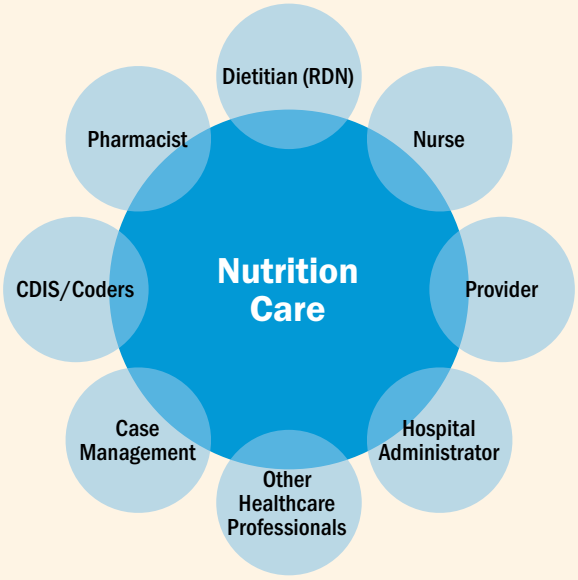
Malnutrition Diagnosis and Documentation: Strategies for Success

Despite continued research and education on malnutrition, challenges remain in accurately diagnosing and correctly documenting this diagnosis for patient and financial reimbursement benefit.

This fact sheet provides strategies on how physicians, providers, dietitians, nutrition clinicians, nurses, pharmacists, and clinical documentation specialists can collaborate together to diagnosis and document malnutrition appropriately.

Diagnosing and Documenting Malnutrition Correctly

Requires a Multidisciplinary Approach



CDIS=clinical documentation improvement specialist

Requires a Standardized Nutrition Care Pathway

Nutrition Screening → **Nutrition Assessment** → **Malnutrition Identified** → **Malnutrition Diagnosis Documented** → **Malnutrition Diagnosis Coded**

Requires Adherence to a Standardized Nutrition Assessment Tool

We recommend **Characteristics for the Identification of Adult Malnutrition** (AND/ASPEN tool).[1]

Suspect malnutrition if two or more characteristics are present:

- Insufficient energy intake
- Unintentional weight loss
- Decreased muscle mass
- Decreased subcutaneous fat
- Fluid accumulation
- Decreased functional status (e.g., hand grip strength)

Requires Use of Appropriate Malnutrition Diagnostic Codes

ICD 10 Code	Description
E40	Kwashiorkor
E41	Nutritional marasmus
E42	Marasmic kwashiorkor
E43	Unspecified severe protein-calorie malnutrition
E44.0	Moderate protein-calorie malnutrition
E44.1	Mild protein-calorie malnutrition
E46	Unspecified protein-calorie malnutrition

Continues on next page

aspen LEADING THE SCIENCE AND PRACTICE OF CLINICAL NUTRITION
American Society for Parenteral and Enteral Nutrition

Supported by: Baxter

Dietitian–Provider Communication: Make Sure the Diagnosis is Documented in the Medical Record

Documentation Recommendations For Dietitian or Nutrition Clinician

Documentation Should Be Organized:

- Easy to locate recommended diagnosis and criteria
- Concise intervention list, noted as initiated or recommended
- Concise statement of context and risk factors
- Source of data (weight, intake, etc.)
- Time, content, and audience for counseling
- Clear outline of follow-up/monitoring plan

Documentation Should Be Uniform:

- Predictable format with information easily locatable
- Consider where to place the most sought-after information

Documentation Recommendations For Provider

Documentation Should Be Precise and Complete:

- Diagnosis and criteria met and clearly stated in the assessment and care plan
  - *Include severity*
  - *Include clinical context*
- Relevant to care
  - *Outline the importance for the current clinical episode*
  - *Include treatments provided regardless of who ordered them*
  - *Include monitoring and follow-up plan*

Rule of Threes and Discharge Summary

- Consistently maintain documentation of the diagnosis throughout the record
- Document the diagnosis in the discharge summary (final diagnostic statement)
- Problem list maintenance: Ensure the diagnosis and pertinent details follow the patient through transitions of care

Provider–Documentation Specialist Workflow: Ensure Accurate, Complete and Appropriate Coding/Billing

*"**Coding a Diagnosis:** the term PROVIDER is used throughout the ICD-10 guidelines to mean physician or any qualified health care practitioner who is legally accountable for establishing the patient's diagnosis. The assignment of a diagnosis code is based on the provider's diagnostic statement that the condition exists."*[2]

Translation: MD, DO, NP, PA (provider) who is providing face to face care must document the diagnosis.

Competency Development and Training

Competency development and training are key for clinicians and clinical documentation staff. The subject areas to be covered include:

- Educate dietitians on nutrition assessment steps and documentation including NFPE
- Provide a dietitian led in-service for new and existing coders
- Ongoing education of CDI teams on malnutrition
- Educate providers via grand rounds, small provider group presentations, fellows conference, and/or monthly resident lectures

KEY MESSAGES

- Multidisciplinary approach
- Utilize a uniform definition and criteria set for diagnosis
- Partner with CDI department and coding for documentation and query initiatives
- Uniform documentation
- Uniform code assignment
- Provider education and competency on both clinical and documentation aspects of malnutrition
- Keep compliance informed
- Consider a clinical validation policy and pathway
- Base initiatives, diagnosis, and coding on "best practice" for clinical care
- Don't change clinical practice or definitions based on denial or audit patterns
- Use EHR where possible to communicate findings to provider in a standardized way.
- ***Patients Are Always First Priority***

References:
1. White J, et al. Consensus statement of the Academy of Nutrition and Dietetics/American Society for Parenteral and Enteral Nutrition: characteristics recommended for the identification and documentation of adult malnutrition (undernutrition). JPEN J Parenter Enteral Nutr. 2012;36: 275-283.
2. National Center for Health Statistics. ICD-10 CM Official Guidelines for Coding and Reporting FY 2021. https://www.cdc.gov/nchs/data/icd/10cmguidelines-FY2021.pdf

aspen LEADING THE SCIENCE AND PRACTICE OF CLINICAL NUTRITION
American Society for Parenteral and Enteral Nutrition

Supported by:
Baxter

