Nestlé Nutrition Institute

April 15, 2021

ADULT MALNUTRITION DOCUMENTATION IMPROVEMENT: TEAM COLLABORATION FOR CLINICAL IMPACT IN THE HOSPITAL SETTING

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Sponsor Disclosure

Financial support for this presentation was provided by Nestlé Health Science. The views expressed herein are those of the presenter and do not necessarily represent Nestlé's views. The material herein is accurate as of the date it was presented and is for educational purposes only and is not intended as a substitute for medical advice.

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Speaker

Terese Scollard MBA RDN LD FAND

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Disclosures

- eNasco
- Nestlé Health Science Consulting Services
- MySurgeryPlate LLC
- Elsevier Care Planning

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Objectives

Identify	Identify tactics that support medical coding workflow in acute care to improve documentation of protein-calorie malnutrition
Review	Review relationships between the ASPEN/Academy Consensus Characteristics of Adult Protein-Calorie Malnutrition and the Global Leadership Initiative on Malnutrition
Propose	Propose opportunities for team collaboration to support clinical validation of the diagnosis of protein-calorie malnutrition.
Recognize	Recognize malnutrition informatics as an avenue to support interprofessional communications and care integration for at-risk adult patient populations

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Agenda

- Background of malnutrition, documentation and CMS management
- Recovery Auditors & Federal Oversight and audits
- Documentation Infrastructure
- What happens to my patient note?
- What is clinical validation?
- Examples of Denials
- Documentation Suggestions
- *No guarantees these suggestions will prevent or reduce reimbursement denials or federal audits*

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Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

HOSPITALS OVERBILLED MEDICARE $1 BILLION BY INCORRECTLY ASSIGNING SEVERE MALNUTRITION DIAGNOSIS CODES TO INPATIENT HOSPITAL CLAIMS

July 2020 https://oig.hhs.gov/oas/reports/region3/31700010.pdf

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Office of Investigator General (OIG) Audit

- Discharge dates 2015-2017 OIG Audited Severe Protein-Calorie Malnutrition
- Audit if hospitals complied with Medicare billing requirements when assigning Severe Malnutrition diagnosis codes to inpatient claims (E41, E43)
- Random Sample 200 claims
- $1 Billion overpayment for $3.4 billion in Medicare payments for 224,175 inpatient claims (2015-2017)
- Reported Issues
  - "Used severe codes when should have used codes for other forms of malnutrition or no malnutrition diagnosis at all"
  - "For these claims, hospitals provided medical record documentation that did not contain evidence that the malnutrition was severe or that it had an effect on patient care."

https://oig.hhs.gov/oas/reports/region3/31700010.pdf

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In Contrast….Economic Burden of Disease-Associated Malnutrition in Older Adults 2016

National (90% Confidence Interval) 8 conditions	Per Capita Cost	Results (65+)	Per Capita Cost (65+)
$15,598,520,320 ($12,632,376,320, $18,970,537,984)	$48 ($39, $58)	$4,320,378,880 ($3,790,066,688, $4,900,164,608)	$93 ($81, $105)

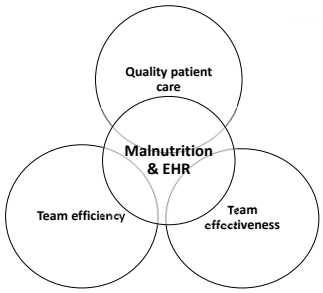
Goates, Scott et al. "Economic Burden of Disease-Associated Malnutrition at the State Level." *PloS one* vol. 11,9 e0161833. 21 Sep. 2016

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

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

9

The EHR and Malnutrition Documentation



Kight, C.E et al, Consensus Recommendations for Optimizing Electronic Health Records for Nutrition Care. Nutrition in Clinical Practice, 35: 12-23.

https://www.eatrightpro.org/practice/practice-resources/nutrition-informatics

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ICD-10 CM E-Codes for Protein-calorie Malnutrition (PCM) Adults

E43	**Unspecified Severe, PCM (MCC)**
E44.0	**Moderate PCM (CC)**
E44.1	**Mild PCM (CC)**

E46 Unspecified PCM
E63.9 Nutritional deficiency, unspecified
R64, Cachexia
M62.84 Sarcopenia

ICD-9 uses term "non-severe". ICD-10 does not use "non-severe"

E46 "Unspecified" code: for use when the information in the medical record is insufficient to assign a more specific code

https://icd10cmtool.cdc.gov/?fy=FY2021

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Diagnostic Related Groups (MS-DRG's)

