

# flourish

CDI IN BLOOM | **acdis 2023**

**MAY 8–11, 2023**



## Malnutrition: The Next Chapter in Vidant's Seven-Year Battle With the OIG

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## Tab 50 OIG Sample 40 File 500

This is a 70-year-old male with prostate cancer, cigarette smoking, hypertension, and Stage III multiple myeloma. He had extensive lytic disease. He was treated with 5 cycles of chemotherapy and most recently had maintenance chemo. He had bone mets with pathologic fractures. After December 2013 he had been admitted multiple times with respiratory issues, pneumonias, and respiratory failure. On this occasion he was admitted with dyspnea, poor appetite, weakness, and weight loss. MRI of the lumbosacral spine showed progression of myeloma. He was noted to be minimally ambulatory.

He has had multiple rounds of chemotherapy, frequent infectious and respiratory illnesses, progressive weakness, weight loss, poor intake, with persistent and worsening of myeloma. These factors **all support the presence of severe malnutrition. The examination findings of cachexia and decreased muscle mass also support the diagnosis. He had 11.6% weight loss over 6 months and energy intake of < 50% over one month.** The patient was treated with appetite stimulant medication, monitored by the dietitian, and was provided high calorie oral nutrition supplements.

The ASPEN-AND criteria are used in determining the diagnosis of malnutrition. According to the ASPEN-AND criteria a minimum of 2 of the 6 categories (clinical characteristics of malnutrition) are needed to establish a diagnosis of malnutrition. 2 of the 6 criteria met in this case: weight loss and inadequate energy intake to meet needs. The clinical information and physician documentation support the diagnosis of severe malnutrition based on the ASPEN-AND criteria.

## OIG Denial

The hospital care on 9/2014 did not meet Medicare coverage criteria as billed with diagnosis code 261 (Nutritional Marasmus). **The patient was dying secondary to his multiple myeloma. The malnutrition was part of the dying process and not a separate factor. It was not a primary process as occurs with Marasmus. No specific treatment was provided.** The member was able to eat, but he declined to do so.

Based on coding review of the medical record, the DRG assignment is not substantiated as billed. The medical record supports the submission of principal diagnosis 203.00 [Multiple myeloma]. However, **the secondary diagnosis of 261 [Marasmus] is not substantiated in the medical record.** As noted above, no ICD-9-CM code should have been assigned. The patient did have a secondary diagnosis of 276.4 [Respiratory and metabolic acidosis] which was substantiated and serves as a complication/comorbidity.

## MAC Redetermination (1<sup>st</sup> Level Appeal)

Upon review, the beneficiary presented to the hospital as a transfer from another facility with complaints of worsening dyspnea on exertion, poor appetite, and weight loss. His past medical history was significantly for prostate cancer, tobacco use, hypertension, and stage III IgG kappa multiple myeloma. A progressive workup performed prior to admission showed progressive multiple myeloma and pancytopenia. He was found to be extremely acidotic and arterial blood gases drawn were consistent with respiratory and metabolic acidosis. Upon nutritional assessment, the beneficiary was noted to have a “normal weight” with a BMI of 19.815. There was no documentation of skin breakdown or muscle wasting noted. His appetite was noted to be “excellent” prior to admission but he continued to lose weight. Serum albumin and protein levels were noted to be moderately reduced at 2.7 and 6.1 respectively. **His weight loss and admitting symptoms were documented as related to his progressive malignancy. The documentation did not support the diagnosis code 261 of “nutritional marasmus” as billed by the provider.** Therefore, Medicare cannot allow payment for the DRG 840 (lymphoma and non-acute leukemia with major complications and co-morbidities) and must affirm that the DRG was appropriately changed to 841 (lymphoma and non-acute leukemia with complications and co-morbidities).

## QIC Determination (2<sup>nd</sup> Level Appeal)

A physician's query message dated September 2014, indicates the diagnosis of severe malnutrition was present on admission. However, the billed secondary diagnosis code of nutritional marasmus (261) is **not substantiated**. Based on the review of the available medical records, the evidence does not support the billed secondary diagnosis code of 261 and the MSDRG 840. The secondary diagnosis code of 276.4 is substantiated. In summary, the evidence supports the principal diagnosis code of 203.00, the secondary diagnosis code of 276.4, and MSDRG xx. As such, allowance cannot be made for the services at issue and an overpayment did occur.



## Reasons Denial Must Be Overturned

- The patient was appropriately diagnosed with severe malnutrition under the ASPEN/AND criteria
  - This patient was clinically diagnosed with severe malnutrition, which is included in Code 261 (Nutritional Marasmus)
- Severe malnutrition was appropriately coded as a secondary diagnosis under the Official ICD-9-CM Coding Guidelines and Coding Clinic advice
  - Meets 3 of the 5 criteria for reporting additional diagnoses, even though only 1 is sufficient
- The contractors have applied unpromulgated rules:
  - Requiring a threshold level of treatment to be provided specific to malnutrition in order for severe malnutrition to be coded as a secondary diagnosis
  - Prohibiting malnutrition from being coded where it is a manifestation of another condition
  - QIC's denial rationale fails to comport with 42 C.F.R. 405.976(b) ("The reconsideration must be in writing and contain . . . an explanation of the medical and scientific rationale for the decision.")

## Presented By



**Vaughn Matacale, MD, CCDS**, director of the physician advisor group at ECU Health in Greenville, North Carolina, specializes in hospital medicine and began in the physician advisor role in 2007. His advisor team has grown to eight full-time physicians and a physician assistant who conduct post-discharge pre-bill reviews and provide support and education for coding, CDI, and medical staff, plus full utilization review (UR) support. He has over 18 years' experience in UR work and continues to practice medicine. He chairs the Patient Safety Indicator committee and sits on the hospital patient safety and quality improvement committee, as well as the ACDIS Advisory Board.



**Ashley Strickland, RDN, LDN, CNSC**, is the adult clinical dietitian supervisor and surgical/trauma intensive care dietitian at ECU Health Medical Center in Greenville, North Carolina. Her career's primary focus has been critical care, complex GI patients, and nutrition support. She also serves as the subject matter expert on malnutrition at her hospital. She is an independent contractor for the Academy of Nutrition and Dietetics, serving as a trainer providing education nationwide. Strickland also sits on the American Society for Parenteral and Enteral Nutrition's Reimbursement Malnutrition Task Force, providing guidance on malnutrition denial cases at a national level.



