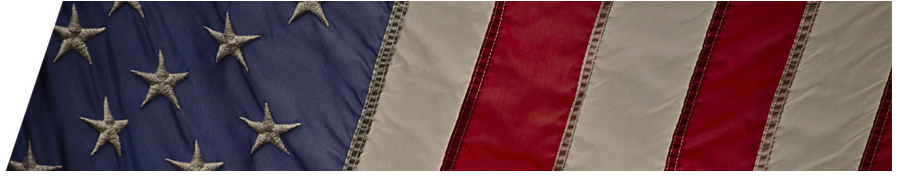# THE LIVANTA CLAIMS REVIEW ADVISOR

A monthly publication to raise awareness, share indings, and provide guidance about Livanta's Claim Review Services

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Higher-Weighted Diagnosis Related Groups (HWDRG) Validation – Malnutrition

In conducting HWDRG reviews, Livanta finds that hospitals often over-report the major complication/co-morbidity (MCC) of severe malnutrition. In fact, Livanta found the MCC to be coded in error in more than12 percent of reviewed cases in which malnutrition was reported. The MCC of severe malnutrition is coded in error when it is not clinically supported in the medical record.

This month's edition of The *Livanta Claims Review Advisor* addresses the accurate reporting of malnutrition codes. The content below is intended to provide hospital staff with detailed information about the guidelines associated with the malnutrition diagnosis codes and clinical validation of the severity level of malnutrition.

OIG and CMS Priorities

The Office of the Inspector General (OIG) recommended that the Centers for Medicare & Medicaid Services (CMS) should recover overpayments resulting from the incorrect assignment of severe

malnutrition diagnosis codes to inpatient hospital claims. The OIG also recommended that CMS should ensure that hospitals bill for malnutrition appropriately moving forward and that the agency should conduct targeted reviews of claims at the highest severity level that are vulnerable to upcoding.

The OIG reviewed 200 claims for which severe malnutrition was reported. Of those claims, severe malnutrition was incorrectly billed 173 times, an error rate of 86.5 percent. The OIG estimated that hospitals were overpaid by approximately one billion dollars for fiscal years 2016 and 2017 due to the overreporting of this diagnosis.

CMS is working on development and creation of policy covering malnutrition diagnostic criteria. Until this policy is implemented, Livanta's physician reviewers are using clinical judgement to determine whether severe malnutrition is clinically valid based on the documentation in the medical record.

OIG, OIG's Top Unimplemented Recommendations: Solutions to Reduce Fraud, Waste, and Abuse in HHS Programs, 2022 Edition
https://oig.hhs.gov/reports-and-publications/compendium/files/compendium2022.pdf

Clinical Validity of Severe Malnutrition

In the American Hospital Association's Coding Clinic First Quarter 2020, several questions and answers were published regarding the severity of malnutrition. One item explained that Coding Clinic cannot establish specific clinical criteria for a diagnosis, including malnutrition. However, Coding Clinic Fourth Quarter 2016 explained that while coders may not use clinical criteria for code assignment, payers may perform clinical validation audits. These audits are performed by clinicians and are different from coding audits even though both can affect the DRGs, and thus, reimbursement. This Coding Clinic article provided an example in which sepsis was documented but denied by the payer due to insufficient clinical indicators. This denial would be a clinical validation issue rather than a coding error.

DRG changes made by Livanta during review can be due to coding errors, clinical validity issues, or both. Livanta is contracted with CMS to do both coding reviews and clinical validity determinations. Livanta's clinical validation functions are performed by board-certified practicing physicians. The most common reason that severe malnutrition is denied is failure of the provider to document the clinical information to support the diagnosis. There is often no documentation of malnutrition at all until the post-discharge query. It is vital for providers to document the clinical information that supports the diagnosis of severe malnutrition, rather than simply stating on a query that it is present.

Documentation Good Practices

Signs and symptoms: To support a diagnosis of malnutrition, describe the clinical signs and symptoms, which may include weight loss, reduced appetite, fatigue, muscle weakness, poor healing, poor concentration, reduced muscle mass, low body mass index, loss of subcutaneous fat, percentage of energy intake compared to calculated energy needs. When documenting weight loss, include the percentage of weight lost within a specific period of time.

