

## **Caring & Coding for Malnutrition Webinar**

### **Responses to Your Questions**

**Q: What nutrition assessment tool do you use? And do you use it for the entire adult hospitalized patient?**

**A:** The Academy & ASPEN's Clinical Characteristics to Identify and Diagnose Malnutrition (see attached).

**Q: How do you confirm that the estimated reimbursement is actually what the hospital is reimbursed?**

**A:** DM&A provides a data analysis services that takes key data points and runs them through our data program to determine the sole CC/MCC on the patient case and then we calculate the change in weight of the MS-DRG with and without the malnutrition co-morbidity. You then take that difference and multiply by the base rate of that insurance and then you can compare to what the hospital billed and received. The Academy has an article on this as well. They do their calculations pretty similar.

**Q: With the MS-DRGs, can multiple MCC/CC add a cumulative effect to the blended rate? Or is just the highest MCC/CC RW calculated?**

**A:** Only one MCC or CC will impact the MS-DRG weight change. Depending on the type of DRG a MCC or a CC will impact that move. Some DRG's are not impacted by the MCC/CC.

**Q: I work in long term care with a transitional care unit. Does this information on coding and reimbursement only work in the hospital setting or can it be utilized in a skilled nursing setting as well?**

**A:** The overall information provided is for acute care. In the case of Medicare patients, if the Prospective Payment System (PPS) is being used then the diagnosis of Severe Protein Calorie Malnutrition (SPCM) may increase the daily rate reimbursement on that patient stay. CMS uses separate PPSs for reimbursement to acute inpatient hospitals, home health agencies, hospice, hospital outpatient, inpatient psychiatric facilities, inpatient rehabilitation facilities, long-term care hospitals, and skilled nursing facilities. In my experience working with an inpatient behavioral health facility, I saw an increase in the reimbursement per day when a patient was diagnosed with SPCM. This was identified using the PPS calculator. I would check and see if your facility uses a PPS calculator and if the diagnosis of SPCM is one of the 10 diagnoses that increases that daily rate. Here is a good link to read: <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ProspectivePaymentSystem/index.html>

**Q: Is there a reference of the exact definition for each malnutrition DRG code?**

**A:** I think you are asking for a list of DRG's and their related names. You can find this on the [www.cms.gov](https://www.cms.gov) website.

**Q: Are malnutrition dx getting any attention and increased reimbursement in SNF or Long term care?**

A: In the long-term care hospitals and skilled nursing facilities, if the facility is using the PPS calculator for Medicare patients you may see an increase in reimbursement if the diagnosis is severe protein calorie malnutrition. We coach and train to use best practice so we encourage the use of the best practice evidence based screening tools for malnutrition, the Academy and ASPEN's Clinical Characteristics to Diagnose Malnutrition, and the use of the nutrition focused physical assessment.

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**Q: Do RDs code in other centers? We have difficulty getting the physicians to enter the billing diagnosis, any suggestions?**

A: Dietitians do not code, we provide nutrition screening, assessment and a nutritional diagnosis. The medical diagnosis comes from the physician or provider and the medical diagnosis code is coded by the hospital coder. DM&A provides education and coaching to physician teams and works with the dietitians and physicians to improve communication verbally and through the electronic health record to increase the communication and medical diagnosis of malnutrition. I recommend first training your dietitians on best practice of nutrition screening for malnutrition and proper assessment using the nutrition focused physical assessment and the Academy & ASPEN's Clinical Characteristics to Identify and Diagnose Malnutrition and then get the physicians together and educate them. It's an ongoing process of education. We've also worked with Physicians who directly work with the clinical documentation specialist and oversee that department to help with physician education.

**Q: How best to inform MDs about findings in Nutritional assessments?**

A: One of the best ways to communicate with physicians is in person. This could be speaking with physicians during interdisciplinary rounds or when working on the floor. Most realistically is to communicate with them through the electronic health record. This is a service of coaching and expertise DM&A provides.

**Q: is there DNV or other regulatory service who limits who can consult RD? Or is it hospital specific?**

A: If you are asking who can send a consult for a dietitian inpatient dietitian nutrition assessment? This is hospital specific.

**Q: Have you addressed the need for accurate weights from perspective of nursing? I routinely find 2-3 different weights and height from ER, Physician office, admission record, then up to 20# discrepancy from day to day.**

A: Yes, this is an issue at each hospital we work with. Our plan of action is to go to nursing leadership and / or nursing education and educate nursing on accurate patient weights, intakes, and use of the nursing nutrition admission tool. This is ongoing education within the focus of malnutrition.

**Q: Do Critical Access Hospitals also get increased reimbursement for diagnosing and coding malnutrition? I have heard conflicting answers**

A: Not specifically to reimbursement for CAH but it will impact the hospitals severity of illness (SOI) and risk of mortality (ROM) scores. See answer above regarding the use of the Medicare PPS system.

**Q: Do you see denials with Mild/Moderate Malnutrition? I have heard that some hospitals only bill for Severe Malnutrition.**

A: Hospitals don't bill directly for malnutrition. Malnutrition is a co-morbidity (CC) or a major co-morbidity (MCC) and that CC or MCC has the potential to move the weight of the Medicare Severity- Diagnosis Related Group (MS-DRG) into a higher MS-DRG and that can increase reimbursement. This only happens if the malnutrition CC/MCC is the only coded one during the patient stay. We see denials at any level of CC/MCC.

**Q: How are you measuring inadequate energy intake as a characteristic? Calculating estimated energy expenditure and doing a diet recall? Is a patient stating poor intake e.g. eating less than 50% of their meals adequate enough?**

A: When we provide coaching on this area of dietitian expertise, we always recommend the dietitian calculate the EEE for that patient. Then when the patient provides a 24hr. diet history or usual food intake prior to the hospital stay we can use our clinical skill and judgment to estimate if it is meeting the EEE goal or not and for what time frame. It is subjective but as dietitians we can estimate well with our clinical judgement. It's great to have food logs and records but typically we only find out specific information if we are speaking with patients that have a care giver or have been admitted from a skilled nursing facility, assisted living, rehab, or nursing home. In the context of intake, we also want to speak with the patient and ask more about the "why." "Why are you having a poor appetite, what is causing it?" This is the "related to" piece of the PES statement that we need to provide an intervention on. This is typically what is causing the malnutrition.