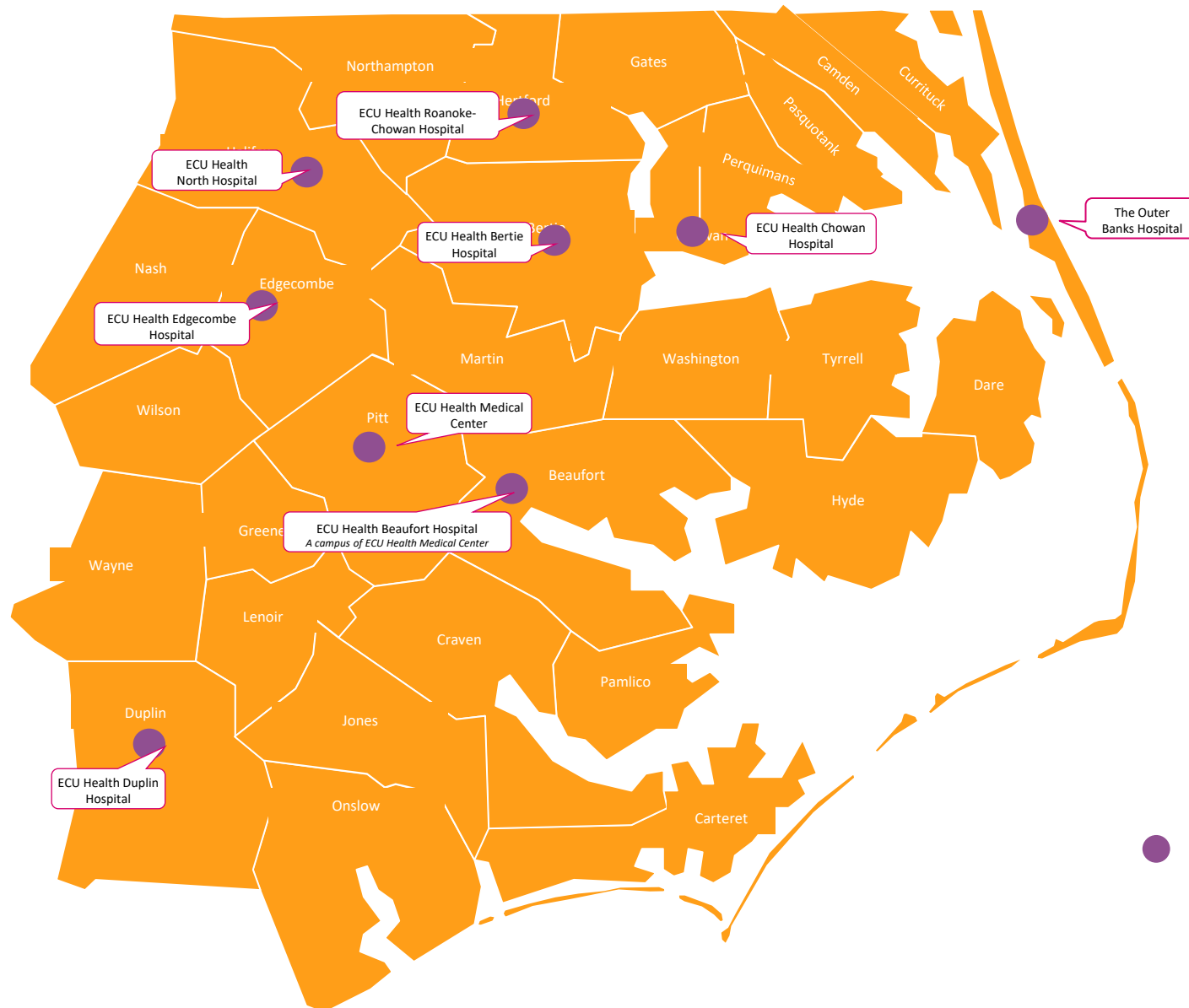
**Anderson McCray Shackelford, JD**, is an associate at K&L Gates LLP in Research Triangle Park, North Carolina. He represents a myriad of healthcare entities in healthcare litigation and regulatory issues/appeals. Shackelford practices before various state and federal courts, the U.S. Department of Health and Human Services' Medicare Office of Hearings and Appeals, the Departmental Appeals Board, and elsewhere. He has also arbitrated before the American Health Lawyers Association's Dispute Resolution Service and the American Arbitration Association.

# Learning Outcomes

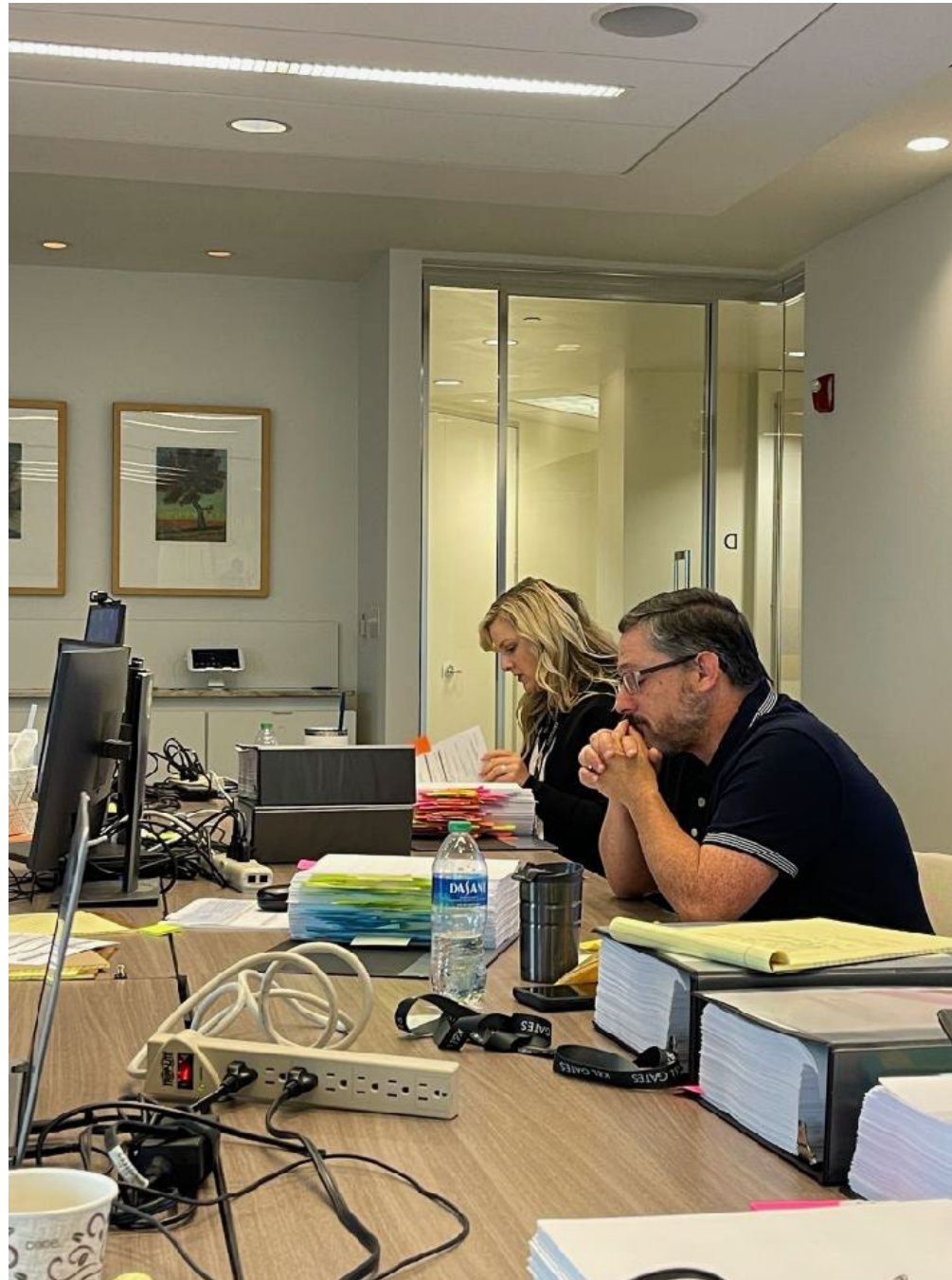
- At the completion of this educational activity, the learner will be able to:
  - Discuss the malnutrition related coding issues reported by the OIG
  - Apply appropriate clinical definitions for diagnosing and validating malnutrition
  - Utilize comprehensive strategies in appeals related to malnutrition denials
  - Defend malnutrition diagnosis code submission with appropriate references