Laboratory results: Although no single laboratory value can confirm a diagnosis of malnutrition, providers should document all supporting lab values such as serum albumin, transthyretin, transferrin, retinol-binding protein (RbP), and total cholesterol, among others.

Other diagnoses: Document other medical conditions that can lead to malnutrition, such as cancer, liver disease, chronic obstructive pulmonary disease (COPD), pulmonary fibrosis, substance use disorders, social and financial problems, stomach or intestinal disorders, malabsorption, and mental health conditions.

Severity: Document the severity level of malnutrition and support the severity level with clinical indicators, laboratory values, and therapies provided such as supplements, percutaneous endoscopic gastrostomy (PEG) tube feedings, and/or total parenteral nutrition (TPN). The following clinical indicators would help support a diagnosis of severe protein-calorie malnutrition:

- Moderate to severe loss of body fat and muscle mass
- Moderate to severe fluid accumulation
- Reduced functional status
- Reduced grip strength
- Weight loss
- Reduced energy intake.

Coding Guidelines

Coding Clinic Third Quarter 2017, page 25, states that E40 (kwashiorkor) and E42 (marasmic kwashiorkor) should not be reported unless specifically documented. Additionally, this article states that kwashiorkor is usually seen in poor, underdeveloped countries and is extremely rare in the United States. The same issue of *Coding Clinic*, page 24, reminds coders that a basic rule of coding is that further research should be done if the title of the code suggested by the index does not identify the condition correctly.

Coding Clinic First Quarter 2020, page 4, provides coders with additional direction in relation to the reporting of malnutrition:

- Malnutrition is not integral to cancer and can be coded separately when documented.
- If the severity level progresses during admission, code the highest level of severity, and assign the POA indicator of "Y" no matter what severity level was present on admission. Do not assign multiple malnutrition codes.
- The terms "malnourished" and "malnourishment" are synonymous with malnutrition.
- Coders may NOT use the nutritionist's documentation of severity level when coding malnutrition. The severity level must be documented by a provider legally authorized to establish a diagnosis.

Other *Coding Clinic* Articles:

- Malnutrition and intestinal malabsorption may be coded together despite the Excludes1 note, as these are two separate conditions that can exist independently (*Coding Clinic Fourth Quarter 2017*, page 108).
- When a patient is admitted for medical stabilization rather than psychiatric treatment of anorexia nervosa, the medical complication such as malnutrition should be the principal diagnosis (*Coding Clinic First Quarter 2022*, page 13).

Common Scenario

By far, the most common reason severe protein-calorie malnutrition is disallowed on a claim is a lack of clinical evidence of this condition. For example, many hospitals submit post-discharge physician queries that mention a few clinical indicators of malnutrition and ask the physician to select severe, moderate, or mild malnutrition—and the physician answers with "severe," yet the condition was apparently not treated during the stay (i.e., malnutrition was not documented during the stay and clinical indicators supporting the diagnosis are not present in the documentation).

Focused Training

Based on HWDRG claim reviews conducted by Livanta, many hospitals could benefit from focused training on the proper documentation and coding of malnutrition, especially when it comes to the determination and documentation of severity levels. Complete and accurate documentation is imperative to ensure proper claim submission and payment.

About Livanta

Livanta is the national Medicare Claim Review Services contractor under the Beneficiary and Family Centered Care – Quality Improvement Organization (BFCC-QIO) Program. As the Claim Review Services contractor, Livanta validates the DRG on hospital claims that have been adjusted to pay at a higher weight. The adjusted claim is reviewed to ensure that the diagnoses, procedures, and discharge status of the patient reported on the hospital's claim are supported by the documentation in the patient's medical record. Livanta's highly trained credentialed coding auditors adhere to the accepted principles of coding practices to validate the accuracy of the hospital codes that affect the DRG payment. When needed, actively practicing physicians review for medical necessity and clinical validity based on the presence of supporting documentation and clinical indicators.

