



## Clinical Validation of Malnutrition

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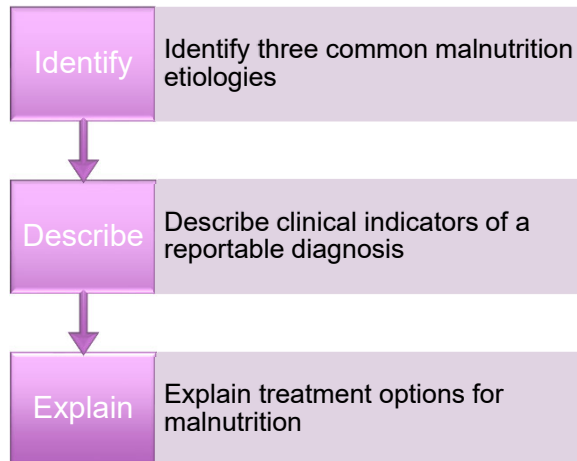
## Presented By



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## Learning Objectives

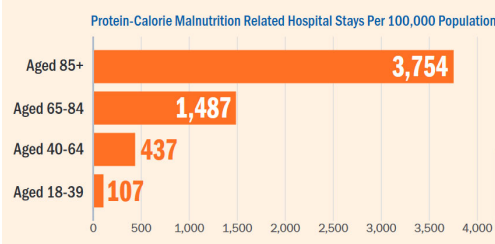
- At the completion of this educational activity, the learner will be able to:



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## Why Is This Diagnosis So Important?

We need to capture this when appropriate to assist with risk adjustment, and recoupment of resources applied. ... more importantly to assist the patient in their dietary needs.

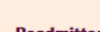


**2.2 MILLION**  
hospital stays involved malnutrition



30-Day Readmissions Are

**1.6x HIGHER**  
in patients with malnutrition



Malnourished Patients Have:

**2x LONGER**  
Hospital Stays

than patients with no malnutrition



Readmitted Malnourished Patients Are

**2x AS LIKELY**  
to be diagnosed with a serious infection



**2x HIGHER**  
Hospital Costs  
than the average cost of all hospital stays

**3x HIGHER**  
Inpatient Death Rate  
than the average death rates of all hospitalized patients

Readmitted Malnourished Patients Have

**22% HIGHER**  
Hospital Costs  
than readmitted patients with no malnutrition



Available: [www.hcup-us.ahrq.gov/reports.jsp](http://www.hcup-us.ahrq.gov/reports.jsp). Data shared is on 2016 protein-calorie malnutrition inpatient [https://www.nutritioncare.org/guidelines\\_and\\_clinical\\_resources/Malnutrition\\_Solution\\_Center/](https://www.nutritioncare.org/guidelines_and_clinical_resources/Malnutrition_Solution_Center/)

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## Malnutrition

It's more than a  
low BMI!



## We all have a moment when we didn't critically think...

Dr. Murphy,

Mrs. Virginia Ham was admitted with acute diastolic heart failure, daily weights have been ordered. Nursing assessment indicates a BMI of 18. Please clarify the diagnosis you are monitoring and treating?

- Moderate protein calorie malnutrition
- Mild protein calorie malnutrition
- Cachexia
- Other \_\_\_\_\_
- Unable to determine

*Nah, she's just skinny*

## Malnutrition

- It is not the role of CDI or coding to require use of a specific definition of malnutrition (i.e., GLIM, ASPEN vs. albumin levels vs. pre-albumin); rather, they should ensure that the totality of the record supports the conditions, allowing that other providers would come to the same conclusion.