# ECU Health (Formerly Vidant Health)



● ECU Health hospital locations





## Introduction and Timeline

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# Timeline

2013

- Vidant begins clinical initiative to adopt AND/ASPEN guidelines

2015

- Oct: OIG letter of intent to audit received
- Nov: Records sent. OIG onsite visit (5 days)

2016

- Apr: OIG review results received
- May: VMC submits rebuttal. **Team presents malnutrition at ACDIS Atlanta**
- Jun: OIG onsite for case discussion (5 days)
- Oct: OIG draft report issued to VMC
- Dec: VMC submits response to OIG draft report (A must read)

2017

- Jan: OIG final report published to OIG website
- Mar: MAC demand letter received
- Apr: 1<sup>st</sup> level appeal submitted to MAC
- Jun: 1<sup>st</sup> level appeal determination received (unfavorable)
- Aug: Revised demand letter received
- Oct: Recoupment occurs
- Dec: 2<sup>nd</sup> level appeal to QIC sent

# Timeline

2018

- Feb: QIC letter received – delayed decision
- Vaughn and Ashley join malnutrition task force (AND, ASPEN, ACDIS, ASN, Public policy consultants)
- May: 2<sup>nd</sup> level appeal determination received. **Team presents OIG and Malnutrition at ACDIS San Antonio**
- Jun: Request for ALJ hearing submitted
- **August: Vidant team presents Malnutrition for ACDIS Live**

2019

- Waiting....

2020

- Waiting....



# Timeline

2021

- Apr: Notice of Hearing received (June, 1 day allotted)
- Apr: Panic
- Apr: Request for Delay of Hearing
- Dec: Notice of prehearing received

2022

- Jan: Revised notice of prehearing conference
- Jan: Prehearing conference with ALJ
- Jan: Identification of expert witnesses
- Feb: Revised Notice of hearing
- Feb, Mar, Apr: Prep
- Apr: Prehearing brief submitted
- May: ALJ Hearing (6 days)
- Jun/Jul/Aug: Waiting....
- Sep: ALJ Ruling received





## Denial Rationales and Pertinent Guidance

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# Denial Rationale Frequency

Rationale	Category	Primary Cases	Total Cases
The patient had malnutrition, but it was not treated “enough” or did not impact the stay enough to be reported as a diagnosis	Coding	30	40
The patient did not have malnutrition in any form	Clinical Validation	29	31
Code 261 (Nutritional Marasmus) was submitted, but the patient did not have Nutritional Marasmus	Coding	4	22
The patient had a form of malnutrition, but not the type of malnutrition that was coded	Clinical Validation	15	18
The patient had malnutrition but it was due to or an integral part of another condition and should not be separately reported as a diagnosis	Coding	11	18



## Vidant's Response:

### Malnutrition Not Treated or Impactful “Enough”

- OIG failed to recognize and acknowledge coding guidance related to secondary diagnosis reporting
- “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
- AHA Letter: “Neither the ICD-9-CM classification, the *ICD-9-CM Official Guidelines for Coding and Reporting*, nor *Coding Clinic for ICD-9-CM* specify a required level of treatment to warrant code assignment for diagnosis code 261 or any other diagnosis code as long as the condition meets the definition of a reportable diagnosis.”



## Vidant's Response:

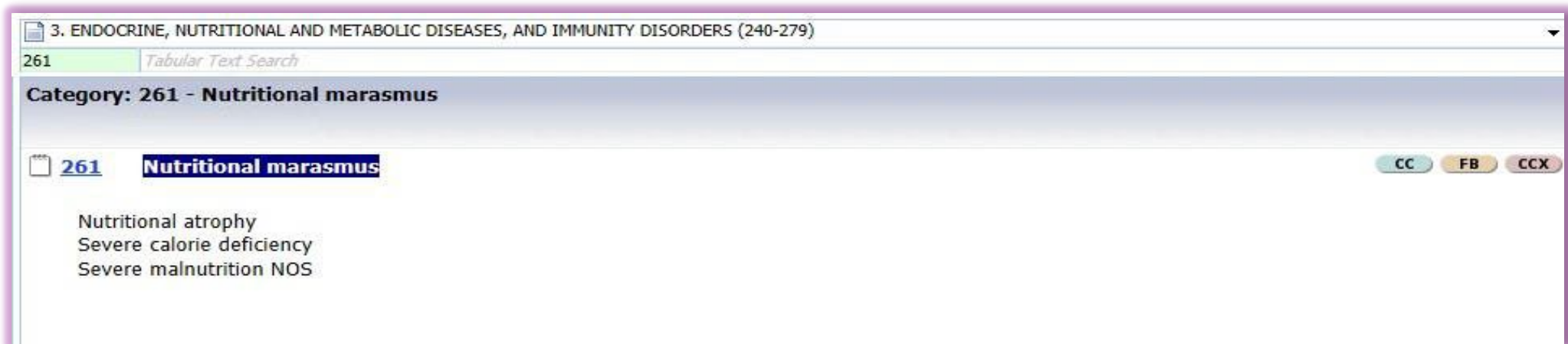
### Patient Did Not Have Any Form of Malnutrition

- OIG failed to identify which clinical standards and guidelines, if any, were used as a basis for decisions
- CMS has not adopted any particular clinical guidelines to evaluate, identify and diagnose malnutrition
- CMS has not published any clarifying guidance on the use of codes 261 and 262 (and more recently the E codes) with respect to its expectation regarding establishing clinical practices, protocols, or documentation requirements

# Vidant's Response:

## Patient Did Not Have Nutritional Marasmus

- The OIG failed to recognize and acknowledge that code 261 (Nutritional Marasmus) includes additional malnutrition conditions:



*An example of direction for coding Severe Malnutrition with code 261 can be found in AHA Coding Clinic, Third Quarter 2012, Page 10, effective with discharges September 15, 2012, which states:*

*“If provider documentation indicates that the malnutrition has progressed from moderate to severe, assign code 261, Nutritional Marasmus, for Severe Malnutrition.”*

## Vidant's Response: Patient Had a Different Form of Malnutrition

- Coding guidance states:
  - Code assignments based on physician diagnostic statements and supporting medical record documentation
  - Diagnoses should be coded with the highest degree of specificity
  - “The physician should code the ICD-9-CM code that provides the highest degree of accuracy and completeness. In the context of ICD-9-CM coding, the ‘highest degree of specificity’ refers to assigning the most precise ICD-9-CM code that most fully explains the narrative description of the symptom or diagnosis.” (CMS, Manualization of ICD-9 Coding, Pub. 100-04, Transmittal 126, CR2857)
- Coding a different or unspecified malnutrition code when medical record documentation supports severe malnutrition is contrary to coding guidance.

