The Offices of Inspector General and Health and Human Services are reviewing and rejecting documentation of severe protein-calorie malnutrition. In 2018, the American Society for Parenteral and Enteral Nutrition (A.S.P.E.N.) formed a task force to assess the current situation and develop a strategy to educate these agencies regarding best practices for diagnosing, documenting and coding protein-calorie malnutrition.

Protein-Calorie Malnutrition is receiving increased scrutiny in acute care settings by federal auditing agencies who are concerned about fraudulent reimbursement for unfounded claims of a malnutrition diagnosis. At the same time, other agencies are actively working to improve identification, prevent malnutrition and improve outcomes of malnourished patients due to the great expense of treatment and care. This program discusses origins of the confusion, national and international activities to reduce confusion, the diversity of perspectives of different stakeholders, and discusses approaches to quality patient care and documentation that may help reduce diagnosis denials and federal level audits.
Even as more hospitals have improved processes for the diagnosis of adult protein-calorie malnutrition, there remains confusion among physicians, regulators and auditors about the diagnosis. Some are not familiar with the modern understanding and metabolism of disease-related malnutrition as described in the Academy of Nutrition and Dietetics and the American Society of Parenteral and Enteral Nutrition 2012 Consensus characteristics.

This presentation and handout discusses the background of perceptions, sources of confusion, reported results of federal audits, opportunities for improved understanding, historical information, and how documentation and diagnosis may help reduce risk, identify the high-risk patient populations, and how metrics and regulatory updates can move our patients' care forward to successful transition to their next stage of care. Identification of malnourished patients allows interventions, improved care transitions and hand-offs. These improvements will help nutrition care move forward to reduce the causes and consequences of malnutrition.

After attending the 2nd part of the session, the participant will be able to:

1. Demonstrate documentation techniques to strengthen evidence for protein-calorie malnutrition that may help reduce risk for audits and denials.
2. Identify ways dietitians, nurses and physicians can collaborate to communicate, create workflow and document to support clinical validation, accurate coding, and post-discharge treatment plans.

Disclaimer

This information is intended to be supportive of the Academy of Nutrition and Dietetics Nutrition Care Process. If variation occurs, defer to the NCP. This information is intended for practical applications for daily operations in inpatient and outpatient nutrition services. It is not implied or known if these suggestions will in fact impact reductions in denials. Communications are strongly urged with organizational compliance officers, medical coders and medical staff for your facility actions and approaches. This presentation does not replace professional guidance from qualified coders and compliance officers.
References

Medical coding references:

ICD-10 CM Official Guidelines for Coding and Reporting FY 2018


These references are sometimes given as sources for denials by RAC auditors.

Merck Manual: reference including that it was physician-reviewed in 2016 after notification of the updated Consensus. A recent update remains inconsistent with Academy ASPEN Consensus, including use of albumin and other laboratory measures.


http://apps.who.int/iris/bitstream/handle/10665/41999/a57361.pdf;jsessionid=4298B716B39E012B9622975DD7034340?sequence=1 page 37-38 accessed 3/1/19

Academy/ASPEN Consensus Characteristics

Adults  http://journals.sagepub.com/doi/abs/10.1177/0148607112440285

Pediatrics  http://journals.sagepub.com/doi/abs/10.1177/0884533614557642

Tips and Suggestions for Medical Record Documentation

Charting about a patient case must contain a very clear and transparent view of what is going on with the patient’s nutrition and diet and the relationship to diseases and conditions. When reading the note there should be few or no dangling “why’s” for the reader. The note must clearly communicate a timeline, how and why nutrition status got to the point it is today, define what that status is, compare the status to the nutritional, medical, behavioral or social gaps and to any applicable standards. Tell the reader what you
are going to do about the gap, and what you want others to do about it with you. Then in future notes, reference back to those plans and either continue them, change them or drop them as issues. There has to be continuity and a nutrition theme carried through each record and subsequent updates to that theme, and periodic notes as to what you are seeking to occur for your patient.

Try these suggestions to make documentation specific, clear and meaningful. There are no guarantees that this will help reduce denials, however, you will have solid information to use and reflect upon in justification of your nutrition diagnosis should you receive a denial.