**Best practices suggest that organizations should have a definition of malnutrition, differentiating mild from moderate to severe and specifying treatment guidelines for each level.**

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## Malnutrition: Etiology

**The 3 etiology-based nutrition diagnoses for adults in clinical practice settings are:**

- “Starvation-related malnutrition”: chronic starvation without inflammation (e.g., anorexia nervosa)
- “Chronic disease-related malnutrition”: inflammation is chronic and of mild to moderate degree (e.g., organ failure, pancreatic cancer, rheumatoid arthritis or sarcopenic obesity)
- “Acute disease or injury-related malnutrition”: inflammation is acute and of severe degree (e.g., major infection, burns, trauma or closed head injury)

[https://www.nutritioncare.org/Guidelines\\_and\\_Clinical\\_Resources/Toolkits/Malnutrition\\_Toolkit/Definitions/](https://www.nutritioncare.org/Guidelines_and_Clinical_Resources/Toolkits/Malnutrition_Toolkit/Definitions/)

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## Malnutrition

- In elderly persons, an indicative sign of malnutrition is delayed healing and an increased presence of decubitus ulcers of stage 3 or higher
- In developed countries, inadequate food intake is a less common cause of malnutrition; protein-energy malnutrition is more often caused by decreased absorption or abnormal metabolism
  - Diseases such as cystic fibrosis, chronic renal failure, childhood malignancies, congenital heart disease, and neuromuscular diseases contribute to malnutrition in developed countries

<http://emedicine.medscape.com/article/1104623-overview>

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## Malnutrition – Screening

### 1. Measuring Weight:

- Serial measurements of body weight is the simplest screen for nutritional adequacy and change in nutritional status in older adults
- Obtaining periodic body weights may be challenging, particularly in frail patients
- Low body weight is defined as <80 percent of the recommended body weight

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**Weight or BMI alone is not enough to support malnutrition - it is but one indicator**

**Sample :  
Screening Tool Using Weight**

**Weight charts for older persons**

| Height (inches) | Weight (pounds) |             |             |
|-----------------|-----------------|-------------|-------------|
|                 | 60-69 years     | 70-79 years | 80-89 years |
| 61              | 127-151         | 121-153     | -           |
| 62              | 131-163         | 125-155     | 119-148     |
| 63              | 135-163         | 127-157     | 120-150     |
| 64              | 140-173         | 129-161     | 128-152     |
| 65              | 144-179         | 130-164     | 125-155     |
| 66              | 148-184         | 133-167     | 128-158     |
| 67              | 153-190         | 136-170     | 130-162     |
| 68              | 158-196         | 139-174     | 133-165     |
| 69              | 162-201         | 142-178     | 137-169     |
| 70              | 167-207         | 146-182     | 140-175     |
| 71              | 172-213         | 149-186     | 144-180     |
| 72              | 177-219         | 154-190     | 148-187     |

Any patient falling below these weights should be considered nutritionally at risk; multiply height by 2.54 to convert to cm, and divide weight by 2.2 to convert to kg.

## Malnutrition – Screening

### 2. Calculating Weight Loss:

Weight loss is considered clinically significant with:

- ≥2 percent decrease of baseline body weight in one month
- ≥5 percent decrease in three months, or
- ≥10 percent in six months

**In the long-term care setting, a clinically significant weight-loss episode is defined by the long-term care Minimum Data Set (MDS) as loss of 5 percent of usual body weight in 30 days, or 10 percent in six months**

## Causes of Involuntary Weight Loss



- Inadequate dietary intake
- Appetite loss (anorexia)
- Disuse or muscle atrophy (sarcopenia)
- Inflammatory effects of disease (cachexia)

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## Inadequate Dietary Intake

- **Social**
  - Isolation, financial limitations
- **Psychological**
  - Depression, dementia
- **Medical**
  - Chronic disease, malignancy, dysphagia, edentulism, substance dependence, endocrine disorders, GI disorders, chronic wounds, end organ disease
- **Pharmacologic**
  - SRIs, digoxin, opioids, etc.

**Clinical Indicator:**  
Ask why?  
And what did we do about it??

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## Inadequate Dietary Intake

### Treatments:

- Lifting of any dietary restrictions
- Assistance with shopping or feeding
- Adjusting diet to match individual tastes (ethnicity/locale)
- Supplements (protein powders, fats) and scheduled snacks
- Multivitamin and mineral supplements
- Appetite stimulants (Megace, Marinol, Remeron etc.)
- Treating underlying cause if related to medical condition



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## Malnutrition

### 3. Screening Assessment Tool

#### Mini Nutritional Assessment – Short Form (MNA®-SF)

- The Mini Nutritional Assessment (MNA) consists of a global assessment and subjective perception of health, as well as questions specific to diet, and a series of body measurements. It has been widely validated and is predictive of poor outcomes.
- The Mini Nutritional Assessment-Short Form (MNA-SF) uses six questions from the full MNA and can substitute calf circumference if BMI is not available.