## Vidant's Response:

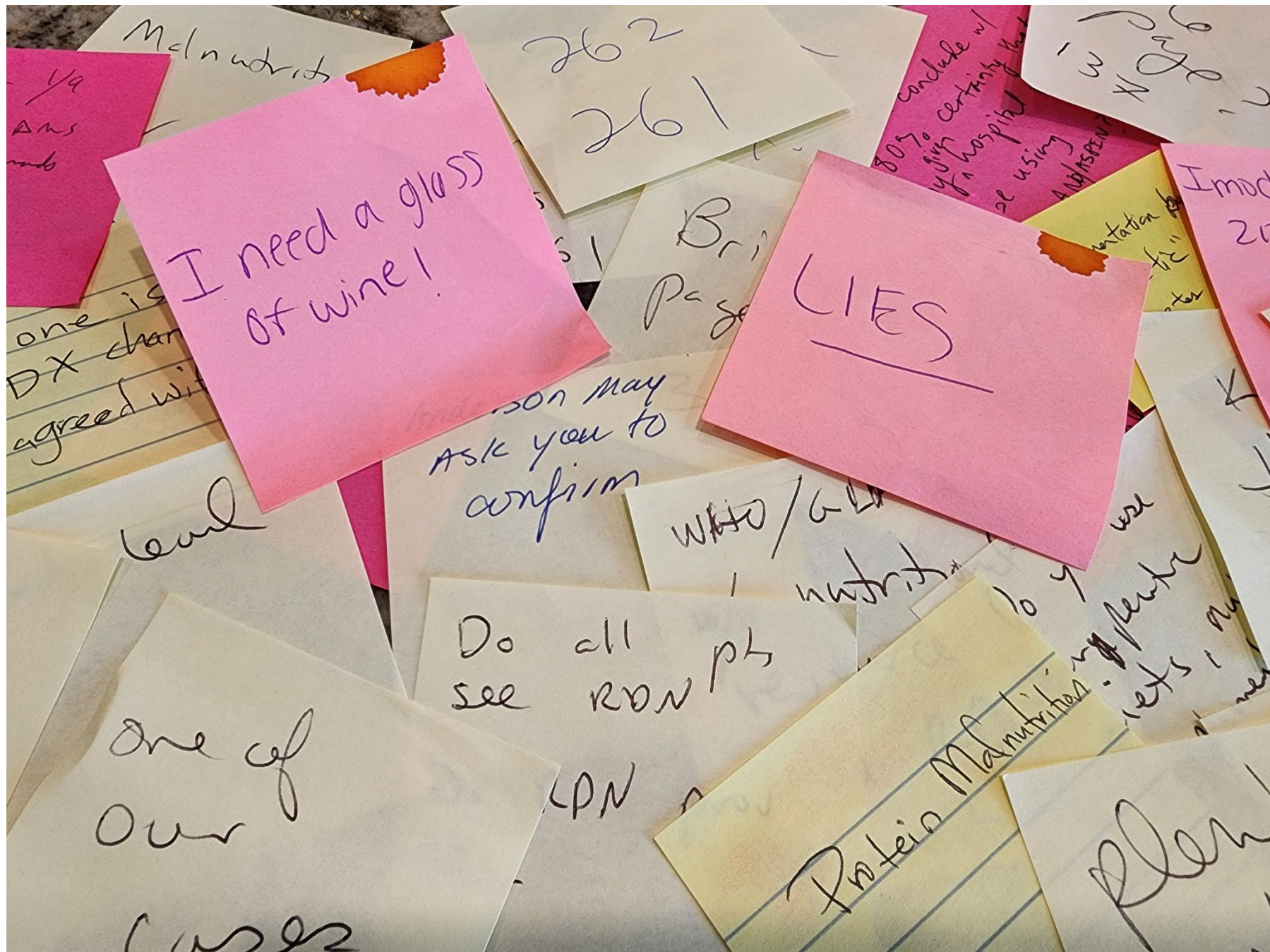
### Malnutrition Integral to Another Condition

- Section I.A.6 of the ICD-9-CM Official Guidelines (I.A.13 ICD-10)
- Section I.B.6-7 of the ICD-9-CM Official Guidelines (I.B.5-6 ICD-10)
- **CC 1Q 2020 Pg 4 Malnutrition in Chronic Illness**

**Question:** Is malnutrition considered integral to chronic illnesses like cancer? For example, if a provider documents malnutrition in a cancer patient receiving chemotherapy may malnutrition be coded separately?

**Answer:** While loss of appetite is a common side effect of chemotherapy, malnutrition is not routinely associated with cancer and therefore the Official Guidelines for Coding and Reporting Section I.B.5 regarding conditions that are an integral part of a disease process does not apply. Assign the appropriate malnutrition code in addition to the code for the specific type of cancer.



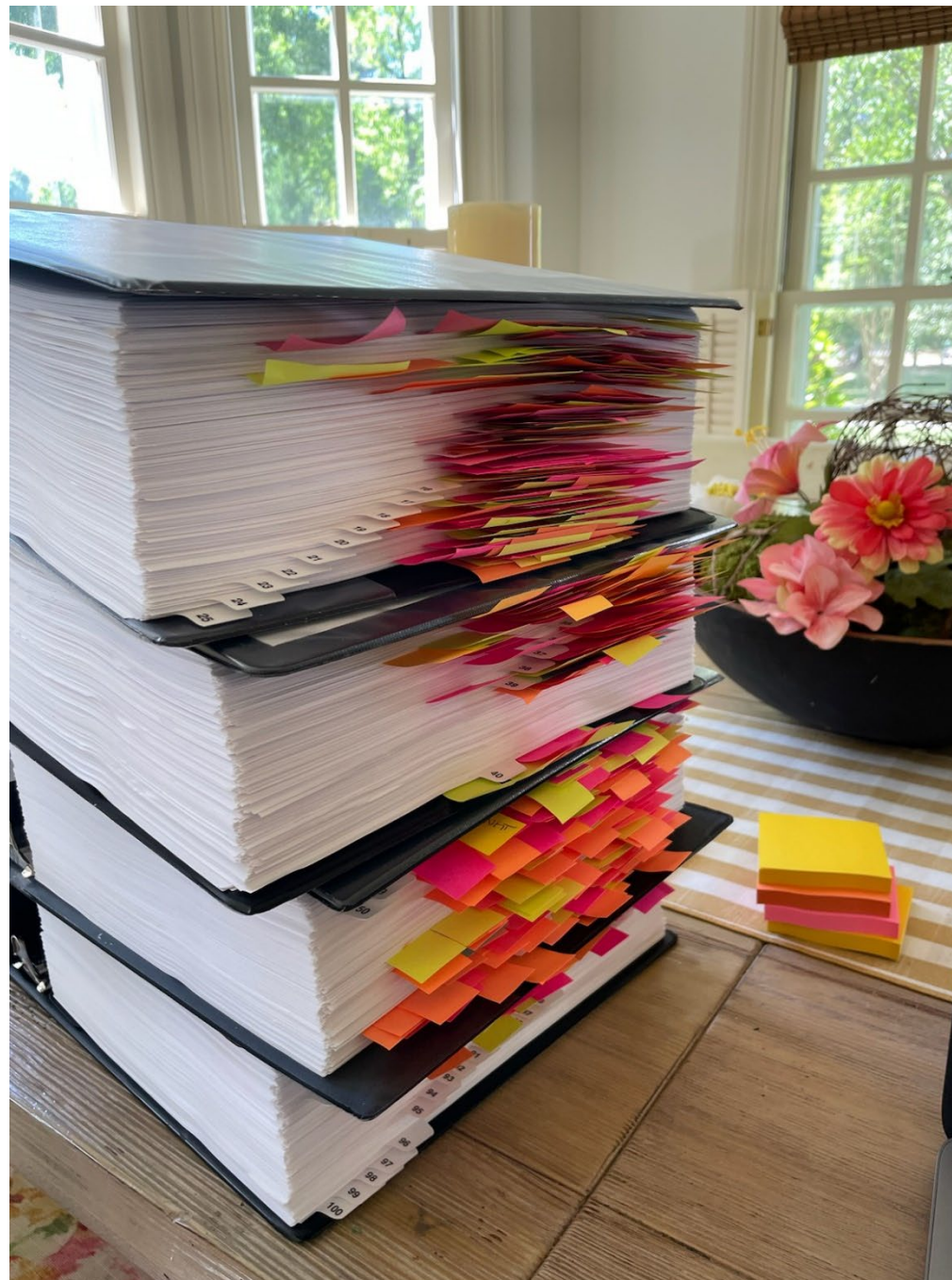






## Clinical Aspects AND/ASPEN

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The Joint Commission Journal on Quality and Patient Safety