- Insurance may reimburse using the MS-DRG system (Medicare)
- Medical Coder applies after reviewing the MD discharge ICD-10 diagnoses
- Severity Levels
  - Coding of Major Complication and Co-morbidity (MCC) increases reimbursement
  - Complications and Co-morbidities (CC) also increase reimbursement
  - Neutral (Non-CC)

Final MS-DRG Coding of the Medical Diagnosis (ICD-10 CM) by a professional medical coder impacts reimbursement and recognizes the medical diagnosis from the physician

Some private insurance uses AP DRGs (All Patient DRG), or APR –DRGs (All patient Refined DRGs)

MS-DRG = **Medicare Severity Diagnosis Related Group. Used for Medicare Billing in the Medicare Inpatient Prospective Payment System**

https://icd.codes/articles/medical-codes-intro

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Example: Impact of Secondary Diagnosis of Severe PCM (MS-DRG system)

DRG	Major Gastrointestinal Disorder
Case Mix	1.29350
ELOS*	6.50
Principal Diagnosis	Clostridium difficile
Secondary Diagnosis	• Chronic diastolic heart failure • Hyponatremia • Asthma • Atrial fibrillation • Bacteremia • HTN • DM
Severity Level	2
Mortality Level	1

DRG	Major Gastrointestinal Disorder
Case Mix	2.0986
ELOS*	8.8
Principal Diagnosis	Clostridium difficile
Secondary Diagnosis	**• Severe protein calorie malnutrition** • Chronic diastolic heart failure • Hyponatremia • Asthma • Atrial fibrillation • Bacteremia • HTN • DM
Severity Level	3
Mortality Level	2

Higher Severity Levels cause higher Medicare payments due to the increased cost for complex patients

Other analysis-Severity of Illness (SOI), Case-mix Acuity (CMI), Other impacts to reimbursement and base payments and physician scores. Other methods (APR-DRGs)

*ELOS- Estimated Length of Stay; ROM – Risk of Mortality, SOI – Severity of Illness

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DOCUMENTATION INFRASTRUCTURE

Supports professional practice and documentation

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Malnutrition: Clinical and Operational Problems

› Dire need to have a common clinical understanding to describe adult PCM
› Under reported, under treated, unrecognized public health problem
› Few embedded preventative measures in healthcare
› Malnutrition viewed as a rare, acute event
› Not followed reliably as a clinical problem once diagnosed
› Sporadic or no insurance coverage for ambulatory prevention
› Iatrogenic clinical practices
› Who "owns" the nutrition problem?
› Not using EHR or patient dining information systems to promote nutrition care
› CMS reimbursement parameters unknown, erratically applied via Recovery Auditors

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EHR & Malnutrition Documentation

› Critical to document the Nutrition Care Process for patient care and team communication
› Supports CMS guidelines and other regulatory groups

- Use Structured Data (Flowsheet) for longitudinal comparison and pull to Note
- Unstructured data is generally not retrievable
- "Semantic Interoperability"
- EHR Design, implementation, maintenance, functionality upgrades
- Use for Flow of nutrition information from admission through discharge and transfer to next team

Kight, C.E et al, Consensus Recommendations for Optimizing Electronic Health Records for Nutrition Care. Nutrition in Clinical Practice, 35: 12-23.

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Nutrition Care Process

› Academy/ASPEN Consensus Criteria to be used in the context of a **Comprehensive Nutrition Assessment** and Intervention and Plan by a registered dietitian.

› Scope of Practice of RDN/RD

› Nutrition Care Process®
- Nutrition Assessment
- Nutrition Diagnosis
  - Consensus Criteria
- Nutrition Intervention
- Nutrition Monitoring & Evaluation

- **Terminology Mapping to SNOMED, LOINC**

https://www.eatrightpro.org/practice/quality-management/nutrition-care-process

https://www.eatrightidaho.org/app/uploads/archive/uploads/Scope-of-Practice-for-the-Registered-Dietitian.pdf

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SNOMED, LOINC & eNCPT®

› User-facing eNCPT terms would then be mapped to federally mandated standard terminologies—SNOMED CT and LOINC—to enable the sharing of data with other providers and for quality reporting measures.

› SNOMED – **Systemized Nomenclature of Human Medicine**
- ***SNOMED CT*** is one of a suite of designated standards for use in U.S. Federal Government systems for the electronic exchange of clinical health information and is also a required standard in interoperability specifications of the U.S. Healthcare Information Technology Standards Panel.