- Nutrition Diagnosis (PES) should state the nutrition specific evidence for the problem, typically not a disease or diagnosis as a rationale (readers that are not dietitians may not understand implications); writers should typically state the signs/symptoms of the problem, not the disease itself as the problem, the nor the medical diagnoses or medical procedure. (If the primary medical diagnosis is a type of malnutrition, then okay).

- When possible, quantify the data in your statements using measurable data whenever possible. Quantified details (calculations) are very powerful and show the rationale for what you are stating and gaps between the patient’s situation and the targeted or calculated goals. Mathematical descriptions are likely understood by readers.
  
  o Example: “Eating 40% (estimate 800 Calories/day) of usual diet for recent 3 weeks (from May 1) since prior discharge”. VS. “recently eating poorly compared to usual diet”.

- When there is a nutrition problem or medical diagnosis that impacts nutrition, or an issue identified from the patient history that impacts nutrition, diet, ability to consume food to sustain oneself, be sure to refer to the problem(s) in planning and interventions—to improve whatever it is connected to.

- If there is a history of weight loss, it has to be defined as how much, the time span, what is weight loss attributed to or what appears to have caused it? Then the intervention needs to include what needs to change so it does not occur again once patient goes back to the previous or to a new care setting.

- The dietitian should always cause something to happen (action) for the betterment of the patient-document this action. Otherwise, why did the dietitian bother to see the patient?

- If there is an oral supplement, modular, TF or TPN, there has to be language about what the indication for it is...for the reader’s understanding. Why is the person unable to tolerate a regular meal? Why is this change being added? Quantify gaps in nutrition and if possible with time frame references. Dietitians will inherently
understand why you have added or altered something, but other readers may not. So, it is useful to spell it out clearly.

- “Added one protein modular (11 grams) to bridge the gap between the target goal of xx grams and the patient’s usual intake of xx grams which will help in healing the wound.”) is more specific and clear than “adding protein module.” And assuming the reader knows why. An auditor may have no idea why and cannot presume, so could disregard this as a nutrition treatment.

- There has to be a nutrition diagnosis or else, what are you seeking to manage? Stating the problem, reason for the problem, and what data you have to prove there is a problem is very powerful. Then once you have that, you then specifically define what you are going to do about it all —which is where goals, interventions and monitoring documentation is required.

- Quantifying and comparing actual data is critical and powerful—time, volumes, quantified nutrient goals, nutrient comparisons to goals, weight changes, and intake changes. Show your reader the deficit or gap and the time frame. This data is highly meaningful clinically, likely only something unique to the dietitian role. The dietitian can quantify the meaning in comparing findings to the Academy/ASPEN Consensus criteria.

- It is ok to have an opinion or professional judgement on a clinical situation, but you must state rationale and show transparently how you came to your conclusions. You can state that your conclusion is an opinion. If you have limited data or are unable to quantify it adequately, but still believe there are issues, it is OK to state that the quantification data or the data itself is not able to be exact, but you are interpreting it a certain way based on your overall impression and judgement, “Suspect...”. You are still expressing to your reader as to how you came to the point of understanding you have at the time of your note. The future dietitian and team will know what you were thinking so will consider new information and adjust as needed.

- There must be reference somewhere as to appropriateness and validity and tolerance of the diet order the patient is on and adequacy of the diet and then the consumption record. This is a key value that a dietitian brings to patient care. Readers should know exactly the current diet order and the intake and tolerance at the point in time when the dietitian was dealing with the patient. Clearly describe.

- Diet history taking, nutrient estimates and food patterns (both in and out of hospital) are critical values the dietitian brings to patient care. Most professions are unable to quantify this very well. “Poor intake prior to admission” would be non-dietitian comment. “Poor intake (25% or less of usual meal intake, estimate 600 Calories and 23 grams protein per day) at breakfast and lunch for the previous 10 days” would be a dietitian comment and bring much power to the nutrition conversations and contribute to the rationale for your nutrition diagnosis of PCM. This foundation is important for the nutrition diagnosis of malnutrition and for the
best intervention and care plan decisions. Auditors would potentially understand the meaning and consequences with this specific language.