Forum

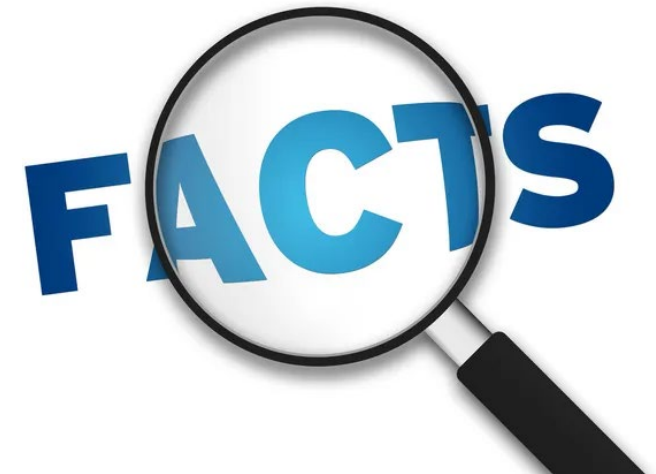
## Addressing Disease-Related Malnutrition in Hospitalized Patients: A Call for a National Goal

*Peggi Guenter, PhD, RN, FAAN; Gordon Jensen, MD, PhD, FASPEN; Vihav Patel MD, FACS, CNSC; Sarah Miller, PharmD, BCNSP; Kris M. Mogensen, MS, RD, LDN, CNSC; Ainsley Malone, MS, RD, CNSC, FAND; Mark Corkins, MD, SPR, CNSC, FAAP; Cindy Hamilton, MS, RD; Rose Ann DiMaria-Ghalili, PhD, RN, CNSC, FASPEN*

**“It is estimated that at least **one third** of patients in developed countries are malnourished on admission to the hospital, and, if left untreated, approximately two thirds of those patients will experience a further decline in their nutrition status during their hospitalization.”**

# Outcomes: Malnutrition in the Hospital

- Malnourished patients:
  - 2x more likely to develop a pressure ulcer in a hospital
  - Hospitalized an average of 2 days longer than those screened and treated early
  - Comprise 45% of patients that fall in a hospital
  - Have 3x the risk for surgical site infection
- Benefits of nutrition intervention:
  - 25% reduction in pressure ulcer incidence
  - 28% decrease in avoidable readmissions
  - 14% fewer overall complications
  - ~2 day reduction in average length of stay



[https://static6.depositphotos.com/1034557/621/i/450/depositphotos\\_6219695-stock-photo-magnifying-glass-facts.jpg](https://static6.depositphotos.com/1034557/621/i/450/depositphotos_6219695-stock-photo-magnifying-glass-facts.jpg)

The Facts on Malnutrition. Available from: <http://malnutrition.com/getinspired/factsheet>. Accessed January 13, 2023.



# Readmission

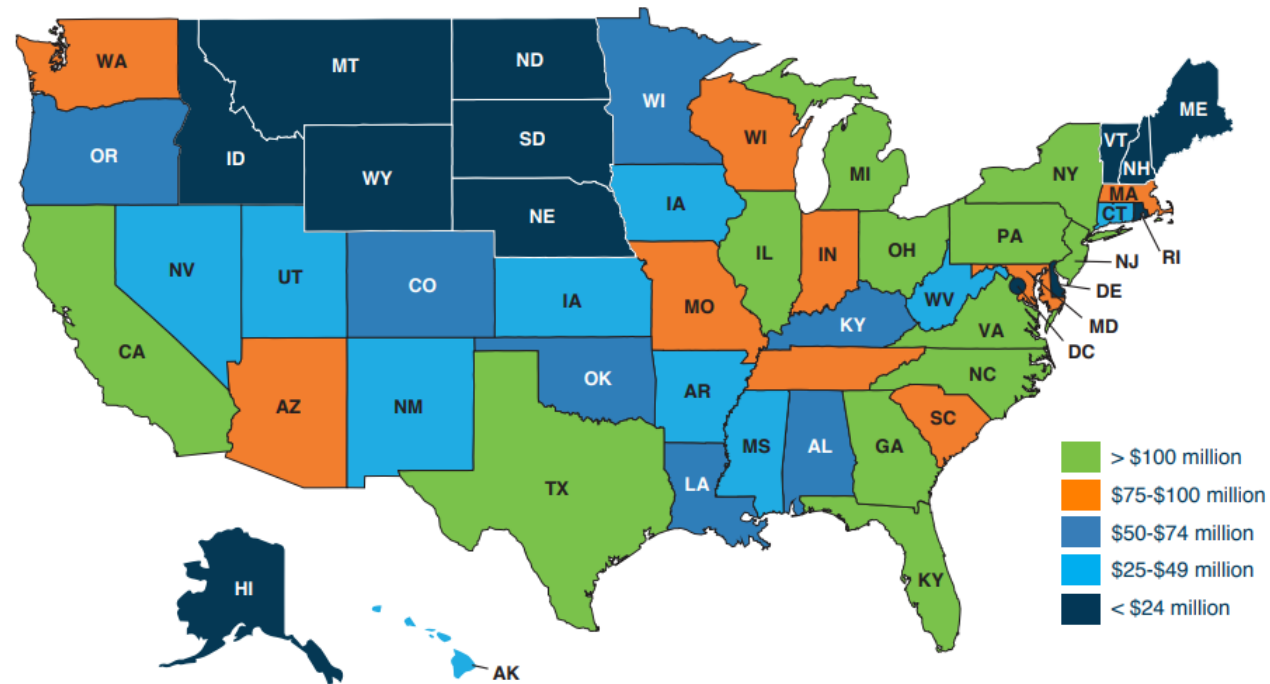
- *“Post discharge, malnourished patients are also at risk for more frequent re-admissions. According to an Agency for Healthcare Research and Quality (AHRQ) Healthcare Cost and Utilization Project (HCUP) Statistical Brief, 30-day all cause readmission was nearly **50% higher among patients with malnutrition** compared to patients with no associated malnutrition.”*

Weiss AJ, Fingar KR, Barrett ML, et al. [Characteristics of hospital stays involving malnutrition, 2013: HCUP Statistical Brief #210](#). In: Healthcare Cost and Utilization Project (HCUP) Statistical Briefs. Rockville (MD): Agency for Healthcare Research and Quality; 2006 Feb-; 2016 Sep. p. 21. PMID: 27854406.