<https://www.mna-elderly.com/sites/default/files/2021-10/mna-guide-english-sf.pdf>

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## Malnutrition – Screening: MNA-SF

- A. Decrease in food intake over three months
- B. Weight loss over three months
- C. Functional mobility
- D. Psychological stress or acute disease in last three months
- E. Neuropsychological problems (dementia)
- F. (1) BMI  
(2) calf circumference  
(If CC is not available BMI can be used)

### Scoring:

- 12-14 points – normal nutritional status
- 8-11 points – at risk for malnutrition
- 0-7 points – malnourished

<https://www.mna-elderly.com/>

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## Malnutrition Criteria: Lab and Weight/BMI

- Traditional measures for identifying malnutrition include reliance on current weight and albumin levels

| Measurement                                 | Normal      | Mild undernutrition | Moderate undernutrition | Severe undernutrition |
|---|-------------|---------------------|-------------------------|-----------------------|
| Normal weight (%)                           | 90–110      | 85–90               | 75–85                   | < 75                  |
| Body mass index (BMI)                       | 19–24*      | 18–18.9             | 16–17.9                 | < 16                  |
| Serum albumin (g/dL)                        | 3.5–5.0     | 3.1–3.4             | 2.4–3.0                 | < 2.4                 |
| Serum transferrin (mg/dL)                   | 220–400     | 201–219             | 150–200                 | < 150                 |
| Total lymphocyte count (per $\mu$ L)        | 2,000–3,500 | 1,501–1,999         | 800–1,500               | < 800                 |
| Delayed hypersensitivity index <sup>†</sup> | 2           | 2                   | 1                       | 0                     |

- These criteria are still used in current publications

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## Malnutrition: GLIM

### Global Leadership Initiative on Malnutrition-Adult

- The GLIM definition of malnutrition is based on five diagnostic criteria, three of which are phenotypic (clinical findings) and two of which are etiologic (causes)
- The diagnosis of malnutrition requires at least one phenotypic criterion and one etiologic criterion. Severity of malnutrition is based on the phenotypic criterion meeting the highest level of severity

The GLIM etiology criteria for acute disease/injury include confirmation of severe systemic inflammation, in contrast to ASPEN

- Biomarkers are recommended by GLIM to confirm chronic or severe systemic inflammation.
- C-reactive protein (CRP) is preferred, but low albumin/prealbumin levels are also included.
- While not specifically mentioned by GLIM, systemic inflammatory response syndrome (SIRS) criteria could also be used to identify systemic inflammation

<https://acphospitalist.org/archives/2018/11/coding-corner-new-global-definition-for-malnutrition.htm>  
<https://onlinelibrary.wiley.com/doi/epdf/10.1002/jpen.1440>

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## Glim Criteria

| Phenotypic Criteria        |  |
|----------------------------|--|
| Weight Loss % (unintended) | > 5% in ≤ 6 months or >10% in > 6months  |
| Low Body Mass Index        | < 20 kg/m <sup>2</sup> if < 70 years or<br>< 22Kg/m <sup>2</sup> if ≥ 70 years   |
| Reduced Muscle Mass        | Reduced according to objective measures or physical exam   |
| Etiologic Criteria         |  |
| Reduced Nutritional Intake | ≥ 50% of requirement for > 1 week, or any reduction >2 weeks , or chronic gastrointestinal disorders with adverse nutrition impact |
| Inflammation               | Chronic disease or acute disease/injury with severe systemic inflammation or socioeconomic/environmental starvation                |

For the diagnosis of malnutrition, GLIM recommends that the combination of at least 1 phenotypic criterion and 1 etiologic criterion is required