Post-payment review of these HWDRG adjustments is mandated under statute and in CMS
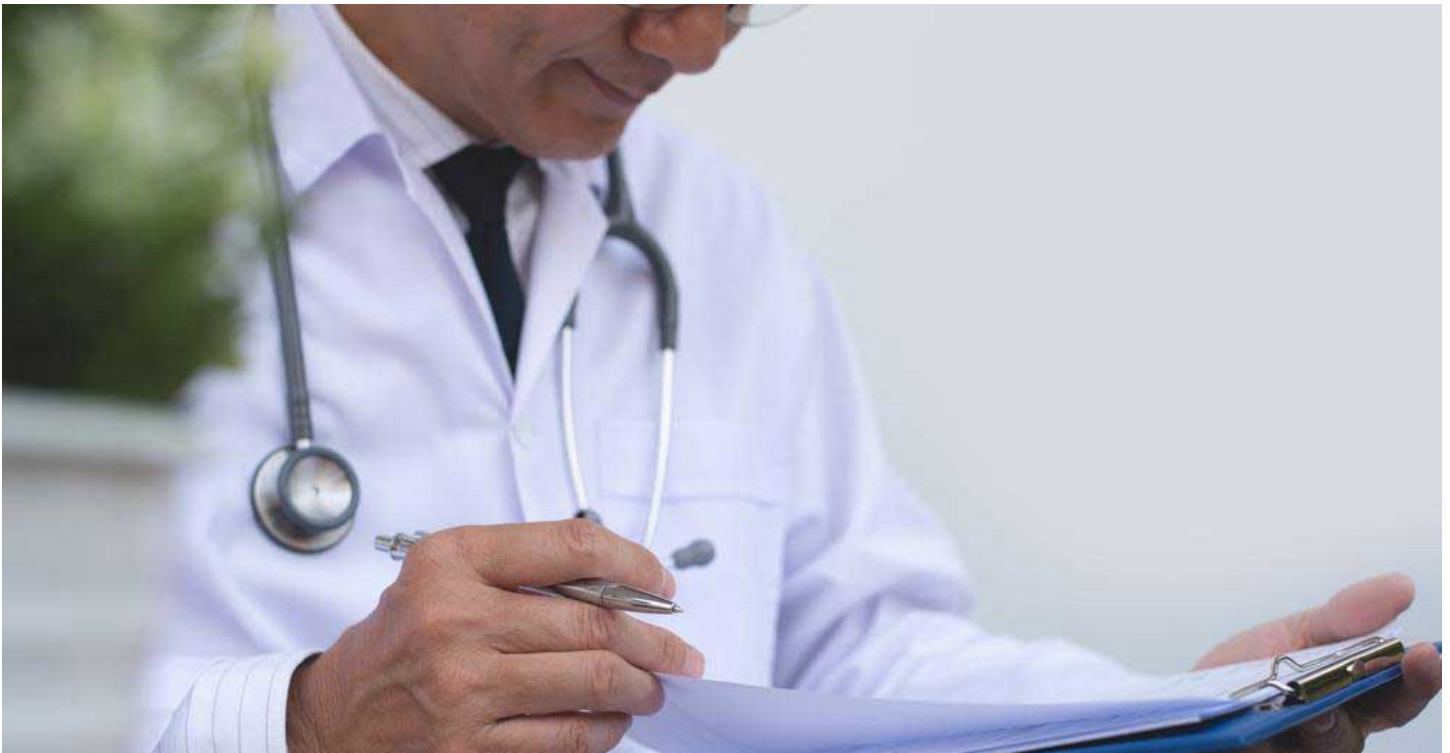
QIO Manual: Perform DRG validation on prospective payment system (PPS) cases (including hospital-requested higher-weighted DRG assignments), as appropriate (see §1866(a)(1)(F) of the Act and 42 CFR 476.71(a)(4)).

Read more: CMS, Quality Improvement Organization Manual, Chapter 4 - Case Review
https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/qio110c04.pdf

Questions?

Should you have questions, please email ClaimReview@Livanta.com.

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