Dietitian involvement resolves malnutrition query quandary

While most CDI specialists know to query for conditions related to malnutrition, such as obesity and cachexia, programs frequently ignore dietitians’ documentation and keep dietary professionals out of the coding/querying conversation when they should be partners at the table.

This was the situation at Carondelet Health in Kansas City, MO. CDI specialists queried for malnutrition specificity only when documentation warranted it, rarely flipping through to the dietary notes. It turned out the physicians weren’t reviewing those notes either, says Joann Agin, RHIT, regional director of data quality for Carondelet Health, St. Joseph Medical Center in Kansas City, MO, and St. Mary’s Medical Center in Blue Springs, MO.

“Even though the dietitians were documenting in the electronic part of the record, the physicians admitted that they didn’t look over in the dietary section of the notes because they didn’t get prompted to do so,” Agin recalls. “When you move to a hybrid or electronic record, if there isn’t something right in front of the physician they may forget about it.” (See related article regarding electronic health records on p. 1.)

During a 2009 dietitian’s conference in Boston, Melinda Hamilton, RD, LD, assistant director of patient services at Carondelet Health (contracted with ARAMARK), learned about the difficulties related to malnutrition documentation and coding and became energized to investigate the problem. She connected with Agin, who leads Carondelet’s CDI program, and the two began work on a new malnutrition tool (see p. 14).

The first step to take, says Hamilton, is to evaluate what’s being done to document malnutrition at your facility. CDI professionals should reach out to dietitians and/or coding staff to determine whether there is currently a process in place for tracking malnutrition. Then use the information to start a dialogue between departments regarding potential improvements (read the checklist below).

If there isn’t enough data to make this determination,

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**Checklist to initiate malnutrition program**

This checklist was developed by Joann Agin, RHIT, regional director of data quality and Melinda Hamilton, RD, LD, assistant director of patient services at Carondelet Health, to help other facilities assess their malnutrition documentation needs.

- Evaluate what is currently being done
  - Determine the current process for reviewing malnutrition documentation/coding
    - Identify stakeholders (CDI/dietitians/coders)
    - Determine rate of current malnutrition documentation
  - Contact team responsible for coding process
    - Introduce registered dietitian roles in malnutrition coding
    - Develop meeting schedule with coding team for implementation
- Review malnutrition criteria
  - Establish biweekly staff meetings to review case studies
  - Review physical appearance of malnourished patients
  - Examine laboratory assessment standards and guidances
  - Discuss potential subjectivity of disease states
- Develop malnutrition diagnostic tool
  - Ensure justification for all diagnostic criteria if asked and provide references
  - Involve physician/medical staff participation/feedback
  - Revise tool, as needed, based on physician feedback
  - Obtain medical records approval
- Educate physicians, nurses, unit secretaries, and coders
- Establish benchmarks for success
  - Create a timeline for program review
  - Establish success criteria (e.g., increase in CC/MCC capture, increase in malnutrition as secondary diagnosis, etc.)
  - Review potential documentation pitfalls and program difficulties
- Implement program

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conduct a random audit of your facility’s top 10 DRGs for
the past year, selecting every fourth record per DRG in a given
month. Review the records for malnutrition clinical indicators
and determine whether those indicators were pulled forward to
a clinical diagnosis and appropriately coded. With this infor-
mation you can extrapolate the effectiveness of the current
program and set expectations for improvement.

Next, develop a meeting schedule and include primary
stakeholders (e.g., physicians, coders, dietitians, and CDI
specialists) to work through the logistics of possible improve-
m ents. During their meetings, Hamilton says her team:

» Reviewed the DRG process and the dietitians’ potential role
» Discussed malnutrition coding requirements and relevant
  AHA Coding Clinic for ICD-9-CM guidance
» Reviewed current clinical malnutrition criteria
» Reviewed malnutrition case studies from within the facility
» Discussed diagnosis ambiguity and the potential for
  changes in clinical criteria
» Developed a malnutrition diagnostic form

Creating the draft of the diagnostic form took about a
week, Hamilton says, but the remainder of the team’s work
took quite a bit longer. “There was definitely a coordination
of care concern, and we really had to spend a lot of time try-
ing to understand each other’s roles and engaging in a lot of
open communication,” she says.

A slight tug-of-war ensued between the various depart-
ments as stakeholders debated who would own responsibility
for the form and who would ensure that physicians used it.
Should it be a dietary form or a CDI query?

“In the beginning, the real questions were around who
was going to do this and when, etc. You just have to push
through that and determine the best fit for your own pro-
gram,” Hamilton says.

The team decided dietitians would “own” the form, that it
would be an assessment tool akin to a wound care nurse docu-
mentation form. Since the dietitians owned this stage of the
process, Agin says it was important not to call the form a query
or clarification, since the dietitians were documenting condi-
tions and physicians were essentially signing their agreement or
disagreement.

The team then turned its attention to enlisting support
from the medical staff. “It had to go through our clinical
effectiveness team, where it went through a number of revi-
sions,” Hamilton explains. Once it earned approval there, the
HIM department worked to incorporate it into the medical
record. Agin’s CDI team set out to educate the physicians
about the process and its importance to accurate documenta-
tion and patient outcomes.

“It has been a wonderful endeavor,” says Agin. “We had
physicians stating that they didn’t get that much education
on malnutrition [when they were in school], so many of
them were happy to have the extra information.”

With all the tools and process finalized, Agin and
Hamilton began their educational campaign by:

» Including information in physician newsletters
» Developing a poster of the new form
» Posting information in the physician lounge
» Presenting information at physician and nursing meetings

The team even arranged an educational blitz aimed at the
nursing staff and unit secretaries, Hamilton says, and made
themselves available for physicians with problems or ques-
tions.

The only concern left to tackle was tracking the team’s
success. They wanted to know how much of an impact the
new form had, so they looked for malnutrition coding that was
prompted by the dietary staff first. Then they went deeper into
the data to see the effect of the new process. In 2009 there were
873 cases with malnutrition documented. In 2010, that number
rose to 1,247. In fiscal year 2011, malnutrition docu-
mentation prompted by the new dietary form brought in more than
$350,000 in potentially lost reimbursement, says Agin.

Now, as physicians’ awareness of the importance of mal-
nutrition documentation increases, they are beginning to doc-
ument within the record on their own and look to the dietary
notes without using the form.

While that means statistically the number of malnutrition
cases “caught” by the dietary staff may start to go down, cli-
nicians are beginning to capture malnutrition as a comorbid
diagnosis early on.

“That’s the thing we focus on,” Hamilton says, “the impact
of malnutrition on risk of mortality and severity of illness.”

“And appropriate documentation of that fact could
help the physician’s profile and the facility’s reimbursement,”
Agin adds.