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## GLIM – Severity of Malnutrition

| Moderate (Stage 1)        |  |
|---------------------------|--|
| Weight loss %- unintended | 5-10% in $\leq 6$ months or >20% in > 6 months   |
| Low BMI                   | < 20 kg/m <sup>2</sup> if < 70 years or<br>< 22Kg/m <sup>2</sup> if $\geq 70$ years    |
| Reduced Muscle Mass       | Mild to moderate deficit<br>(per validated assessment methods)                         |
| Severe (Stage 2)          |  |
| Weight loss %- unintended | > 10% in $\leq 6$ months or<br>> 10-20% in > 6 months                                  |
| Low BMI                   | < 18.5 kg/m <sup>2</sup> if < 70 years or<br>< 20 Kg/m <sup>2</sup> if $\geq 70$ years |
| Reduced Muscle Mass       | Severe deficit (per validated assessment methods)                                      |

It is clinically useful to categorize the severity of malnutrition depending on the degree of aberration from established thresholds

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## Malnutrition Criteria: ASPEN

- Criteria were established and published in the May 2012 *Journal of the Academy of Nutrition and Dietetics*
  - Consensus statement of the American Academy of Nutrition and Dietetics and the American Society for Parenteral and Enteral Nutrition (ASPEN)
    - ASPEN is an organization comprised of healthcare professionals representing the disciplines of medicine, nursing, pharmacy, dietetics, and nutrition science

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## ASPEN Guidelines

- The ASPEN clinical guidelines offer clinical advice for managing adult and pediatric patients receiving nutrition support therapy in the hospital or home
- Because guidelines cannot account for every variation in circumstances, the practitioner must always exercise professional judgment in their application. These clinical guidelines are intended to supplement, but not replace, professional training and judgment



## ASPEN Guidelines

- The guidelines indicate that malnutrition should be diagnosed when at least two or more of the following six characteristics are identified:
  - Insufficient energy intake
  - Weight loss
  - Loss of muscle mass
  - Loss of subcutaneous fat
  - Localized or generalized fluid accumulation that may sometimes mask weight loss
  - Diminished functional status as measured by hand grip strength

## Severe Malnutrition

Documentation considerations (must have two or more)

|                    | Acute Illness/Injury                           | Chronic Illness   | Social/Environmental  |
|--------------------|--|---|---|
| Weight Loss        | > 2%/1 week<br>> 5%/1 month<br>> 7.5%/3 months | > 5%/1 month<br>> 7.5%/3 months<br>> 10%/6 months<br>> 20%/1 year | > 5%/1 month<br>> 7.5%/3 months<br>> 10%/6 months<br>> 20%/1 year |
| Energy Intake      | ≤ 50% for ≥ 5 days                             | ≤ 75% for ≥ 1 month   | ≤ 50% for ≥ 1 month   |
| Body Fat           | Moderate depletion                             | Severe depletion  | Severe depletion  |
| Muscle Mass        | Moderate depletion                             | Severe depletion  | Severe depletion  |
| Fluid Accumulation | Moderate → severe                              | Severe  | Severe  |
| Grip Strength      | Not recommended in ICU                         | Reduced for age/gender  | Reduced for age/gender  |

<http://journals.sagepub.com/doi/pdf/10.1177/0148607112440285>

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## Malnutrition

- The type of “severe” malnutrition most likely to be associated with elderly hospitalized patients in the United States is
  - E43 Unspecified **severe** protein-calorie malnutrition
    - **Inclusion term of starvation edema**

This should rarely be your only MCC, as someone w/severe malnutrition will likely have other complex conditions. Ensure there is corroborating documentation by other healthcare professionals to support the diagnosis of severe malnutrition (PT notes, dietary notes, nursing notes, etc.). Ensure the treatment supports this diagnosis, as it is unlikely someone with severe malnutrition will not receive treatment for it

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## CDI Focus: Malnutrition – Common Co-Morbidities

- Malignancy, chemotherapy
- Major Depressive Disorder
- Dysphagia or CVA
- Alcoholism
- Substance abuse/dependence
- GI disorders
  - Gastritis, obstruction, Crohn’s disease, GI malignancy, pancreatic disorders
  - Mucositis, PUC, diverticulitis, postop ileus, malabsorption
- Severe sepsis
- End-stage disease process
- Suppressed appetite, dysphagia, depression
- Poor wound healing
- Immunocompromised (leukopenic state) and anemia
- Hypermetabolic state (COPD, sepsis, cancer, etc.), low BMI, cachexia

## CDI Focus: Malnutrition Contributing Factors



- Socio-economic deficiencies
- Institutionalized state
- Financial difficulties
- Advanced age
- Status post major bowel surgery
- Prolonged NPO status beyond 72 hours
- Cultural or dietary restrictions
- Cognitive impairment
- Unintentional weight loss

## Malnutrition: Critical Thinking

So you have a  
low BMI .....



