

# Malnutrition in the Hospital Setting

## *What's Your Plan? Part 2: Q&A*

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**Thank you!**

# Results and Stats

Our references for our program results are due to our experience in the field.

We work in the hospital setting with administration, dietitians and the interdisciplinary team over a course of 6-12 months depending on the need at that facility.

# Documentation

**Q.** What will happen if the RD writes Marasmus in the note?

**A.** Opportunity for education

**Q:** Should the documentation of malnutrition be only on admit or throughout hospital stay?

**A:** Yes, all **documentation** for malnutrition and BMI should be at anytime during the hospital stay. This is the same for the **diagnosis** of malnutrition.

**Q:** Physicians are hesitant to use malnutrition unless it is very obvious.

How do I encourage them to mention malnutrition?

# Physician Documentation

- Include characteristics or indicators
- Include the diagnosis of malnutrition and state the severity of malnutrition
- Include the PLAN

To code malnutrition: the coder needs more than a lab value, or a few words.

**Q:** How often does the dietitian **have** to be available to document

**A:** What do your policies say for coverage?

The more often the dietitians are available the more screening and assessments that can be done.

# Dietitian Documentation

- Document the severity of malnutrition in the diagnostic PES statement in the Nutrition Care Process Note.

**Q:** Currently we have the MD use:

Severe Protein Calorie Malnutrition

Moderate Protein Calorie Malnutrition

Starvation Related Malnutrition

Is this correct for the time being?

**A:** We recommend that your terminology fits the definition of the guidelines (characteristics / indicators) you are using to identify malnutrition.

Stick with the terms that are used in the ICD-9 terminology.

# Oh, Albumin!

**Question:** Physicians continue to use albumin and pre-albumin as the sole criteria for malnutrition

Communicate with Coding – what are they using?

See references on AND / ASPEN Clinical Characteristics for Malnutrition

# Coding & Insurance

# Our Experience...

Talk to your coders and find out...

- Guidelines
- Timeframe for documentation
- Timeframe for re-billing

Include the Quality & Compliance Department

**“They Don’t Always Read Our Notes.”**

Communicate with the physician

**What works?**

Forms

Verbal Communication

Different Notes

**Be careful to not lead the physician.**

# What trigger's what?

In documentation there are certain “terms” or words or criteria that lead a coder to choose a specific path to choose a diagnosis to query the physician...

This is a great first step in communication with your coding team!

They have the answers.



**Q:** Does the RD have to make a severe malnutrition assessment for the CC to be utilized with the DRG for reimbursement?

**Q:** Is the malnutrition program appropriate to start in a long term care facility, rural/swing bed facility, critical access hospitals?

**Q:** Will you see more reimbursement if the physicians are already coding for malnutrition?

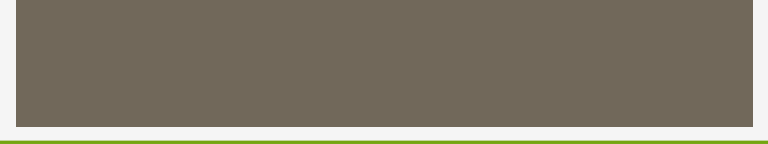
**A:** There are always opportunities for improvement.

## Q: Who is RAC?

**A:** Medicare Recovery Audit Contractor (RAC) program who identify improper Medicare payments - both overpayments and underpayments-in all 50 states. RACs are paid on a contingency fee basis, receiving a percentage of the improper overpayments and underpayments they collect from providers.

<http://www.aha.org/aha/issues/RAC/index.html>





**Q:** If the documentation specialist has enough MCC,CC's already, she tells me that it is difficult to produce a report out of HIM department to tell us what the numbers of malnutrition codes are.

How do you get this data out of medical records department?

# Characteristics & Guidelines

# AND & ASPEN

Clinical Characteristics that the RD can obtain and document to support a diagnosis of malnutrition.

## **Terminology:**

Severe Malnutrition

Non Severe (moderate) Malnutrition

**Q:** How does non-severe malnutrition and severe malnutrition pertain to the ICD-9 codes?

**Q:** On the Clinical Characteristics Document from ADA/ASPEN they state a minimum of 2 characteristics is recommended for dx of severe or non-severe malnutrition. Many staff feel they are not competent in assessing the physical findings. Is a dx on intake and weight loss enough to dx?



**Q:** What training/resources are available to improve competency with physical assessment?

# Final Questions & Comments...



**Q:** We're partially programmed for coding, but very little has been communicated.

Should I coordinate a meeting to bring coders and RD's together?

# Other Benefits of Malnutrition Documentation

- Improved Patient Care through identification, assessment, and care.
- Readmission tracking
- Length of stay, and quality outcomes
- Performance Improvement Projects

# Why Move Forward with a Malnutrition Program?

- We need to recognize an “at risk” population and intervene!
- A process is important to capture data, organize and track it.
- Acuity measures for hospital ratings and report cards.

***Recognition of Registered Dietitians  
contribution to care!***

# Moving forward...

- You can't and shouldn't do it alone
- Time is a factor
- Keep Momentum! Don't drop the ball
- Take one step today

You're invited to tell a friend or listen again...

**Thursday April 19, 2012**  
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### *What's Your Plan?*

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