COSMOS
Navigate the Compliance Universe

Report on Medicare Compliance Volume 29, Number 36. October 12, 2020

M.D. Review of Dietician Notes May Help Prevent Malnutrition Denials

By Nina Youngstrom

Hospitals will continue to see Medicare denials for severe protein-calorie malnutrition when reviewers aren't convinced the code is accurate or the clinical evidence supports it, experts say. There's a Catch-22 because registered dieticians evaluate patients for malnutrition, but malnutrition can't be coded unless physicians diagnose it, and they may not review the notes of the registered dieticians. Hospitals are trying to bridge that gap with smart phrases and other strategies.

Hospitals are already in a malnutrition billing pressure cooker. It was the focus of a July report[1] from the HHS Office of Inspector General (OIG), which estimated that hospitals overcharged Medicare $1 billion by incorrectly assigning two malnutrition diagnosis codes—nutritional marasmus (E41) or unspecified severe protein-calorie malnutrition (E43) as the sole major comorbid condition or complication—on inpatient claims. OIG recommended that CMS and hospitals split the job of repaying Medicare, with CMS recouping money from the reopening period and instructing providers to follow suit under Medicare's 60-day refund rule.

Malnutrition is usually a secondary diagnosis, which means it may serve as a complication and comorbidity (CC) or major CC (MCC) that will increase the reimbursement of the MS-DRG it's attached to, rather than as the principal diagnosis that occasioned the admission.

Secondary diagnoses are defined as "other diagnoses" in the Uniform Hospital Discharge Data Set (UHDDS). 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."

Compliance experts have raised the question of whether Medicare denials are really more clinical denials than coding denials. If the documentation supports one of the five criteria in the UHDDS and the provider documents the diagnosis, malnutrition can be coded. The question then becomes whether a clinical evaluation of the physician's documentation and clinical indicators support the diagnostic statement, said Leslie Slater, specialist leader at Deloitte Advisory in New York City. A coder cannot make that determination, she noted. "This has been a longstanding documentation issue, because physicians typically rely on the registered dieticians for their clinical expertise of the patient's nutritional status and dietary requirements," Slater explained.

Smart Phrases Prompt Physician Review

At UCHealth in Denver, Colorado, the goal is to have an "airtight" malnutrition diagnosis, with support from registered dieticians, said Debra Anoff, M.D., senior medical director of clinical documentation integrity. They use American Society for Parenteral and Enteral Nutrition (ASPEN) guidelines. To further that goal, UCHealth has added smart phrases to its electronic medical records.

"The purpose is not to try to get malnutrition documented on everyone, but to find those patients with moderate or severe malnutrition and make sure we are telling their story," Anoff said. The smart phrase—"Upon nutritional assessment by the registered dietician, the patient meets the criteria for malnutrition type _____"—

prompts physicians to review the dietician's assessment and document whether they agree with the assessment. Only when physicians agree with the dietician would malnutrition be a reportable secondary diagnosis.

The smart phrase helps compensate for the risk that physicians skip over nutritional evaluations. "There is so much white noise in charts and so much to see," she said. "They may assume registered dieticians are able to carry out their recommendations without a physician order."

Also, if the patient doesn't meet any of the five UHDDS criteria for a secondary diagnosis, "we wouldn't create a query for the doctor," Anoff said. But if one or more of the criteria are met, they could query the physician, unless the dietician's note is on the day before discharge or the day of discharge, because "there's not even time for further evaluation or treatment."

Slater warns of the risk of malnutrition downcoding when the notes in the chart contradict. The doctor may have copied and pasted an old note that described the patient as a well-nourished 90-year-old, while the registered dietician has documented a malnourished patient.

Some hospitals allow physicians to sign the dietician's note to indicate they've read it and agree with the patient's nutritional status and how it affects their recovery, Slater said. The documentation should also spell out what the physician found in the exam, such as muscle wasting, weight loss and cachexia.

Contact Slater at leslater@deloitte.com and Anoff at debra.anoff@ucdenver.edu.

1 Nina Youngstrom, "OIG: Hospitals Overbilled $1B for Malnutrition, CMS Will Recoup; Other Audits to Resume," *Report on Medicare Compliance* 29, no. 26 (July 20, 2020), https://bit.ly/33IYlHo.