- **What are the risk factors?**
  - Acute or chronic systemic illness disease state
- **What are the indicators?**
  - ASPEN criteria
- **What are the labs telling you?**
  - H&H, BUN, electrolytes, vitamin deficiency
- **What is the treatment?**
  - Is there any workup or treatment?

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## Why Is Clinical Validation of This Diagnosis So Important? Who Is Watching?

Department of Health and Human Services

**OFFICE OF  
INSPECTOR GENERAL**

**HOSPITALS OVERBILLED MEDICARE  
\$1 BILLION BY INCORRECTLY  
ASSIGNING SEVERE MALNUTRITION  
DIAGNOSIS CODES TO INPATIENT  
HOSPITAL CLAIMS**



I am!

<https://oig.hhs.gov/oas/reports/region3/31700010.pdf>

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## OIG Investigation – Malnutrition Report

### Is There a Severe Level of Malnutrition?

#### Support

- Chronic Illness – COPD, oxygen dependent, HTN and Non-Hodgkin pneumonia
- Documentation states inadequate oral intake, decreased appetite
- Started on nutritional supplements of breakfast drink and ensure
- Albumin level low

#### Against

- No recent weight loss
- BMI 35.5
- ED physician states, “well developed/well nourished”
- No changes in diet – listed as cardiac on admission and upon discharge
- Nursing notes list appetite as fair

OIG Sample #1, Audit #A-03-17-00010B, Case # AS18-001440

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## OIG Investigation – Malnutrition Report

### Let's Learn From the Report

#### Determination – *Severe PCM is not present*

- No weight loss documented in an obese patient.
- No documentation of micronutrient deficiency
- No evidence of inadequate intake
- Low serum albumin likely due to prednisone therapy
- Dietary interventions appear to be more consistent with prevention of malnutrition and were nonspecific
- No medical management

OIG Sample #1, Audit #A-03-17-00010B, Case # AS18-001440

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## What Is the Lesson to Learn?



- Consistency within the record is important
- Treatment plan must address malnutrition throughout the stay beyond pre-existing plan and be addressed in discharge plan
- Although malnutrition can appear in conjunction with obesity, it is important to clarify the type of malnutrition as well as the evidence to support its presence

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## Malnutrition in the Obese Patient Points to Ponder:

- Excess weight may not be due to fat – what are the fluid levels?
  - Is the patient in overload
  - Accurate weight and height will assist in BMI capture
  - Repeat assessment after diuresis, documentation should explain this
- Weight loss may not be as apparent in the obese population
  - It may not be reported or described accurately
  - Was it intentional?
  - Vitamin deficiencies are very common s/p gastric bypass, especially if the patient does take all of the vitamin and mineral supplements as ordered
  - Documentation of non-compliance is needed

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## Common Micronutrient Deficiencies in the Obese

- Thiamine B1
- Pyridoxine B6
- Cobalamin B12
- Folic Acid
- Vitamin C, A, D, E
- Zinc
- Chromium
- Selenium

The documentation should identify the deficits related to micronutrients and discuss plans and treatments

What is the primary source of calories?  
(concept – empty calories)  
Dietician assessment should clearly assess and document this

## OIG Investigation – Malnutrition Report Is There a Severe Level of Malnutrition?

### Support

- Admit with pneumonia
- Hx. Non-small cell lung cancer, COPD, depression
- Decreased appetite/ described as poor
- BMI 21
- Unintentional weight loss of 26 pounds in 3 months
- Reduced grip strength/fat loss and decreased strength
- Continue with boost as prior to admit and diet education on high protein

### Against

- Discharge diet – return to previous/no change
- No interventions applied as different than prior
- Length of stay 3 days – matching GMLOS for DRG 194 Simple Pneumonia w/ CC

## OIG Investigation – Malnutrition Report Let's Learn From the Report

### Determination – Severe PCM was present but did not affect the patient's treatment plan

- A diagnosis of severe protein calorie malnutrition can be supported, the nutritional intervention was not complex and consisted of a high protein diet with oral supplements
- Neither the length of stay nor the treatment plan were affected by the nutritional diagnosis
- Medicare coverage criteria was not met for the secondary diagnosis of severe protein calorie malnutrition

OIG Sample #2, Audit #A-03-17-00010D, Case # AS18-002458

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## What Is the Lesson to Learn?

