices whereby an improper or leading query can invalidate the answer, even if it is clinically accurate.
- Written and approved medical staff and facility policies and procedures guiding the staff, processes, and technology involved with ICD-10-CM diagnosis coding and reporting.
- Data analytics identifying potential errors of omission or commission that can guide compliance officers and facilities in averting or identifying compliance risk.
- Adherence to OIG model compliance plans in order that identified errors will be less likely to be construed as fraud.

Definitions

- As registered dietitian nutritionists and other clinical nutrition professionals are approached by their coding departments about the potential use of the GLIM criteria in place of the Academy/ASPEN criteria, we refer them to our previous statement on the topic, available at https://tinyurl.com/y6jy7kqy.
  - "Both sets of criteria represent consensus-based frameworks and are currently undergoing validation testing. Until those studies are completed, we are not recommending one approach over the other."
- "A facility or a payer may require that a physician use a particular clinical definition or set of criteria when establishing a diagnosis, but that is a clinical issue outside the coding system" as a foundation for clinical validation workflows - **Coding Clinic, 4th Q, 2016, pp 147-149**

Coding Clinic Advice
1st Q, 2020, pages 4-7

- Malnutrition is not integral to cancer or any other non-nutritional diagnosis, contradicting multiple statements in previous OIG audits.
- Nonsevere malnutrition present at the time of the inpatient order that progresses to severe during an inpatient stay should be coded as severe and designated as present on admission.
- **ICD-10-CM coding of malnutrition based solely on a provider's agreement with a nutritional assessment should only occur if governed by a facility's policy.**

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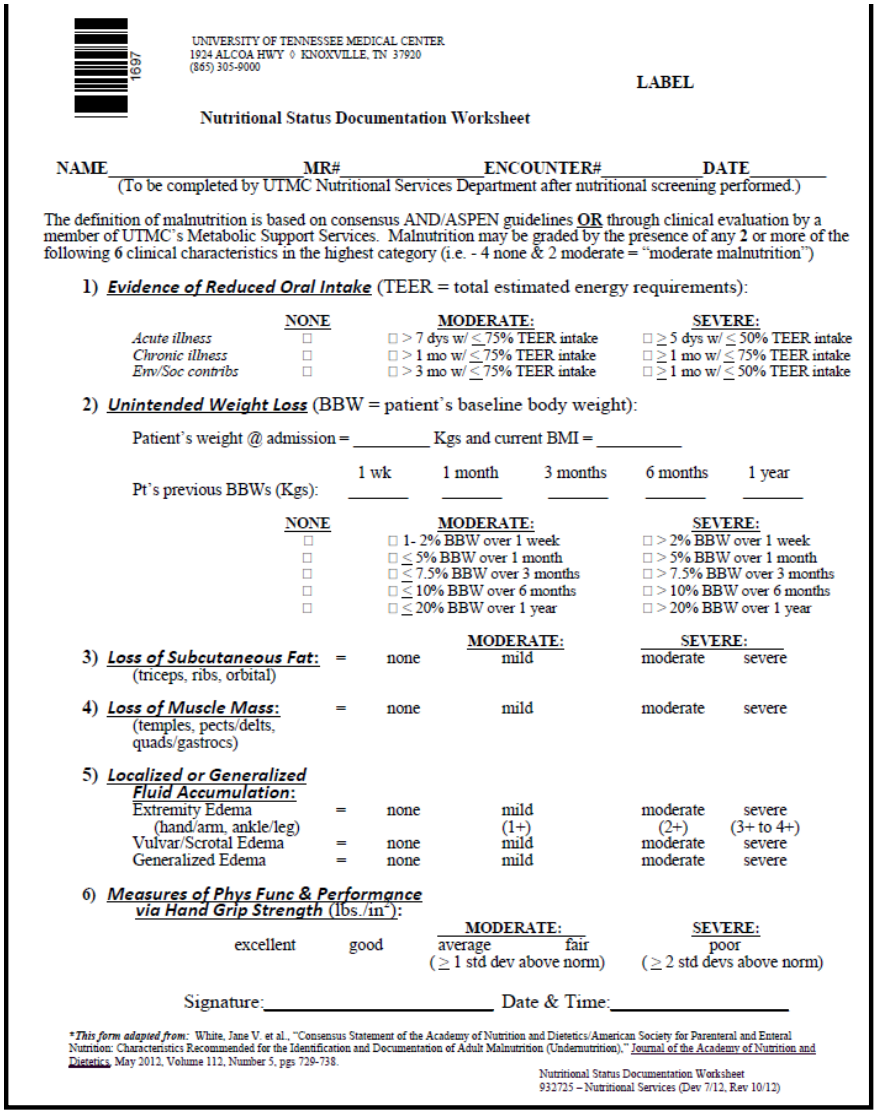
Cosigning Dietician Assessments

- Dr. LaCharite's and Jane White's assessment discussed at the 2013 ACDIS conference in Nashville
- While signed below by a dietician, documentation of the diagnosis and its impact by the provider is essential



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UNIVERSITY OF TENNESSEE MEDICAL CENTER
1924 ALCOA HWY ◊ KNOXVILLE, TN 37920
(865) 305-9000

LABEL

Nutritional Status Documentation Worksheet

NAME_____ MR#_____ ENCOUNTER#_____ DATE_____
(To be completed by UTMC Nutritional Services Department after nutritional screening performed.)

