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In Malnutrition Audits, Use of Manual Over UHDDS Raises Concern

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Frustration with severe malnutrition reviews is mounting at one hospital because the HHS Office of Inspector General and a Medicare administrative contractor (MAC) are pushing past the *ICD-10-CM Official Guidelines for Coding and Reporting*, according to the compliance officer. The risk is the auditors will remove secondary diagnoses of severe malnutrition, which could change MS-DRG reimbursement.

Coders rely on the Uniform Hospital Discharge Data Set (UHDDS), which the compliance officer calls "the coding bible." UHDDS defines secondary diagnoses as "other diagnoses," and for reporting purposes, "the definition of 'other diagnoses' is 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 operative word in this definition is "or"; any one of the five scenarios would allow the coding of a secondary diagnosis on the claim, which affects MS-DRG assignment because it's a complication and comorbidity.

"If a physician documents that the diagnosis is present either at time of admission or developed during the hospital stay, according to this guidance, the condition should be coded," said the compliance officer, who preferred not to be identified. For example, the nutritionist evaluates the patient and determines he's severely malnourished, and the physician reviews the nutritionist's notes and documents accordingly. The information helps the physician care for the patient and the coder adds it to the claim.