New malnutrition criteria could help ensure consistent coding

New clinical guidelines for malnutrition could help alleviate compliance challenges associated with coding the condition, which has never had universally accepted clinical criteria.

New guidelines published in the May 2012 *Journal of the Academy of Nutrition and Dietetics* represent a consensus statement of the American Academy of Nutrition and Dietetics (the Academy) and the American Society for Parental and Enteral Nutrition (ASPEN). The Academy and ASPEN both advocate for provider use of a standardized set of diagnostic characteristics to identify and document adult malnutrition, says Jane White, professor emeritus in the Department of Family Medicine at the University of Tennessee in Knoxville. White also serves as chair of the Academy’s adult malnutrition work group.

The Academy and ASPEN say malnutrition should be diagnosed when at least two or more of the following six characteristics are identified:

1. Insufficient energy intake
2. Weight loss
3. Loss of muscle mass
4. Loss of subcutaneous fat
5. Localized or generalized fluid accumulation that may sometimes mask weight loss
6. Diminished functional status as measured by hand grip strength

Providers must assess these six characteristics in the context of an acute illness or injury, a chronic illness, or social or environmental circumstances to determine whether malnutrition is present and whether it’s severe or non-severe (moderate). The article, available at http://tinyurl.com/ckbclxa, provides a table with more detailed clinical criteria to which providers can refer when documenting severity levels for malnutrition.

The Academy and ASPEN have asked the NCHS to adopt ICD-9-CM malnutrition codes that use etiological-based nomenclature, says White. If adopted, the ICD-9-CM codes will better reflect the clinical presentations that providers encounter when assessing malnutrition, she says.

Don’t fall into a compliance trap

This all comes as good news for coders and providers who continue to struggle with third-party audits of CC and MCC conditions, including malnutrition, says James S. Kennedy, MD, CCS, CDIP, managing director at FTI Consulting in Atlanta.

At a Maryland hospital employees allegedly used leading queries to add malnutrition as a secondary diagnosis. The Baltimore facility denied the accusations, but agreed to pay nearly $800,000 to resolve the False Claims Act violation allegations, according to a March 28 press release from the U.S. Department of Justice, available at [http://tinyurl.com/d4j6hpy](http://tinyurl.com/d4j6hpy).

“If patients had truly had malnutrition, it wouldn’t have been as much of an issue,” says Kennedy. He attributes incorrect malnutrition coding to a lack of consistent clinical criteria and says that many CDI programs also incorrectly define malnutrition based solely on low albumin or prealbumin levels.

Another facility in Redding, Calif., allegedly billed Medicare for treatment of more than 1,000 cases of kwashiorkor over a two-year period, according to a California Watch analysis of state health data.

Kwashiorkor, a form of malnutrition that occurs when a diet lacks sufficient protein, is very rare in the United States, and is not something that coders encounter frequently, says
Alice Zentner, RHIA, director of auditing and education at TrustHCS in Springfield, Mo. Physicians must specifically document the term “kwashiorkor” for coders to report it, she says.

Although the ICD-9-CM index instructs coders to report code 260 (kwashiorkor) for unspecified protein malnutrition, Coding Clinic, Third Quarter 2009, p. 6 discourages assignment of this code when physicians document moderate or mild protein malnutrition, says Kennedy.

Rely on helpful strategies

Coders should remember and use the following strategies:

» Don’t always assume documentation is correct. It may seem counterintuitive, but coders should question a diagnosis when it appears that no clinical evidence supports it, says Kennedy.

For example, physicians often incorrectly diagnose malnutrition based solely on a low albumin or prealbumin, he says. Third-party auditors will challenge this diagnosis, and coders should also question it, he says.

Coders must ensure that severe protein-calorie malnutrition—an MCC—is documented consistently and treated, says Zentner. “If that code is on a record, it’s certainly a red flag for a RAC to audit,” she says.

Malnutrition must also meet the definition of a reportable secondary diagnosis, says Zentner. Coders should also remember not to report cachexia, a wasting syndrome, as malnutrition—instead, cachexia is denoted by a symptom code (799.4), she says.

Hospitals should develop policies that explain how coders should address inconsistent and unreliable diagnoses, says Kennedy. Unreliable diagnoses are those that don’t meet reasonable criteria established by the medical staff. Once identified, these diagnoses should be vetted by a coding supervisor, physician advisor, or CDI specialist, he says.

» Beware of leading queries. A malnutrition diagnosis often may not be documented when a patient does, indeed, have the condition. However, CDI staff cannot lead physicians when requesting clarification, says Kennedy.

“We are allowed, as coders [and CDI professionals], to ask providers for the clinical significance of abnormal labs or clinical findings,” he says.

Consider the following query based on the new criteria from the Academy and ASPEN:

Dear Dr. Malnutrition

The following clinical indicators are in the medical record:

» Current BMI _____

» Stress indicator (circled) — Acute illness — Chronic illness — Social

» Energy intake over the previous ____ days ____% 

» Amount of weight loss over ____ days ____% 

» Loss of subcutaneous fat (circled)
  — None — Mild — Moderate — Severe

» Loss of muscle mass (circled)
  — None — Mild — Moderate — Severe

» Fluid accumulation (circled)
  — None — Mild — Moderate — Severe

» Measurably reduced grip strength present (circled)
  — Yes — No

Please indicate what diagnosis best correlates with these findings:

» Cachexia without malnutrition

» Nutritional risk without malnutrition

» Malnutrition, severity unknown

» Malnutrition, non-severe (moderate)

» Malnutrition, severe, not otherwise specified

» Marasmus — A specified severe protein-calorie malnutrition

» Kwashiorkor — A specified severe protein malnutrition

» Another medical diagnosis

» Other (please specify)

» Cannot be determined

Other clinical evidence in the record that might suggest malnutrition includes chronic disease, insufficient intake pre- or postoperatively, infection, malabsorption, muscle wasting, poor wound healing, or lethargy, says Zentner.

» Collaborate and educate. Ask CDI specialists to educate physicians about malnutrition clinical indicators, advises Kennedy. Also advocate for predischarge queries.

“The query for malnutrition is really best done in a predischarge environment in collaboration with dietitians, nutritional teams, and the CDI team,” he says.

Editor’s note: This article originally appeared in the July issue of Briefings on Coding Compliance Strategies.