Ensuring Compliant Malnutrition Coding

By Gloryanne Bryant, RHIA, CCS, CCDS

Coding malnutrition has always been a challenge, especially since MS-DRGs were implemented. However, with Recovery Audit Contractors and other regulatory auditing being initiated across the country, providers and HIM professionals must be proactive rather than reactive when coding this condition.

This article shares new concerns regarding malnutrition documentation and coding practices and highlights steps for improving coding compliance.

Malnutrition Defined

There are many published definitions for malnutrition. The *New York Times*' health guide defines malnutrition as the condition that occurs when a person's body is not getting enough nutrients. The condition may result from an inadequate or unbalanced diet, digestive difficulties, absorption problems, or other medical conditions.[1]

Malnutrition may be mild enough to show no symptoms. However, in some cases it may be so severe that the damage done is irreversible, even though the individual survives.

Worldwide, malnutrition continues to be a significant problem, especially among children who cannot fend adequately for themselves. Often malnutrition is seen in patients with liver disease, hepatitis, chronic and systemic diagnoses, and in alcoholics.

Coding and Reimbursement for Malnutrition

ICD-9-CM separates malnutrition into several codes to capture the degree and specific type of malnutrition. The ICD-9-CM Index of Diseases includes a list of malnutrition subcategories; however, coding professionals know not to code from the alpha index alone. It is necessary to consult the tabular listing and the "includes" and "excludes" instructional notes.

ICD-9-CM code 260, Kwashiorkor, represents a syndrome that includes nutritional edema with dyspigmentation of skin and hair. It affects children and involves excessive carbohydrate with inadequate protein intake, inhibited growth potential, anomalies in skin and hair pigmentation, edema, and liver disease. Kwashiorkor often is seen in third-world countries.

According to *The Merck Manuals*, kwashiorkor is derived from an African term that means "first-second child." This is because it usually affects children who are weaned due to the birth of a second child.[2]

In some inpatient cases a diagnosis of "protein malnutrition" may be documented, which would be assigned to code 260, Kwashiorkor. But did the physician really intend for the diagnosis of kwashiorkor to be reported?

Under the Inpatient Prospective Payment System MS-DRGs, ICD-9-CM code 260 is a major complication/comorbidity, or MCC. In some cases, ICD-9-CM code 260 may be the only MCC, which groups to a higher relative weight MS-DRG. The diagnosis "protein malnutrition" indexes to 260, Kwashiorkor, while "protein-caloric malnutrition" indexes to ICD-9-CM code 263.9 (which is a CC).

For example, a 65-year-old female is discharged from a hospital in May 2011 with a principal diagnosis of acute kidney injury (ICD-9-CM code 584.9) and a secondary diagnosis of protein malnutrition (ICD-9-CM code 260). This results in assignment of MS-DRG 682 Renal Failure with MCC, with a relative weight of 1.6407. The hospital has a base rate of $6,000, so it will expect a payment of $9,844.20.

If, however, the secondary diagnosis was documented as protein-calorie malnutrition (ICD-9-CM code 263.9) instead of protein malnutrition (ICD-9-CM code 260), then MS-DRG 683 Renal Failure with CC, with a relative weight of 1.0243, would be assigned, and the expected reimbursement would be $6,145.80.

Ensuring Accurate Malnutrition Coding

Assignment of code 260 has gained increasing attention from auditors and the media. A February 2011 article in the *San Francisco Chronicle* flagged hospitals that frequently assigned code 260 for inpatients, highlighting how the code affects payment for Medicare Part A patients.[3]

In order to ensure accurate malnutrition coding, facilities should review electronic tools that automate diagnosis selection. Several aspects of electronic checklists or pick lists need consideration, including the following:

- The programming of diagnosis lists should be reviewed by a coding professional who understands the classification system.
- The diagnosis list should include all choices of a particular condition (e.g., all entries under the main term malnutrition). This may require an additional "click" by the provider, but the increased accuracy is worth the effort.
- The format of the diagnosis list should encourage a review of all possible selections. The first-listed diagnosis or condition is often the one most selected by providers. Facilities should provide physicians training on selecting the correct diagnosis from the list.
- Facilities should validate the mapping of the diagnostic terms on the section list to ensure they link to the correct ICD-9-CM code.

Other steps to take to validate the accuracy of ICD-9-CM code 260 and to identify any potential risk include the following:

Hospitals should develop and adopt clinician documentation requirements and clinical criteria for the various types of malnutrition. This should be done with input from the medical staff, registered dieticians, coding professionals, and clinical documentation specialists using reliable resources.

Facilities should run a data report from October 2007 to the present for inpatient cases with ICD-9-CM code 260 assigned as a principal or secondary diagnosis code. Cases with ICD-9-CM code 260 assigned should be reviewed for accuracy for documentation and the clinical components of malnutrition. Facilities should then determine whether the terminology clinicians are using requires further clarification.

Facilities should discuss the review findings with medical staff and provide education on the correct coding for code 260. They should collaborate with the medical staff on a plan of action to improve the documentation of malnutrition and share the findings with the coding staff, clinical documentation improvement staff, and nutritionists who may query physicians on the nutritional diagnosis or status. Organizations should consider generating physician queries concurrently through a clinical documentation improvement program.

If all documentation improvement efforts fail, coding professionals should query physicians to clarify malnutrition documentation. Organizations should follow references and resources to ensure an effective query process, including the October 2008 AHIMA practice brief "Managing an Effective Query Process," available in the AHIMA Body of Knowledge at www.ahima.org. They should use a physician query that offers a brief explanation and choices for the physician so they can better understand the malnutrition classification.

Coding professionals must apply basic coding competencies when they see proper malnutrition documentation. Since kwashiorkor is not often seen in the United States, coding professionals should review the clinical documentation and clinical indicators carefully and ultimately query when clarification is appropriate. Accurate documentation, coding, and reimbursement will help maintain compliance and diminish potential regulatory risk.

Notes

1. *New York Times*. "Malnutrition." http://health.nytimes.com/health/guides/disease/malnutrition/overview.html.
2. The Merck Manuals. Robert S. Porter and Justin L. Kaplan, eds. Whitehouse Station, NJ: Merck, 2010.

3. Williams, Lance, Christina Jewett, and Stephen K. Doig. "Hospital Chain, Already under Scrutiny, Reports High Malnutrition Rates." *San Francisco Chronicle*, February 19, 2011. http://californiawatch.org/category/free-tagging/kwashiorkor.

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