› LOINC **Logical Observation Identifiers Names and Codes**
- ***LOINC*** applies universal code names and identifiers to medical terminology related to electronic health records. The purpose is to assist in the electronic exchange and gathering of clinical results (such as laboratory tests, clinical observations, outcomes management and research).

https://www.eatrightpro.org/practice/practice-resources/nutrition-informatics

https://www.nlm.nih.gov/healthit/snomedct/index.html

https://www.eatrightpro.org/practice/quality-management/quality-improvement/ecqms-frequently-asked-questions

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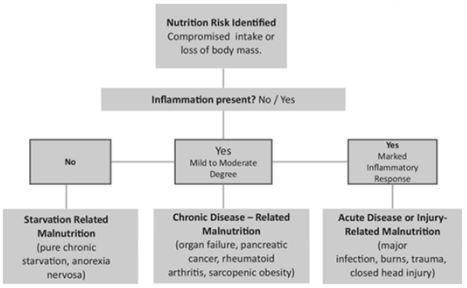
ASPEN Consensus: Etiology Adult Malnutrition



Journal of Parenteral and Enteral Nutrition, Volume: 36, Issue: 3, Pages: 275-283,
First published: 24 April 2012, DOI: (10.1177/0148607112440285)

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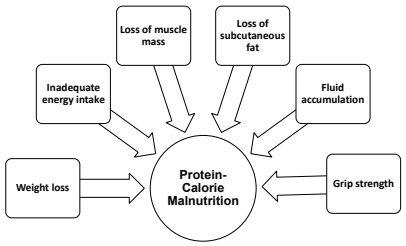
Academy/ASPEN Adult Malnutrition Consensus 2012



JPEN J Parenter Enteral Nutr. 2012; 36: 275-283.

https://aspenjournals.onlinelibrary.wiley.com/action/downloadSupplement?doi=10.1177%2F0148607112440285&file=jpen0275-sup-0001.mp3. Podcast

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Types, Severity, Duration & Characteristics

Types
- ✓ Starvation/Semi-starvation
- ✓ Acute
- ✓ Chronic

Severity
- ✓ Severe
- ✓ Moderate
- ✓ (Mild)

Clinical Characteristics to describe
- ✓ Intake
- ✓ Weight
- ✓ Muscle Mass
- ✓ Fat Stores
- ✓ Fluid Accumulation
- ✓ Functional: Grip Strength

Duration
- ✓ Days, weeks, months
- ✓ Significant events that impact

Academy of Nutrition and Dietetics and American Society of Parenteral and Enteral Nutrition, 2012, *Consensus Statement: Characteristics Recommended for the Identification and Documentation of Adult Malnutrition Undernutrition.*

Demling RH. Nutrition, Anabolism, and the Wound Healing Process: An Overview. ePlasty 2009,65-94

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WHAT HAPPENS TO MY PATIENT NOTES?

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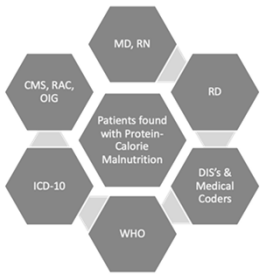
Who are we documenting PCM for?



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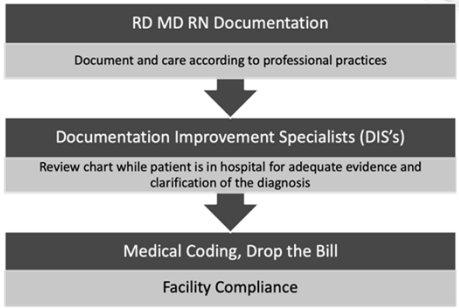

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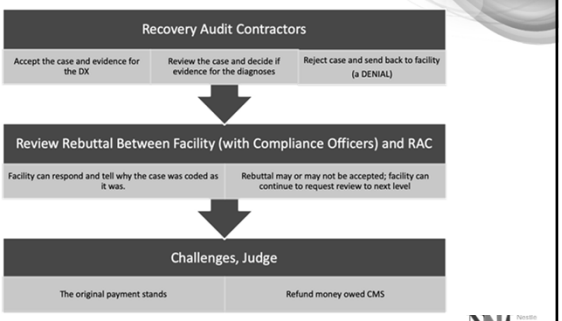

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Steps: PCM Documentation Workflow

- Comprehensive nutrition assessment and nutrition diagnosis by RDN
- Physician assessment and medical diagnosis (ICD-10)
- Documentation Integrity Specialists "Query" and audits for compliance
- Medical Coders code the DRG, Drop the Bill to CMS or insurance
- Bill paid by CMS or other insurance
- Recovery Auditors audit targeted cases,
  - Deny or reduce the DRG code assignment
  - Notify of need to refund the original payment
- Facility may appeal the Recovery Auditor's Denials