# Economic Burden of Malnutrition

State Economic Burden of Disease-Associated Malnutrition in Older Adults <sup>17</sup>



National	Per Capita Cost	Results (65+)	Per Capital Cost (65+)
\$15,598,520,320	\$48	\$4,320,378,880	\$93

Goates, Scott et al. "Economic Burden of Disease-Associated Malnutrition at the State Level." PloS one vol. 11,9 e0161833. 21 Sep. 2016

<http://bit.ly/state-toolkit> DefeatMalnutrition.Today

<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5031313/>

## “Classic Approach” to Diagnosing Malnutrition

- Physicians and providers traditionally used the “classic” approach to identify malnutrition in hospitalized patients. This would involve the use of bedside clinical judgment based on the following, but understanding that no one factor is diagnostic or preclusive; the **key factor is the clinical judgment of the provider**:
  - Physical findings such as fat and muscle wasting, or emaciation
  - Biochemical markers (Albumin, Prealbumin, etc.) with interpretation in the context of other factors
  - Risk factors increasing the patient’s risk for developing malnutrition
  - Body mass composition (BMI) or weight loss (%IBW)

# 2012 Malnutrition Consensus

## Journal of Parenteral and Enteral Nutrition

<http://pen.sagepub.com/>

**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, Peggi Guenter, Gordon Jensen, Ainsley Malone, Marsha Schofield, Academy Malnutrition Work Group, A.S.P.E.N. Malnutrition Task Force and the A.S.P.E.N. Board of Directors

*JPEN J Parenter Enteral Nutr* 2012 36: 275

DOI: 10.1177/0148607112440285

# Severe Malnutrition: 2 Categories Required

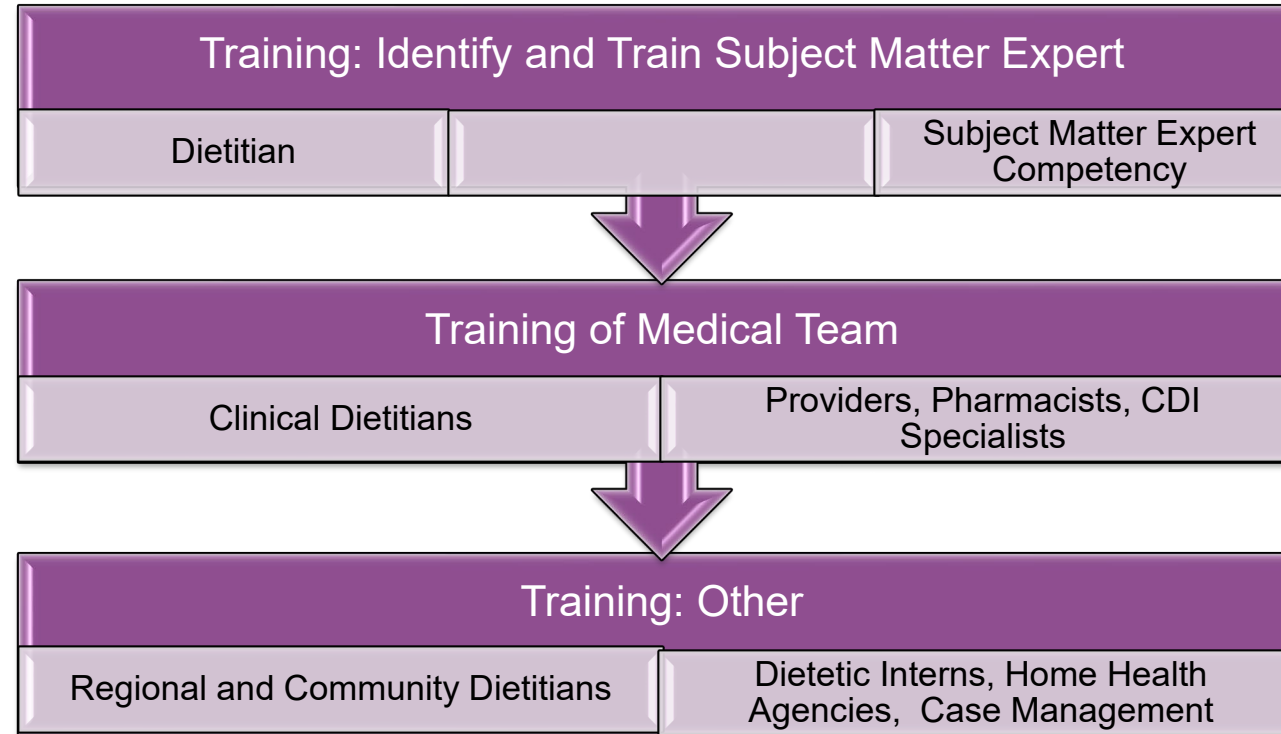
<b>ICD-10: E43</b> <b>Severe, Protein-Calorie Malnutrition</b>	<b>Severe Malnutrition in the context of Acute Illness/Injury</b>	<b>Severe Malnutrition in the context of Chronic Illness</b>	<b>Severe Malnutrition in the context of Social/Behavioral/Environmental Circumstances</b>
<b>Weight Loss</b>	Weight Loss >2% in 1 week >5% in 1 month >7.5% in 3 months	Weight Loss >5% in 1 month >7.5% in 3 months >10% in 6 months >20% in 12 months	Weight Loss >5% in 1 month >7.5% in 3 months >10% in 6 months >20% in 12 months
<b>Intake</b>	Energy Intake ≤50% energy intake compared to estimated energy needs for ≥ 5 days	Energy Intake ≤75% energy intake compared to estimated energy needs for ≥1 month	Energy Intake ≤50% energy intake compared to estimated energy needs for ≥1 month
<b>Body Fat</b>	Body Fat Moderate depletion	Body Fat Severe depletion	Body Fat Severe depletion
<b>Muscle Mass</b>	Muscle Mass Moderate depletion	Muscle Mass Severe depletion	Muscle Mass Severe depletion
<b>Fluid Accumulation</b>	Fluid Accumulation Moderate to Severe	Fluid Accumulation Severe	Fluid Accumulation Severe
<b>Grip Strength</b>	Reduced Grip Strength for age and gender or Regressed Functional Status	Reduced Grip Strength for age and gender or Regressed Functional Status	Reduced Grip Strength for age and gender or Regressed Functional Status

## Moderate Malnutrition: 2 Categories Required

<b>ICD-10: E44 Malnutrition of Moderate Degree</b>	<b>Moderate Malnutrition in the context of Acute Illness/Injury</b>	<b>Moderate Malnutrition in the context of Chronic Illness</b>	<b>Moderate Malnutrition in the context of Social/Environmental Circumstances</b>
<b>Weight Loss</b>	Weight Loss 1-2% in 1 week 5% in 1 month 7.5% in 3 months	Weight Loss 5% in 1 month 7.5% in 3 months 10% in 6 months 20% in 12 months	Weight Loss 5% in 1 month 7.5% in 3 months 10% in 6 months 20% in 12 months
<b>Intake</b>	Energy Intake <75% energy intake compared to estimated energy needs for >7days	Energy Intake <75% energy intake compared to estimated energy needs for ≥1 month	Energy Intake <75% energy intake compared to estimated energy needs for ≥3 months
<b>Body Fat</b>	Body Fat Mild depletion	Body Fat Mild depletion	Body Fat Mild depletion
<b>Muscle Mass</b>	Muscle Mass Mild depletion	Muscle Mass Mild depletion	Muscle Mass Mild depletion
<b>Fluid Accumulation</b>	Fluid Accumulation Mild	Fluid Accumulation Mild	Fluid Accumulation Mild
<b>Grip Strength</b>	Reduced Grip Strength Not applicable	Reduced Grip Strength Not applicable	Reduced Grip Strength Not applicable



# Competency Development 2014-2015



- **Order entry considerations** – Dietitian consults
- **Modifications to dietitian documentation** for clarification and specificity
- **Education** for Coding/CDI teams, provider groups (initial and ongoing, utilizing multiple educational platforms)
- **Improved query structure** – Clinical indicators and dietitian recommendation