- Treatment plan must address malnutrition throughout the stay beyond pre-existing plan and be addressed in discharge plan
- Physician orders should address diet changes and plans for discharge reflect follow up
- Length of stay was not impacted – why?
- Does one can of Boost a day for three days allow for an extra \$2,500? That is a pretty expensive can of Boost!



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## OIG Investigation – Malnutrition Report

### Is There a Severe Level of Malnutrition?



#### Support

- Admit with esophagitis, gastritis and GI bleed
- Chronic kidney disease, dementia
- Severe malnutrition POA – related little oral intake
- Hx of nausea, difficulty swallowing, progressive weight loss, poor appetite
- Nutritional supplements ordered
- Consideration for Megace vs. feeding tube

#### Against

- Low admission malnutrition risk score – did not trigger dietician consult.
- Discharge diet as tolerated
- No quantification of weight loss history

OIG Audit # A-03-17-00010D, Case # AS18-00249 OIG Sample # 3

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## OIG Investigation – Malnutrition Report

### Let's Learn From the Report



*“Review of the medical records found that documentation does not support the diagnosis of severe protein-calorie malnutrition. The patient medically had severe protein-calorie malnutrition, with a BMI of 15 kg/m<sup>2</sup>, in association with being a debilitated patient with limited mobility and advanced dementia, although there is no documentation of other criteria present in the record. However, while the patient was severely malnourished, the nutritional condition did not affect the length of stay or treatment plan. The nutritional interventions were not complex and consisted of offering an oral diet. The Medicare criteria were not met to support the secondary diagnosis of severe protein-calorie malnutrition.”*

OIG Audit # A-03-17-00010D, Case # AS18-00249 OIG Sample # 3

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## What Diagnoses are Reportable?

- Is the diagnosis considered reportable?
  - Clinical evaluation?
  - Diagnostic procedures?
  - Therapeutic treatment?
  - Extended length of stay?
  - Increased nursing care/monitoring?



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## Reportable Diagnoses: Acronyms

- M- Monitored
- E- Evaluated
- A- Assessed
- T- Treated

- T- Treatment
- A- Assessment
- M- Monitor/Medicare
- P- Plan
- E- Evaluate
- R- Refer

ionHealthcare®, LLC

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## OIG Investigation – Malnutrition Report Is There a Severe Level of Malnutrition?



### Support

- Surgical wound infection. Hx. Diabetes, ESRD, HTN
- Nutrition consult, “patient meets criteria for severe malnutrition in the setting of chronic illness.”
- Weight loss 7.5% of body weight over 6 weeks
- Severe loss of muscle in temple, clavicle, acromion, dorsal, hand, patellar, thigh and posterior calf.
- Severe loss of fat in orbital region and upper arm

### Against

- No edema
- Albumin and protein WNL
- Regular diet
- Inconsistencies in recorded weight measurements noted

OIG Audit # A-03-17-00010B, Case # AS18-001441 OIG Sample # 4

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## OIG Investigation – Malnutrition Report Let's Learn From the Report



***“Review of the medical records found that a diagnosis of severe protein-calorie malnutrition is not supported. The patient was overweight and had a weight of greater than 75 kg. He weighed 70kg on admission. His weight loss over the preceding six weeks was about two pounds per week; this is not excessive weight loss in an overweight person. Although he was said to have lost >7.5% of his body weight since kidney transplantation roughly two months earlier, no weights from earlier medical records were brought forward for inclusion in documentation for this episode to support that observation.”***

OIG Audit # A-03-17-00010B, Case # AS18-001441 OIG Sample # 4

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## OIG Investigation – Malnutrition Let's Learn From the Report

- “The nutritionist noted severe muscle wasting in multiple areas, and severe fat loss in the orbital area and in the upper arm. However, the interventions for appetite were standard care; frequent weights are routine part of ESRD care. Appetite monitoring is a routine part of extended hospital care. There was no intervention that was specific to his nutrition status, no blood work that was not a routine part of ESRD care, nor did nutrition status complicate or prolong hospitalization.”
- “All objective measures of nutritional status were within a range that fails to support a diagnosis of malnutrition. The observations that might have secured the diagnosis were not substantiated by provision of serial weights or current anthropomorphic measurements.”