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Recovery Auditors/Contractors (RA or RAC)

- Malnutrition under scrutiny by RACs and OIG
  - Severe PCM under scrutiny 2016, 2017, 2018, 2019, 2020
- RA audit records for documentation and coding that may be considered fraudulent to assure proper payments (of our tax dollars)
- RA not required to share criteria used in their decision to accept or deny code assignment
- Unknown if RA are required to have completed basic or advanced nutrition and metabolism course, or stay current with nutrition and metabolism in disease
- Summary report July 2020: CMS contractors can recover overpayments for Severe PCM

HOSPITALS OVERBILLEDMEDICARE$1BILLION BY INCORRECTLY ASSIGNING SEVERE MALNUTRITION DIAGNOSIS CODES TO INPATIENTHOSPITAL CLAIMS
https://oig.hhs.gov/oas/reports/region3/31700010.pdf

https://www.americanhealthlaw.org/getmedia/b6353b75-2a91-4939-991b-09609b139f86/20_OCT_FINAL.pdf?ext=.pdf

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RA Audit Rejections - Samples

- Rejection of a severe malnutrition dx in a patient record
- RA communicates the rejection (Denial of reimbursement) to the facility compliance department
- States reasons the record was Denied- because it did not show evidence of PCM (sample reasons)
  - That no albumin was documented
  - And that BMI was not less than 16
  - Not "enough" documentation
  - Did not have malnutrition in any form
  - Malnutrition did not impact the length of stay
  - Form of malnutrition, but not the coded form
- Facility reviews the record and can make an appeal of the denial
  - Compliance department requests MD or RDN to review the records
- Appeals available by hospital up to judge if desired.

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RA Denial Comment Example

ASPEN/GLIM Criteria Used against one another

79-year-old with BMI 17.95, 5' 4" 103#
4.3% weight loss in 6 weeks, severe weight loss (9%) in 3 months
Type 2 Diabetes, lung and cervical cancer, CKD, radiation enteritis, recurrent SBO presented to ED for evaluation of abdominal pain similar to past SBO's

"certain aspects of these criteria denote risk of malnutrition but are not markers that validate the presence."
"GLIM…..casts doubt on validity of short-term weight loss as a criterion"

Auditor disregarded intake, weight loss, low weight, and preferred BMI

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Appeal to the Denial (example)

- Include statements, references and published literature from Professional Organizations
  - Call out RA errors if present
- Describe current, modern understanding of PCM over historic, misapplied-misunderstood criteria
- Clarify obese patient with low lean mass, overinterpretation of albumin, weaknesses of BMI
- Include date/time stamped examples of EHR documentation refuting what the denial stated was not true, if present
- Organize Appeal message using *Consensus* criteria, templates can help

https://www.eatrightpro.org/payment/coding-and-billing/diagnosis-and-procedure-codes/malnutrition-codes-characteristics-and-sentinel-markers

GLIM Statement July 2019 ASPEN Clinical Practice Highlights
http://www.nutritioncare.org/Guidelines_and_Clinical_Resources/Clinical_Practice_Highlights/

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Coding is Based on Provider Documentation

› **Physicians responsible for the patient's care**

› **Licensed Independent Practitioner**

"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."

Nutrition Assessment by a registered dietitian nutritionist
- Cannot make a medical diagnosis - Not in scope of practice, registration or license
- Is in scope of practice registration and license to make a nutrition diagnosis

https://www.cdc.gov/nchs/data/icd/10cmguidelines-FY2021.pdf

ICD-10-CM Official Guidelines for Coding and ReportingFY 2021Page 12

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PCM is most often a Secondary Diagnosis

› Reporting 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***
- ***other 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.*

› *Diagnoses that relate to an earlier episode which have no bearing on the current hospital stay are to be excluded."*

ICD-10-CM Official Guidelines for Coding and Reporting FY 2021Page 115 of 126

https://www.cdc.gov/nchs/data/icd/10cmguidelines-FY2021.pdf

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What is Clinical Validation?

"Clinical validation involves a clinical review of the case to see whether or not the patient truly possesses the conditions that were documented in the medical record."