- When weight loss or gain is noted, it is important to be able to attribute it to something—what was going on? Or if unable to attribute, then state “unable to attribute”. This is important as the attribution then defines something to change to improve the patient’s nutrition.

- When writing about malnutrition (or talking to non-dietitian colleagues), use the language/phrasing such as “...has a nutrition diagnosis of protein-calorie malnutrition...” rather than something like “can be coded for malnutrition”. The dietitian is discussing nutrition risk criteria and relationships and not a medical coder who decides what to code. MD’s make the medical diagnosis, we are making a nutrition diagnosis of malnutrition based on Academy/ASPEN Consensus criteria. Perhaps mincing words, but something to consider for the audience. The dietitian does not have to mince words. State what the condition is. Documentation specialists and medical coders need to see the specific words because it helps them code, know if there is adequate evidence to code and to reduce or clarify in queries to the physician.

- Pay attention to the context and use of the words low, high, increased, decreased and make sure they are used accurately for the situation and intended meaning. Get specific.
  
  o “Appetite is reported as reduced” VS “Appetite is reported by spouse as ‘reduced by half’ for recent 4 weeks, with no interest in dinner or snacks, especially beef.”

- Be aware of writing healthcare vernacular in the chart of such casual nature as you could use when speaking with someone. While dietitian colleagues will know what you mean, it often does not come across clearly to readers, weakens the nutrition message and leaves openings for denials.

- When patient is on TF and oral diet, it is more specific and meaningful to document how much nutrition they actually receive from each contributing route rather than a combined report.

- There can be a great difference between what the patient is “supposed” to get or “ordered” to get, and what was actually delivered over a time period. Stating the nutritional values in the intended diet/TF/TPN order is fine, but very different from what the patient actually received. Therefore, instead compare the actual intake to the target nutrient goals. Example: “intake is an average of 50 grams protein daily for the last 3 days, which is 60% of the calculated protein goal of 90 grams/d. Ordered amount is 90 grams per day”. Or another way: “Ordered 2000 Calories, 90 grams protein; Received 60 grams protein and 1500 Calories in last 24 hours.”
Tips that may help reduce RAC Malnutrition Denials (No guarantees!)

- Document all Consensus criteria that apply to the case when they can be described. (A minimum of two is suggested, however, many facilities require all conditions that can be determined to help with adequate evidence).
- Include mathematical quantifications of intake, weight changes, time frames.
- Document and describe appearance of specific the body anatomy and of lesions when the nutrition focused physical exam is completed. Describe adequate and inadequate muscle mass, fat stores, and comments patient/others make of weakness and functional ability, lesions or abnormal findings.
- Document the impact on the person’s ability to move and function, and ability to sustain independently an adequate intake, including measurements such as baseline and subsequent hand grip or other functional status conditions.
- Document details as to why fortified foods and supplements are needed,
  - Example: Added high protein milkshake to increase protein to target XX grams/day, to supplement the inability to eat adequate regular foods due to fatigue and support healing of surgical wound.
- Be clear and specific about the patient’s status and the target goal especially for calories, protein or other nutrients and fluids. State what the target is and what the gaps are in real numbers and percentages.
- Start meeting, communications and education about clinical malnutrition with the group that functions as clinical documentation specialists (CDS) in your facility. Encourage them to refer patients to you if they find nutrition problems during their chart reviews; Encourage dietitians to contact CDS’s if a physician is not responding to the nutrition diagnosis or communications. They will contact the physician using their normal work process.
- Read, keep-up and study professional journals and attend conferences to learn about clinical malnutrition, NFPE and national and international work.
- Obtain education and training in advanced practice and specialty nutrition topics to increase ability to see, understand, better describe and document clinical malnutrition.
- Teach, teach, teach! Learn, learn, learn!
Tips for Action if you receive a Denial (No Guarantees!)