## OIG Investigation – Malnutrition Report Is There a Severe Level of Malnutrition?

### Support

- Admit sepsis, UTI, renal calculi and bladder cancer
- Appearance- cachectic
- BMI- 13.69 with 30-pound weight loss in 3 months

### Against

- No peripheral edema
- Only supplements- Boost and discharged on general diet to hospice care



## OIG Investigation – Malnutrition

### Let's Learn From the Report

*“Review of the medical records found that documentation does not support the diagnosis of severe protein-calorie malnutrition. The patient had an admission weight of 70 pounds and BMI of 13.69 kg/m<sup>2</sup> and was severely undernourished. She was described as cachectic and was significantly weak. There was no specific documentation of muscle or fat wasting but with the documented cachectic appearance and BMI of 13.69 kg/m<sup>2</sup>, this can be plausible extrapolated. However, although severe protein calorie malnutrition was adequately documented by the medical record, the intervention was not highly complex and consisted of advancing oral diet and offering supplements. The treatment plan and length of stay were not affected by the diagnosis.”*

OIG Audit # A-03-17-00010D, Case # AS18-001440 OIG Sample # 5

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## Treatments for Malnutrition

- Nutritional Consult/dietician assessment and plan
- Calorie Counts/daily weights
- Ordered diet (high protein, high calorie)\*
- Supplements (vitamin, protein, calories)
- Patient/family education related to dietary choices and food preparation
- Enteral Feeding
- Parental feeding – TPN, Lipids
- Post discharge plans- dietician, social services, home health, weight monitoring, supplements, follow up

\*If a special diet is not ordered... why?

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## Physician Documentation

- Needs to state more than “severe malnutrition”
- Should identify the treatment plan
- Discuss how the nutritional state is considered in the patient’s care as well as how it will impact patient’s prognosis and need for further monitoring and interventions
- Discuss when expected treatments cannot be performed due to any contraindications related to co-morbidities, patient compliance etc.

## Physician Education Malnutrition

- **State the diagnosis...**
  - Identify severity (with severity: mild, moderate, severe) and any associated comorbidities and concerns related to the encounter
- **As demonstrated by...**
  - Risk factors:
  - Weight/BMI History:
  - Patient physical assessment:
  - Intake history and activity level:
  - Diagnostic findings:
- **With a treatment plan of...**
  - Dietary consult
  - Specific diet/caloric/supplement orders
  - Enteral/parenteral feeding as appropriate
  - Follow-up monitoring/assessments
  - Special considerations/contraindications related to planned treatment
- **Discharge planning needs and follow-up**

How is the malnutrition complicating the patient’s encounter, treatment, prognosis etc.?

## Example of Strong Documentation

Admitted with **non-healing surgical wound with infection**. Medical history **ESRD on dialysis, DM, and chronic diastolic heart failure**. **Poor nutritional status** contributing to **delayed wound healing**. **I concur with dietician assessment of severe PCM** in the setting of chronic illness and acute infection. Records indicate **15-pound weight loss over 12 weeks or 10% of body weight**. Physical assessment demonstrates **temporal muscles wasting, loss of muscle mass noted in thighs and lower legs**. Severe **depletion of fat deposits** with **peripheral edema noted**. Dietician to complete dietary education in relation to renal status and needed protein/caloric intake. Supplements to include **Nepro shakes, multivitamin**. Patient to be referred to home health for dietician follow up post discharge. **Social services to evaluate** need for financial assistance and meal prep assist from home health aid.



## Thank you. Questions?

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In order to receive your continuing education certificate(s) for this program, you must complete the online evaluation. The link can be found in the continuing education section of the program guide.