Clinical Validation and Medical Coding are different professional roles and steps

- Usually, Clinical Validation is done by Documentation Integrity Specialists during the hospital stay, who may Query the Physician for clarifications
- Medical Coders read notes after discharge and use the notes to assign MS-DRG Codes; Cannot interpret, infer the physician notes or intentions
  - Independent functions
  - Independent workflows
  - Professional standards

https://www.cdc.gov/nchs/data/icd/10cmguidelines-FY2021.pdf

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QUALITY DOCUMENTATION & PREVENTION

Activities to help assure evidence and reduce denials

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High Quality Documentation

Legible | Complete | Timely

Reliable | Consistent | Precise

Clear | Direct

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Potential Preventative Activities

› Use professional literature-based definitions and clinical indicators, references
- ASPEN and Academy Position Papers, Guidelines etc

› Physician medical decision-making and documentation practices defined, taught

› ICD-10-CM conventions, guidelines and advice shared

› Clinical validation – adequate information to support the diagnosis of PCM

› Clinical documentation integrity and coding practices and formal query processes

› Medical staff approved policies, procedures and guidance for coding and reporting

› Data analytics identifying potential errors of omission or commission that alert compliance officers to avert risk

› Adherence to federal OIG model compliance plans

Compliance Corner: OIG Malnutrition Audits Confound Compliance—Time to Act https://www.americanhealthlaw.org/getmedia/b6353b75-2a91-4939-991b-09609b139f86/20_OCT_FINAL.pdf?ext=.pdf accessed 4/5/2020

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Academy/ASPEN Consensus & GLIM

- GLIM is a framework developed for use by clinicians who may have little nutrition background and who may not have access to registered dietitians who can perform a comprehensive nutrition assessment
- GLIM is not intended to be or replace a comprehensive nutrition assessment
- Professional organizations are not advising to replace *Consensus* with GLIM
- GLIM is more general than Academy/ASPEN Consensus
- Ongoing research for core diagnostic criteria for a global consensus
- GLIM is not in conflict nor intended to overshadow or replace Academy/ASPEN *Consensus*
- CMS is aware of the *Consensus* and GLIM framework
  - Does not endorse or require either or both
  - Does not provide guidance to auditors
  - Recovery Auditors sometimes apply their own interpretation of either/both

Jensen, G.L., Cederholm, T.,et al. (2019), GLIM Criteria for the Diagnosis of Malnutrition: A Consensus Report From the Global Clinical Nutrition Community. Journal of Parenteral and Enteral Nutrition, 43: 32-40. https://doi.org/10.1002/jpen.1440

Global Leadership Initiative on Malnutrition = GLIM

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Value of Common Global Diagnostic Criteria

- Regional criteria and preferences can be retained with GLIM
- Research applications - Able to compare patient populations, settings
- Appreciates historic and regional approaches and practices
- GLIM requires validation and reliability testing
  - Various health conditions
  - Repeatability among professions
- *Consensus* and GLIM are expert opinion and by consensus

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EXAMPLES DENIAL ISSUES

Modern Clinical Care compared to Denial Rationale

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Issues: Denials based on Albumin

- RA Overpayment reversed due to an albumin measure in a discharge summary by the MD.
- RA rejection letters reference *WHO*, *Merck* and *Consensus* plus albumin (Cherry pick?)
- RA rejection letters using the *Consensus* plus albumin
- Acceptances with and without albumin
- Denials with and without albumin

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Consult Referral Based on Albumin

- Sample internal message or communication
- *"Thank you for the RD consult. Albumin level remains low, which indicates increased risk morbidity/mortality but is no longer used as a direct marker, determinant or characteristic of protein-calorie malnutrition or nutritional status (it more closely reflects overall inflammatory status related to the metabolic stress response). Serum albumin and pre-albumin are negative acute phase reactants and are known to decrease in the presence of inflammation/injury/chronic illness. Albumin half-life is about 3 weeks, and pre-albumin is 2-3 days. Increasing patient's protein intake will not necessarily have any effect on albumin level. Pt does not meet ASPEN criteria for protein-calorie malnutrition at this time."*
- Share References with other professionals:
  - https://soundcloud.com/user-67457490 ASPEN Podcast
  - https://aspenjournals.onlinelibrary.wiley.com/doi/epdf/10.1002/ncp.10588. ASPEN POSITION PAPER: VISCERAL PROTEINS February 2021
  - JPEN 2018 Souters, Hypoalbuminemia: Pathogenesis and Clinical Significance
  - NCP 2019 Loftus, Serum Levels of Prealbumin and Albumin for Preoperative Risk Stratification
  - Journal of Clinical Medicine 2019: Keller Review: Nutritional Laboratory Markers in Malnutrition
  - ACS Strong for Surgery: Lab Screening-Serum Albumin Fact Sheet

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An Online Manual – Professional Version

Values Commonly Used to Grade the Severity of Protein-Energy Undernutrition

Measurement	Normal	Mild Undernutrition	Moderate Undernutrition	Severe Undernutrition
Normal weight (%)	90–110	85–90	75–85	< 75
Body mass index (BMI)	19–24*	18–18.9	16–17.9	< 16
Serum albumin (g/dL)	3.5–5.0	3.1–3.4	2.4–3.0	< 2.4
Serum transferrin (mg/dL)	220–400	201–219	150–200	< 150
Total lymphocyte count (per mcL)	2000–3500	1501–1999	800–1500	< 800
Delayed hypersensitivity index†	2	2	1	0

* In older patients, BMI < 21 may increase mortality risk.