- Ask the medical coders to send every Denial to you or your clinical manager to review the case; let them know you will review the case and provide a rebuttal to send back to compliance to communicate to the Auditors.
- Contest the Denial every time if when you believe it is erroneous and with organizational permission, in collaboration with your compliance officers and medical coders. Show them that documentation that includes good evidence and is usable in an official appeal response.
- Provide evidence to the auditors of your organizations actions to reduce incidence of malnutrition, such as discharge meal programs, actions of the medical nutrition committee, meeting minutes, educational presentations to internal professionals, education on malnutrition to the community, any data that is collected by the organization to learn about the malnourished population. Retain information that is evidence that the organization is working on reducing malnutrition and uses diagnosis data to identify the population and its needs. Sure, there is reimbursement, but your organization wants to know about the population so you can reduce malnutrition. Do not let them presume you are only doing this for reimbursement purposes.
- If a denied case is not well-documented by the dietitian, let your compliance officers know, and use the record as a teaching example of inadequate documentation.
- For each case reviewed: point-out the evidence for each Consensus criteria and other pertinent conditions, and reference the evidence sources. In detail. Audit reviewers may or may not have a health background. Some levels of review are accountants. Rebuttals should describe the findings such that non-health care readers will understand. Include respected references.
- Point out the significance of how the current/modern understanding of clinical malnutrition conflicts with historic and misapplied standards, such as from the original characteristics from the 1970’s, the misapplication from the 1999 WHO refugee standards for pediatrics with a tiny paragraph for adults and any other references given in the denial. Point out any discrepancies between current science, respected text books, journal articles and inconsistencies between the denials’ references between themselves and the scientific literature. This approach is needed for common misunderstandings such as obese patient with low lean mass and overinterpretation of serum albumin.
- Persist with organizational and professional improvements.
Additional Comments and References

Yellow highlights are key messages


INPATIENT ICD 10 Official Coding Guidelines for Coding and Reporting FY 2018

These excerpts describe 2018 obligations of a Medical Coder when they perform their coding function.

This document therefore provides information about what professionals would document.

Excerpts:

19. Code assignment and Clinical Criteria

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

Documentation for BMI, Depth of Non-pressure ulcers, Pressure Ulcer Stages, Coma Scale, and NIH Stroke Scale

• For the Body Mass Index (BMI), depth of non-pressure chronic ulcers, pressure ulcer stage, coma scale, and NIH stroke scale (NIHSS) codes, code assignment may be based on medical record documentation from clinicians who are not the patient’s provider (i.e., physician or other qualified healthcare practitioner legally accountable for establishing the patient’s diagnosis), since this information is typically documented by other clinicians involved in the care of the patient (e.g., a dietitian often documents the BMI, a nurse often documents the pressure ulcer stages, and an emergency medical technician often documents the coma scale). However, the associated diagnosis (such as overweight, obesity, acute stroke, or pressure ulcer) must be documented by the patient’s provider. If there is conflicting medical record documentation, either from the same clinician or different clinicians, the patient’s attending provider should be queried for clarification.

• The BMI, coma scale, and NIHSS codes should only be reported as secondary 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.

CD-10-CM Official Guidelines for Coding and Reporting FY 2018 Page 105 accessed 3/21/18

H. Uncertain Diagnosis
- If the diagnosis documented at the time of discharge is qualified as “probable”, “suspected”, “likely”, “questionable”, “possible”, or “still to be ruled out”, or other similar terms indicating uncertainty, code the condition as if it existed or was established. The bases for these guidelines are the diagnostic workup, arrangements for further workup or observation, and initial therapeutic approach that correspond most closely with the established diagnosis.
- Note: This guideline is applicable only to inpatient admissions to short-term, acute, long-term care and psychiatric hospitals.


A few notes about Outpatient: Outpatient records are not audited according to inpatient standards. Below are coding guidelines for outpatient Coders. Dietitians are best documenting malnutrition with an eye for this information:

Outpatient rules are different; but there are opportunities to help communicate patient’s nutritional status/malnutrition

C. Accurate reporting of ICD-10-CM diagnosis codes
- For accurate reporting of ICD-10-CM diagnosis codes, the documentation should describe the patient’s condition, using terminology which includes specific diagnoses as well as symptoms, problems, or reasons for the encounter. There are ICD-10-CM codes to describe all of these

ICD-10-CM Official Guidelines for Coding and Reporting FY 2018 Page 108

G. ICD-10-CM code for the diagnosis, condition, problem, or other reason for encounter/visit
- List first the ICD-10-CM code for the diagnosis, condition, problem, or other reason for encounter/visit shown in the medical record to be chiefly responsible for the
services provided. List additional codes that describe any coexisting conditions. In some cases the first-listed diagnosis may be a symptom when a diagnosis has not been established (confirmed) by the physician.