# Dietitian Documentation

## Nutrition Interventions & Recommendations for Provider

- Recommend continue with current TF orders at present: at goal rate of 55ml/hr = 1980kcal/d, 89gm/d pro, 1L free water, 100% RDI.
- Protein modular BID = 30gm pro and 120kcal
- **Recommended Malnutrition Diagnosis:**
- Severe Protein Calorie Malnutrition pt meets criteria for severe protein calorie malnutrition in the context of an acute illness/injury 2/2 moderate fat/muscle wasting (see below) and pt consuming <50% of est energy needs for >5 days
- **Nutrition Focused Physical Findings/Exam**
- Skin: abd wound, R-buttock abrasion, L-back abrasion
- Muscle Loss Locations: Temple region – Moderate, Clavicle bone region – Moderate, Shoulder/Acromion bone region – Moderate
- Subcutaneous Fat Locations: Orbital region – Moderate; Triceps region – Moderate

# Malnutrition Criteria

## ASPEN-AND SEVERE MALNUTRITION CRITERIA

<i>ASPEN-AND Severe Malnutrition Criteria Met in the Context of Chronic Illness:</i>			
<i>2 of 6 Required for the Diagnosis of Severe Malnutrition</i>			
Category	Criteria	Present	Documentation
Weight Loss	>5% over 1 month >7.5% over 3 months >10% over 6 months >20% over 1 year	Yes	11.6% weight loss x 9 months – RDN note 9/16/14
Energy Intake	≤ 75% of estimated energy requirement for ≥ 1 month	Yes	Less than 50% of energy needs intake for greater than 1 month – RDN note 9/16/14
Body Fat	Severe Depletion		
Muscle Mass	Severe Depletion		
Fluid Accumulation	Severe		
Grip Strength	Reduced for Age/Gender		

## Interventions include....

- Counseling to patient and/or family/caregivers
- Diet modifications: texture, dietary restrictions
- Oral nutrition supplements
- Micronutrients: oral and/or IV
- Medications: appetite stimulants, etc...
- Tube feeding: NGT/OGT, post pyloric tube, surgically placed feeding tube (PEG, PEJ, or PEG/J)
- Parenteral nutrition: PPN or TPN
- DOCUMENTATION!

## Interventions

# CODING GUIDELINES FOR DIAGNOSIS REPORTING

ICD-9-CM Official Coding Guidelines for Coding and Reporting, Section III. “Reporting Additional Diagnosis”  
*(only 1 required to support reporting of diagnosis code)*

Clinical Evaluation; or	<ul style="list-style-type: none"> <li>This patient underwent a nutritional consult on 9/16/14 in which the nutritionist stated the patient met criteria for severe malnutrition in the setting of chronic illness based on energy intake less than 50% for &gt; 1 month and weight loss of 11.6% (17 lbs.) in 9 months.</li> </ul>
Therapeutic Treatment; or	<ul style="list-style-type: none"> <li>Oral nutrition supplements provided</li> <li>Micronutrients provided</li> <li>Appetite stimulant provided</li> </ul>
Diagnostic Procedures; or	
Extended LOS; or	
Increased Nursing Care and/or Monitoring	<ul style="list-style-type: none"> <li>Monitoring performed by Dietetics Team.</li> </ul>



# The Academy and ASPEN Indicators to Diagnose Malnutrition (AAIM) Validation and Optimal Staffing Study

- We strive to validate a standard method for diagnosing malnutrition in adult and pediatric populations
  - + Assess the interrater reliability of the Malnutrition Clinical Characteristics (MCC)
  - + Determine the validity of the adult and pediatric MCC relative to a portfolio of medical outcomes
  - + Estimate the level of RDN care necessary to improve patient outcomes
  - + Identify the additional level of RDN care necessary to improve the medical outcomes in patients who have been identified as malnourished
  - + Goal recruitment of 60 adult facilities and 60 pediatric inpatient acute care site.
  - + Currently working with **58 adult site and 50 pediatric sites**

## Adult MCC

- Energy Intake
- Weight Loss
- Body Fat
- Muscle Loss
- Fluid Accumulation
- Reduced Grip Strength

## Pediatric MCC

- |                                         |                                         |
|-----------------------------------------|-----------------------------------------|
| • Z-scores for weight for height/length | • Z-scores for weight for height/length |
| • Body mass index-for-age               | • Body mass index-for-age               |
| • Length/height for age                 | • Length/height for age                 |
| • Mid-upper arm circumference           | • Mid-upper arm circumference           |



## Legal Perspective

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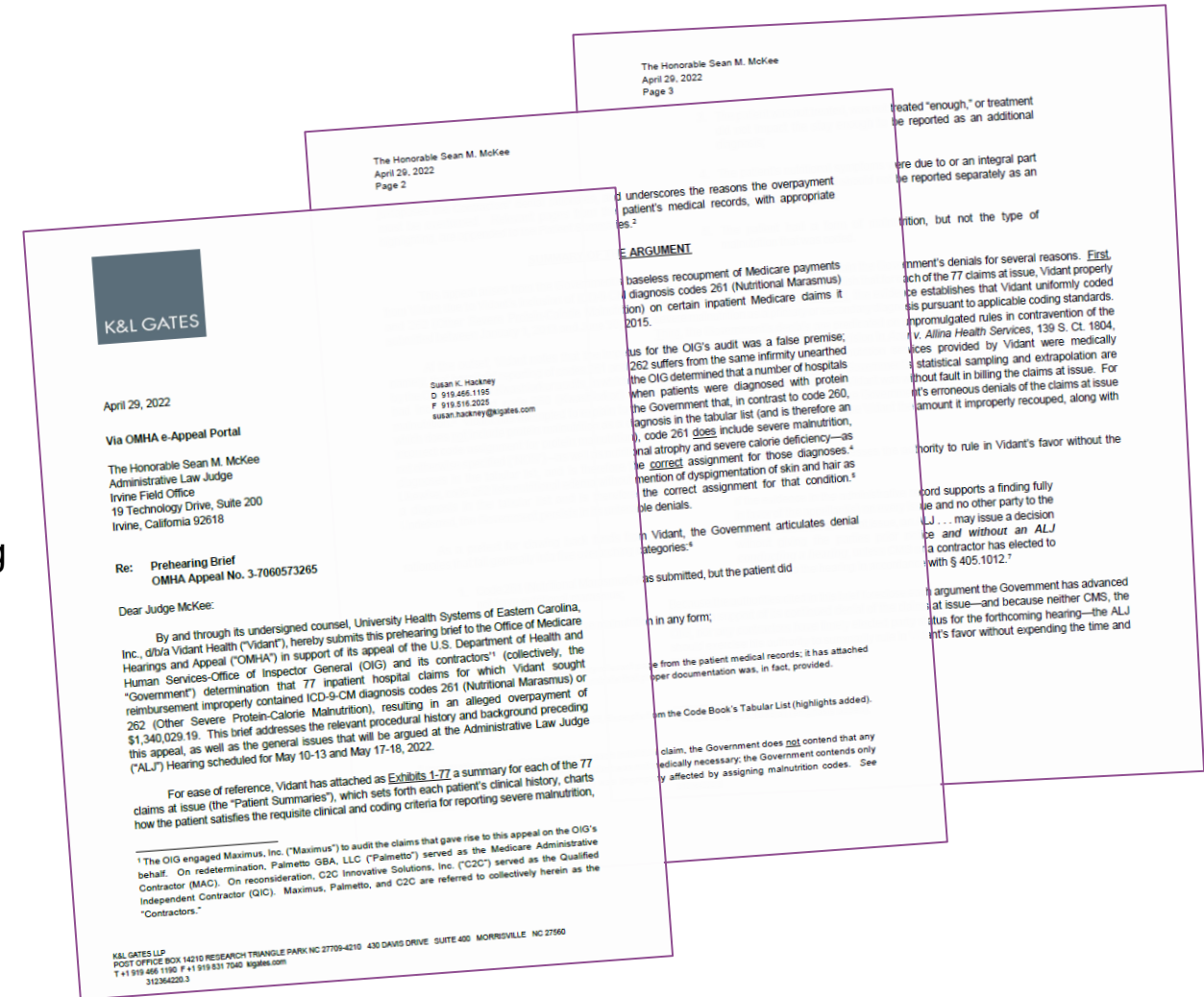
# Structure of Defense – Overview