† Delayed hypersensitivity index uses a common antigen (eg, one derived from *Candida* species or *Trichophyton* species) to quantitate the amount of induration elicited by skin testing. Induration is graded: 0 =< 0.5 cm, 1 = 0.5–0.9 cm, 2 =≥ 1.0 cm.

https://www.merckmanuals.com/professional/nutritional-disorders/undernutrition/protein-energy-undernutrition-peu Accessed 4/5/2021

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BMI 23 or less, Be Alert in Age 65+

› Mini Nutrition Assessment tool (MNA®)

F Body Mass Index (BMI) = weight in kg / (height in m)²
0 = BMI less than 19
1 = BMI 19 to less than 21
2 = BMI 21 to less than 23
3 = BMI 23 or greater

- Lower score is worse

› BMI and all-cause mortality in older adults
- BMI of 24 – 30 associated with lowest rates of death
- BMI of 20.0 or less associated with a 28% higher risk of death
- BMI <23 underweight for older adults

https://www.mna-elderly.com/default.html

Jane E Winter, Robert J MacInnis, Naiyana Wattanapenpaiboon, Caryl A Nowson, BMI and all-cause mortality in older adults: a meta-analysis, *The American Journal of Clinical Nutrition*, Volume 99, Issue 4, April 2014, Pages 875–890, https://doi.org/10.3945/ajcn.113.068122

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WHO? How?

Management of severe malnutrition: a manual for physicians and other senior health workers

World Health Organization Geneva 1999

› **"Preface This manual provides guidelines for the treatment of severely malnourished children (below 5 years of age) in hospitals and health centres. The treatment of severely malnourished adolescents and adults is also briefly considered. The manual is intended for health personnel working at central and district level,…." page v.**

Table 13. Classification of malnutrition in adults by body mass index

Body mass index	Nutritional status
>18.5	Normal
17.0–18.49	Mild malnutrition
16.0–16.99	Moderate malnutrition
<16.0	Severe malnutrition

This 1999 document represents a brief paragraph of a 68-page document about malnourished children in refugee situations Where the <16 BMI comes from

https://apps.who.int/iris/handle/10665/41999

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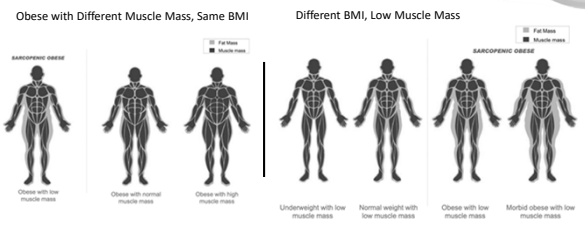
Obese & Muscle Mass



Carla M. Prado, Sarah A. Purcell, Carolyn Alish, Suzette L. Pereira, Nicolaas E. Deutz, Daren K. Heyland, Bret H. Goodpaster, Kelly A. Tappenden & Steven B. Heymsfield (2018) Implications of low muscle mass across the continuum of care: a narrative review, Annals of Medicine, 50:8, 675-693, DOI: 10.1080/07853890.2018.1511918

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DOCUMENTATION SUGGESTIONS

No Guarantees

Translating Clinical Findings into Coding Requirements

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Facility Coding Guidelines

› Connect with Coding and Compliance departments

› Facilities can work with their medical staff to develop facility-specific coding guidelines which promote complete documentation needed for consistent code assignment
- Committee approval of Consensus, Policies, procedures, Review with Compliance Dept

› These guidelines can guide the coding professionals as to when they should query physicians for clarification of their documentation

› Guidelines support consistent, reliable documentation

AHA Coding Clinic® 2004 Volume21, Number 2, Page 14

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EHR Functionality Can Help Quality Documentation

› EHR flow sheets and note templates that pull flow sheet data into Notes (longitudinal value)
- NFPE results
- Weight histories
- Grip Strength
- Nutrition Diagnosis
- Push messages, data to MD workflow
- Embed the Nutrition Care Process and Terminology®
- Document all clinical characteristics available in comprehensive nutrition assessment
- Write out the specific types of Malnutrition in notes often (dot phrases help)
- Missed patients and undiagnosed malnutrition, with no specific treatment plan contribute to morbidity, expensive downstream interventions and mortality
- Reduces writing, duplicate/triplicate writing when well set up