The definition of malnutrition is based on consensus AND/ASPEN guidelines **OR** through clinical evaluation by a member of UTMC's Metabolic Support Services. Malnutrition may be graded by the presence of any **2** or more of the following **6** clinical characteristics in the highest category (i.e. - 4 none & 2 moderate = "moderate malnutrition")

1) ***Evidence of Reduced Oral Intake*** (TEER = total estimated energy requirements):

	NONE	MODERATE:	SEVERE:
Acute illness	☐	☐ > 7 dys w/ ≤ 75% TEER intake	☐ ≥ 5 dys w/ ≤ 50% TEER intake
Chronic illness	☐	☐ > 1 mo w/ ≤ 75% TEER intake	☐ ≥ 1 mo w/ ≤ 75% TEER intake
Env/Soc contribs	☐	☐ > 3 mo w/ ≤ 75% TEER intake	☐ ≥ 1 mo w/ ≤ 50% TEER intake

2) ***Unintended Weight Loss*** (BBW = patient's baseline body weight):

Patient's weight @ admission = _____ Kgs and current BMI = _____

Pt's previous BBWs (Kgs):	1 wk	1 month	3 months	6 months	1 year
	_____	_____	_____	_____	_____

NONE	MODERATE:	SEVERE:
☐	☐ 1- 2% BBW over 1 week	☐ > 2% BBW over 1 week
☐	☐ ≤ 5% BBW over 1 month	☐ > 5% BBW over 1 month
☐	☐ ≤ 7.5% BBW over 3 months	☐ > 7.5% BBW over 3 months
☐	☐ ≤ 10% BBW over 6 months	☐ > 10% BBW over 6 months
☐	☐ ≤ 20% BBW over 1 year	☐ > 20% BBW over 1 year

			MODERATE:	SEVERE:	
3) ***Loss of Subcutaneous Fat:*** (triceps, ribs, orbital)	=	none	mild	moderate	severe
4) ***Loss of Muscle Mass:*** (temples, pects/delts, quads/gastrocs)	=	none	mild	moderate	severe
5) ***Localized or Generalized Fluid Accumulation:***					
Extremity Edema (hand/arm, ankle/leg)	=	none	mild (1+)	moderate (2+)	severe (3+ to 4+)
Vulvar/Scrotal Edema	=	none	mild	moderate	severe
Generalized Edema	=	none	mild	moderate	severe

6) ***Measures of Phys Func & Performance via Hand Grip Strength*** (lbs./in²):

		MODERATE:		SEVERE:
excellent	good	average	fair	poor
		(≥ 1 std dev above norm)		(≥ 2 std devs above norm)

Signature:_____ Date & Time:_____

**This form adapted from:* White, Jane V. et al., "Consensus Statement of the Academy of Nutrition and Dietetics/American Society for Parenteral and Enteral Nutrition: Characteristics Recommended for the Identification and Documentation of Adult Malnutrition (Undernutrition)," Journal of the Academy of Nutrition and Dietetics, May 2012, Volume 112, Number 5, pgs 729-738.

Nutritional Status Documentation Worksheet
932725 – Nutritional Services (Dev 7/12, Rev 10/12)

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Physician Attestation of Dietician's Assessment

PHYSICIAN ATTESTATION

I have reviewed the clinical indicators and nutritional assessment outlined above and I:

_____ Agree with this assessment; the patient has the nutritional diagnoses cited above, that this diagnosis increases the patient's risk for morbidity and mortality, requires nursing care to monitor the recommended therapy, will impact the patient's length of stay, and will require discharge planning that addresses food insecurity or social determinants that continues the dietary intervention upon leaving

_____ Have a different opinion; the following diagnoses apply: _____

_____ Believe the patient is well nourished and has no other nutritional diagnoses

s/_____Electronic signature_____

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Other Suggestions

- Engagement of compliance officer and legal counsel
  - Obtain your own copy of the FOIA documents for your own review or ask for outside assistance from those who have review this FOIA document
- Develop and implement a plan
  - Definitions and policies
  - Order sets (much like SEP-1) that include monitoring for refeeding syndrome
  - Pre-bill review of severe or nonsevere malnutrition serving as the only MCC or CC (or the main factor in an APR-DRG or an HCC)
  - Internal data analytics benchmarking and trending malnutrition capture
- Apply same principles to all high risk diagnoses

Additional information may be obtained from:

http://www.cdimd.com

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