H. Uncertain diagnosis (Note, this is different than used in inpatient).

- Do not code diagnoses documented as “probable,” “suspected,” “questionable,” “rule out,” or “working diagnosis” or other similar terms indicating uncertainty. Rather, code the condition(s) to the highest degree of certainty for that encounter/visit, such as symptoms, signs, abnormal test results, or other reason for the visit.
- Please note: This differs from the coding practices used by short-term, acute care, long-term care and psychiatric hospitals.


I. Chronic diseases

- Chronic diseases treated on an ongoing basis may be coded and reported as many times as the patient receives treatment and care for the condition(s)

J. Code all documented conditions that coexist

- Code all documented conditions that coexist at the time of the encounter/visit, and require or affect patient care treatment or management. Do not code conditions that were previously treated and no longer exist. However, history codes (categories Z80-Z87) may be used as secondary codes if the historical condition or family history has an impact on current care or influences treatment.


Ambulatory care: Hierarchical Condition Codes accessed 3/21/18

TABLE 1: Final Adult Risk Adjustment Model Factors for 2018 Benefit Year

Date: April 18, 2017

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Center for Consumer Information and Insurance Oversight
200 Independence Avenue SW
Washington, DC 20201

https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/Downloads/2016-RiskAdj-FactSheet.pdf
CMS uses risk adjustment to account for differences in beneficiary-level risk factors that can affect quality outcomes or medical costs, regardless of the care provided. The goal of risk adjustment is to enable more accurate comparisons across TINs that treat beneficiaries of varying clinical complexity, by removing differences in health and other risk factors that impact measured outcomes but are not under the TIN’s control.
Tips but No Promises:
Considerations in the RD response to Malnutrition Denials
& Ideas for Infrastructure

Language tips:

- “History of...” is interpreted as the condition no longer exists.
  - It does not mean that “History of” means the condition still exists but is under control with ongoing treatment.
- If the patient’s condition is really protein-calorie malnutrition, document as such and not ‘failure to thrive’.

Reference: Coding Corner: OIG’s coding and documentation “hot button” issues, Prime Pointers Provider Updates Summer 2012

- Terms can be used such as “probably,” “suspected,” “likely,” “questionable,” “possible,” or “still to be ruled out” in their documentation. (Physicians in their discharge note or order), and if the clinical circumstances or treatment reasonably support the coded diagnosis.

http://blr.hcpro.com/content.cfm?content_id=310448

Systems Infrastructure to Consider

Set up safeguards and systems with Compliance and Clinical Documentation Specialists and Medical Coders within the facility.

Consider the following recommendations:
- Use a clinically non-leading, robust physician clarification process;
- Encourage providers to document clinical support for malnutrition diagnoses;
- Provide education to all providers;
- Collaborate with dieticians in establishing standards and agreement for malnutrition assessment tools, which should include talks about risks and clinical presentation;
- Include the clinical documentation specialists (CDS) in review of clinical forms; and
- Establish an internal review process for monitoring the use of Code 260


Response suggestions when reviewing and reporting documentation in denied charts
- Itemize each detail documented from MD, RD, RN that supplies evidence for the diagnosis.
- Include numerical relationships such as percentages and pounds of changed weight, percentages and amount of the nutrient target and deficit
- Describe or ‘quote’ comments that indicate increased utilization of resources during the hospital stay that are related to nutrition. Describe services and events that are required due to malnutrition.
- The patient can present to the hospital with malnutrition or acquire it during the stay. Be clear in the timing and descriptions of these separate locations.

Potential format of dietitian response when reviewing a denied case. This response could be used by the Compliance officer to appeal to the RAC denial. Defer to your Compliance Officer.