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Comprehensive Nutrition Assessment

› Nutrition Care Process®
- Nutrition Assessment
  - ADIME
  - Nutrition Focused Physical Exam
  - Grip Strength
- Nutrition Diagnosis
- Nutrition Intervention
- Nutrition Monitoring & Evaluation

https://www.eatrightpro.org/practice/quality-management/nutrition-care-process

https://www.eatrightpro.org/practice/quality-management/scope-of-practice

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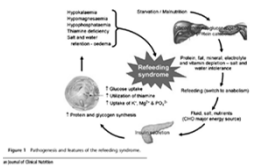
Document Why Type & Severity of Malnutrition Matter

- Metabolic intervention differs
- Metabolic consequences to organ function
- Over feeding or Underfeeding
- Refeeding syndrome
- Nutrient mix and ratios
- Safe pace and timing of treatments
- When to start, slow and transitioning feedings
- Electrolyte and micronutrient imbalances
- Pending surgical or medical treatments
- Infections and immune response demand



da Silva, J.S.V., et al (2020), ASPEN Consensus Recommendations for Refeeding Syndrome. Nutrition in Clinical Practice, 35: 178-195. doi:10.1002/ncp.10474

Nutrition in clinical practice—the refeeding syndrome: illustrative cases and guidelines for prevention and treatment Z Stanga, et al *Journal of Clinical Nutrition* (2008) 62, 687–694; doi:10.1038/sj.ejcn.1602854; published online 15 August 2007 http://www.nature.com/ejcn/journal/v62/n6/full/1602854a.html

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Uncertain Diagnosis: Inpatient

› "Probable", "suspected", "likely", "possible", "questionable" or other terms indicating uncertainty
- OK to make a nutrition diagnosis and treat patient as if they have the severity and type of PCM you judge to be present
- Use the nutritional assessment and treatment approach that corresponds most closely with the nutrition diagnosis

› Suggestion: "Due to evidence of a, b, c, suspect nutrition diagnosis of chronic, severe Protein-Calorie Malnutrition …..and therefore am treating as such with x, y, z"

› Then update medical record when indicators become available to confirm or clarify

This guideline is applicable only to inpatient admissions to short-term, acute, long-term care and psychiatric hospitals

https://www.cdc.gov/nchs/data/icd/10cmguidelines-FY2021.pdf page 117

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Inpatient "History of.."

› Interpreted as the condition no longer exists
- Does not mean that the condition still exists but is under control with ongoing treatment

- Make sure note indicates the patient arrived to the facility malnourished.
- Clarify the time frame, dates, patient struggles and condition on arrival
- Malnutrition often occurs prior to admission
  - Clearly describe the timing with best available subjective/objective information
  - Patient, family stated concerns, quotes

https://www.cdc.gov/nchs/data/icd/10cmguidelines-FY2021.pdf

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Dealing with Weight Errors?

Describe using "suspected" and Uncertain Diagnosis Approach

- Ask for a weight
- Weigh patient yourself if safe
- Summarize weight history
- "Weight Cross Encounter" in some EHR's
- Discuss pattern of what you know and what you suspect
- Take care of the patient now with your best clinical judgement
- Assess malnutrition when you see it so you can start interventions

Awaiting weights, time, or other information for a full nutrition diagnosis?

RD note could document that treatment plain is ***as if*** *the patient has the severity and type of PCM.*

Update assessment, nutrition diagnosis, intervention, nutrition treatment plan when more information obtained

https://www.cdc.gov/nchs/data/icd/10cmguidelines-FY2021.pdf page 117

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Clearly Describe Nutrition Gaps

- State nutrient targets and why those targets exist
- Measure gaps in actual numbers and percentages
- Specify the intervention is to reduce the nutrient gap
- Mathematical quantification of intake, weight changes, time frames
- Describe historical and current malnutrition status on patient's ability to sustain adequate intake independently — And what nutrition plan is critical to improve
- Clear, specific

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Examples: Stronger Documentation

"Weight loss before admission"	"14 lb. weight loss, (12% loss) in 2 months before 4/5/19 admission".
"Poor Intake"	"Inability to chew, swallow or drink adequate fluids due to dental pain and inflamed mouth; Only eating bites at breakfast and lunch for 6 weeks and very small dinner with about 2 ounces of protein."
"Weak"	"Weakness: Grip strength just beyond – 2 sd from the mean for age and sex and spouse describes 6 weeks of taking 3 times as long to walk from car to house."
Intervention: "High Protein Milkshake"	"Adding high protein chocolate milkshake (adds 20 grams protein) to help achieve patients target protein demand of 90 grams per day, to supply protein and calories to support healing of surgical incision."
"Normal Range Albumin"	Albumin within normal range, which is a normal response to starvation state metabolism as body attempts to preserve lean mass and use fat for fuel for this patients with history of 3 months of semi-starvation due to eating behaviors surrounding his psychiatric diagnosis.