- Prepared comprehensive prehearing brief addressing all topics at issue
  - Appended individual patient summaries
  - Appended expert CVs
  - Appended authorities relied upon in combatting denials
- At ALJ hearing, presented expert witnesses first, so that ALJ had framework in mind before contemplating individual cases
  - AND/ASPEN standards
  - Coding guidelines
  - Extrapolation
- Persuasively presented each individual case
- Attacked each and every denial rationale, whether raised by the OIG or any contractor
  - Tied to standard, guideline, or other authority to illustrate why the denial could not stand



# Prehearing Brief

- Summary of the argument
- Background
- Case history
  - Audit
  - Redetermination
  - Reconsideration
- Argument
  - Appropriately diagnosed severe malnutrition according to widely accepted clinical standards
  - Properly coded malnutrition claims
  - Each adverse decision predicated on improper denial rationales
  - Malnutrition services were reasonable/necessary
  - Extrapolation fatally flawed
  - Liability should be waived because Vidant not at fault
- Conclusion





## Expert Witnesses



### **Ainsley M. Malone, MS, RDN, LD, CNSC, FAND, FASPEN**

- Registered dietitian
- Employed by Mount Carmel East Hospital (Columbus, OH) as Nutrition Support Dietitian – Clinical Nutrition Services
- Also serves as Clinical Practice Specialist with ASPEN
- Provided testimony on origin of AND/ASPEN criteria, rationale underlying same, and why these criteria have been widely adopted as clinical standard for diagnosing severe malnutrition

## Expert Witnesses (cont.)



### **Garry L. Huff, MD**

- Board-certified in internal medicine; certified coding/clinical coding specialist
- President and Founder, Enjoin
- Provided testimony regarding clinical coding guidelines vis-à-vis severe malnutrition and reportability standards

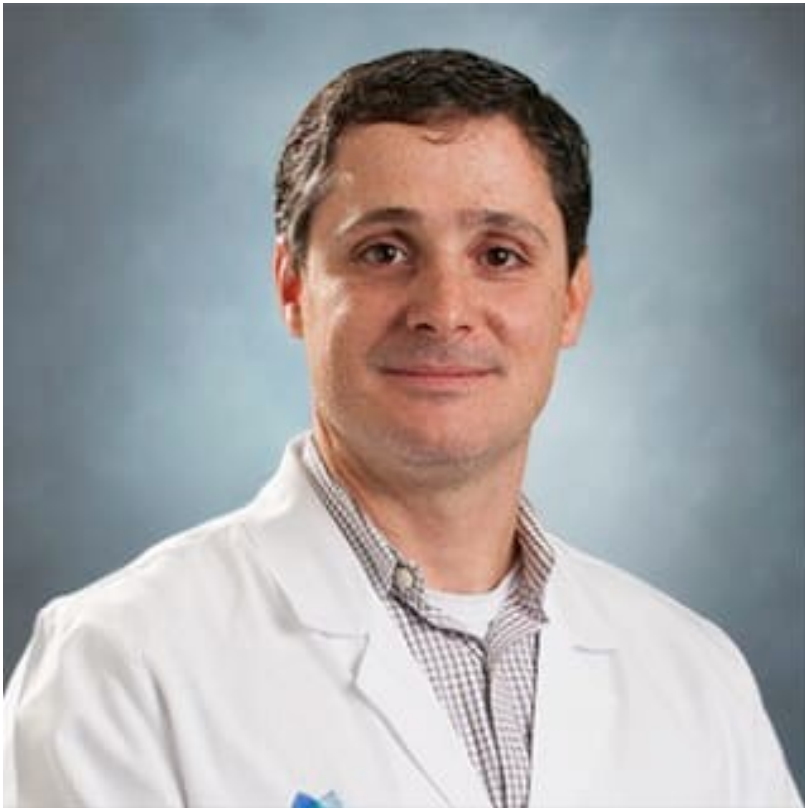
## Expert Witnesses (cont.)



### **M. Timothy Renjilian, CPA**

- Certified Public Accountant
- Employed by FTI as Senior Managing Director, Health Solutions
- Provided testimony/analysis regarding the validity of the statistical sampling and extrapolation employed by the OIG and the CMS contractors

## Expert Witnesses (cont.)



### **Vaughn M. Matacale, MD, CCDS**

- Board-certified in internal medicine
- Employed by ECU Health (formerly Vidant Health) as Physician Advisor for Documentation
- Provided clinical/coding testimony for each individual patient
- Addressed questions posed by ALJ during hearing

## Expert Witnesses (cont.)



### **Ashley Strickland, RDN, LDN, CNSC**

- Registered dietitian
- Employed by ECU Health (formerly Vidant Health) as Adult Clinical Nutrition Supervisor
- Provided clinical testimony and explained conformity with Classic Approach or AND/ASPEN criteria, as applicable
- Addressed questions posed by ALJ during hearing



# Case Organization Concepts

- Patient identification
- Clinical summary
- Chart compliance with Classic Approach or AND/ASPEN criteria
- Chart compliance with coding guidelines
- Summarize denial rationales
  - OIG Initial Determination
  - MAC Redetermination
  - QIC Reconsideration
- Provide bespoke list showing why the patient's denial must be overturned

# Why Make Case-by-Case Arguments?

- Addressing each patient individually reduces likelihood the ALJ can uphold denial based on alternate (non-categorical) rationale
- Impresses upon ALJ that each patient—even when analyzed individually—comports with the clinical diagnostic criteria and reportability standards for severe malnutrition
- Creates comprehensive record for next level of appeal, if needed
- Assists with case organization/presentation
- Makes it easy for the ALJ to access all pertinent information in one place when formulating his/her decision
  - Medical record evidence
  - Denial rationales
  - Rebuttals of denial rationales



## Summary

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Department of Health and Human Services  
Office of the Secretary

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September 14, 2022

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## **NOTICE OF DECISION**

## Outcome

Based on a *de novo* review of the record and considering the appellant's arguments in light of the applicable Medicare guidelines, I enter a **FULLY FAVORABLE** decision. This decision is

## Highlights of the Decision

- Validation of appropriate criteria use by Vidant and absence of stated criteria by any CMS reviewers
- Validation of Vidant's use of index, tabular, and includes notes
- Confirmation that neither Coding Guidelines nor *AHA Coding Clinic* require a minimum threshold of treatment for reporting additional conditions, including malnutrition
- Acknowledgement that Vidant's use of classic approach and subsequent transition to AND/ASPEN is consistent with national practice patterns
- Reiteration of guidance stating malnutrition is not integral or inherent to other conditions (e.g., cancer)

## Summary

- PATIENT CARE FIRST
- Consistent and uniform use of diagnostic criteria with standardized and compliant documentation
- Education
- Proactive partnerships: CDI, Coding, RDNs, PAs, Clinical Staff, Compliance, Legal
- **Fight when right!**







## Thank you. Questions?

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In order to receive your continuing education certificate(s) for this program, you must complete the online evaluation. The link can be found in the continuing education section of the program guide.

**Watch the “ACDIS Live! Malnutrition OIG Investigations and Auditor Denials” presentation here:**  
**<http://events.hcpro.com/materialspub.cgi?YZHHA082318A>**

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