Title: Reviewer Summary of case xxxxxx

Identification code number, patient name, DOB

Admit date
Discharge date

Final code (per RD reviewer):
- Itemize all details of the Consensus Criteria and any other data from the record that describes why the patient is malnourished and events and actions taken due to the malnutrition

Reviewer Comments:
- Itemize key points of what happened in the reviewer’s analysis

Physician Note Excerpts:
- Quote date/time of excerpted comments and quotes and note from physician record
- Copies of the actual MD note that had any comments related to malnutrition/nutrition and treatment of same
- Can include actual pictures from chart for example using ‘Snagit” type software tools.

Dietitian Note Excerpts:
- Quote date/time of excerpted comments and quotes and notes from dietitian records
- Can include actual pictures from chart for example using ‘Snagit” type software tools.
Nursing Note Excerpts:
- Quote date/time of excerpted comments, quotes and notes from nursing records
- Can include actual pictures from chart for example using ‘Snagit” type software tools.

EHR messaging to alert MD to the nutrition diagnosis
- “Snagit” type software picture of the communication from the RD to notify the MD that the facility uses.

Additional records to consider adding:
Documentation and picture or attachment of the facility and medical staff approved policy, for example a chart or diagram that was used to describe the type of malnutrition identified for this case.

If the RD writes a draft of the actual Appeal Letter to provide to the Compliance officer or Legal:

Excerpted from
- Do not assume the denial is accurate
- Include all the necessary data in the first response in case the records go higher to be appealed
- Recap the situation and what the RAC identified.
- Clearly state disagreement
- Clear and concise arguments to support your position. Use as many as possible
- Reference the medical record and cite and highlight the pertinent entries
- Cite historical payer experience with the same conditions
- Include all pertinent information related to coding

“If you believe you are right and have the evidence to support your argument, continue to escalate your appeal to higher levels if you are not initially successful. Experience has shown that the ALJ level is the first real voice you will have to defend your position. ……..The outline followed for the first level of appeal will be the defining argument presented to the ALJ.” (ALJ=Administrative Law Judge)
**Appeals: typically processed by facility Compliance and Legal Departments**

RAC auditors follow Medicare appeals process.

There are five levels in the Medicare Part A and Part B appeals process. The levels are:

1. **First Level of Appeal:** Redetermination by a Medicare Administrative Contractor (MAC)
2. **Second Level of Appeal:** Reconsideration by a Qualified Independent Contractor (QIC)
3. **Third Level of Appeal:** Decision by the Office of Medicare Hearings and Appeals (OMHA)
4. **Fourth Level of Appeal:** Review by the Medicare Appeals Council
5. **Fifth Level of Appeal:** Judicial Review in Federal District Court


ICD-10 Monitor September 26, 2016 by Erica E. Remer MD, FACEP, CCDS

[https://www.icd10monitor.com/aggressive-tactics-by-third-party-auditors-should-make-providers-vigilant](https://www.icd10monitor.com/aggressive-tactics-by-third-party-auditors-should-make-providers-vigilant) excerpt from: ICD-10-CM Official Guidelines for Coding and Reporting, “The assignment of a diagnosis code is based on the provider’s diagnostic statement that the condition exists. The provider’s statement that the patient has a particular condition is sufficient. Code assignment is not based on clinical criteria used by the provider to establish the diagnosis.”

T. Scollard comment: But this does not seem to be happening and other evidence is required.

**For information on the Office of Inspector General and Malnutrition**

2018

2019

Reports on various audits:
[https://oig.hhs.gov/oas/reports/region3/31500011.asp](https://oig.hhs.gov/oas/reports/region3/31500011.asp)
[https://oig.hhs.gov/oas/reports/region3/31300034.pdf](https://oig.hhs.gov/oas/reports/region3/31300034.pdf)
[https://oig.hhs.gov/oas/reports/region3/31700005.pdf](https://oig.hhs.gov/oas/reports/region3/31700005.pdf)

The information in the presentation and handout information is not medical, legal, coding or compliance advice. Use at your own risk. This information is solely for educational purposes. Readers are encouraged to discuss with their local officers, coders and other professionals.