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Examples: Stronger Documentation

"Obese, weak"	Nutrition physical exam reveals reduced muscle mass on upper arm, thigh, scapula underneath subcutaneous fat, with poor muscle quality, consistent with sarcopenic obesity. Requires nursing assistance to eat meals and drink fluids due to weakness. PT reports gait speed at 0.5 m/sec.
"High calorie and protein needs"	Target goal 2500 Calories and 100 grams protein/day; 3-day protein/calorie intake record shows average consumption of 60 % of calories (~1500 kcal/day) and 50 % of protein (~50 grams consumed/day from meals, high protein oral nutritional supplements, cottage cheese); this is a significant deficit that impairs recovery and wound healing on abdominal surgical incision; Conferred with physician who agrees to start high protein tube feeding in 2 days if appetite stimulant, oral supplements, snacks and food texture modifications do not allow for increased intake to meet 95% of target calorie/protein goals.
"Malnutrition"	Severe, chronic protein-calorie malnutrition evidenced by ….periodically spell it all out

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Adequate Evidence During Covid-19 Isolation?

- What to do for NFPE during With the COVID situation?
- No guidance specific to NFPE
- Local guidance may vary by facility
- Consensus requires minimum of 2 characteristics
- Use any information you can get:
  - Self-observation of patient exposed areas, head, shoulders, arms
  - Other professionals' verbal or written observation of muscle, fat and any lesions (Ask them)
  - Inflammatory state so can describe the metabolic condition, fuel utilization and deficits
  - Intake prior to admission, can be weeks of poor intake, contact family-quote responses
  - Use of technology in the room to show conditions

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Connect Clinical Information & Interpret

- NFPE: Appearance and description of specific body anatomy
  - connect to fuel demand and utilization from starvation, stress, intake, history etc.
- Include "WHY" you are applying an intervention for the downstream reader to understand
- Include "HOW" malnutrition has impacted the patient's abilities
  - Malnutrition impact on activities and caring for self
  - gait speed, grip strength, self-care, self-feeding
- Create NCP templates, smart phrases, etc. in electronic medical record
- Educate patient and include direct information about why nutrition is critical for their conditions
- Describe nursing impact adding modular nutrients, managing tube feeding, feeding assistance
- Find an analyst and learn EHR functionality that can be used to improve nutrition documentation
  - Learn about the process to request EHR improvements

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Summary:

- Document all available evidence
- Make a strong "case"
- BMI when pertinent (low)
- Connections between clinical malnutrition information
- Connect with Compliance, Coding & Documentation professionals
- Policies, procedures, audits, monitoring of workflow
- Chart reviews to assure clinical staff documenting detail
- Educate and teach
- Discuss cases, metabolism in teaching rounds
- Industry continuing education
- Appeal every rejection if clinically justified
- Evidence to support the diagnosis-Assure:
  - Medical Diagnosis
  - Nutrition Diagnosis
  - Contributors
  - Physical findings
  - Metabolism
  - Treatments, rationale for interventions
  - Impact on nursing, nursing assessments

No Guarantees but should help

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Questions?

ACCESS ADULT MALNUTRITION RESOURCES at:
https://www.NestleMedicalHub.com/therapeutic-areas/malnutrition

Visit the new MyCE site at
NestleMedicalHub.com/myce
Offering CE to dietitians and registered nurses

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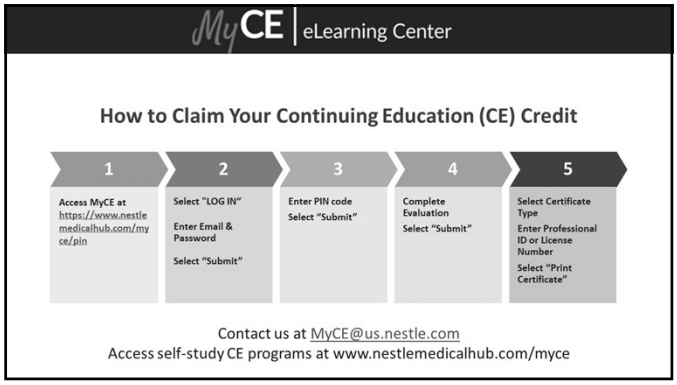
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