

# Current Practices and Perceived Barriers to Diagnosing, Documenting, and Coding for Malnutrition: A Survey of the Dietitians in Nutrition Support Dietetic Practice Group



**M**ALNUTRITION IS A PREVALENT condition among hospitalized patients worldwide. Approximately 30% to 50% of patients are malnourished.<sup>1-5</sup> Malnutrition is associated with negative clinical outcomes, including delayed wound healing, immune dysfunction, infections, and prolonged length of hospital and intensive care unit stays.<sup>6-8</sup> More resources and care are required for these patients, resulting in increased hospital costs. In the United States, the estimated cost of disease-associated malnutrition is \$157 billion/yr.<sup>9</sup>

In 2012, the Academy of Nutrition and Dietetics (Academy) and the American Society for Parenteral and Enteral Nutrition (A.S.P.E.N.) published the consensus statement, “Characteristics Recommended for the Identification and Documentation of Adult Malnutrition (Undernutrition).”<sup>10</sup> Six characteristics were proposed: insufficient energy intake, weight loss, loss of muscle mass, loss of subcutaneous fat, localized or generalized fluid accumulation, and diminished functional status. Serum

protein markers were not included as diagnostic criteria. These negative acute-phase proteins decrease during illness and inflammation (due to increased vascular permeability and reprioritization of hepatic protein synthesis) regardless of nutrition status.<sup>11,12</sup>

Proper diagnosis of malnutrition not only brings focused interventions on treatment, but also impacts institutional financial status. Curtis and colleagues<sup>13</sup> evaluated hospital lengths of stay and costs associated with malnutrition among those with severe or moderate malnutrition compared with well-nourished patients. Compared with well-nourished patients, malnourished patients had, on average, increased hospital lengths of stay (18% longer with moderate malnutrition;  $P=0.014$  and 34% with severe malnutrition;  $P=0.000$ ) and total hospital costs (31% to 34% higher with moderate malnutrition;  $P<0.05$  and 38% with severe malnutrition;  $P=0.003$ ). Within the Medicare Severity Diagnosis Related Group system, hospitals are paid the same dollar amount for each patient admitted with the same principal diagnosis. Secondary diagnoses and case-mix index also affect reimbursement.<sup>14</sup> Secondary diagnoses are defined as either comorbidities (present on admission)/complications (conditions that occur during hospitalization) (CCs) or major comorbidities/complications (MCCs). Case-mix index reflects the complexity of provided services and acts as a multiplier to increase reimbursement for hospitals providing higher complexity of care. Lastly, CCs and MCCs must be coded under the International Classification of Disease 10th Revision (ICD-10) codes. ICD-10 codes are numerical values that translate medical diagnoses into billable data. Malnutrition is recognized as a secondary diagnosis, which can influence Medicare Severity Diagnosis

Related Group reimbursement and case index.<sup>15,16</sup> As seen in Table 1, a CC or MCC of malnutrition can have a significant influence on the relative weight/case-mix index and hospital reimbursement. Potential reimbursement is unclaimed if malnutrition is present and not documented or coded appropriately. Multiple studies have noted missed opportunities for identifying, documenting, and coding malnutrition, resulting in estimated tens of thousands of dollars in reimbursement shortfalls.<sup>17-19</sup> Of note, the use of the ICD-10 codes for “kwashiorkor,” “marasmus,” and “marasmic kwashiorkor,” is discouraged, as these diagnoses are very uncommon in the United States.

Within the current system, Medicare Severity Diagnosis Related Groups, MCCs, and CCs can only be coded from the review of medical record documentation of the provider (medical doctor, nurse practitioner, and/or physician assistant). Without documentation of malnutrition within the provider’s note, malnutrition cannot be coded as a CC or MCC. Recently, there has been growing interest among registered dietitian nutritionists (RDNs) to ensure proper diagnosis and documentation of malnutrition to provide an accurate description of patient acuity, establish appropriate nutrition care, and improve reimbursement. The utilization of valid and reliable processes to diagnose and document malnutrition is one of the ways RDNs can enhance the potential for adequate clinical resources to care for malnourished patients.

To provide additional insight into this emerging topic of interest, Dietitians in Nutrition Support, a dietetic practice group of the Academy, conducted a survey of members ( $n=2,718$ ) to determine RDNs’ current practices and perceived barriers to identifying, documenting, and coding malnutrition

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within their institutions. Participants were also asked to provide information regarding dietetics practice characteristics (years of RDN experience, health care setting, and health care institution size). In addition, participants were asked to share information regarding the process at their respective institution for communicating the malnutrition diagnosis to health care providers. An online, self-serve, survey platform (SurveyMonkey) was used to create the survey questions and collect responses. The New England Institutional Review Board approved the study protocol via expedited review. Participants provided electronic informed consent. The survey was distributed in June 2016. To encourage participation, reminder e-mail notifications were sent after the initial e-mail. The online survey was closed 3 weeks after the initial e-mail was sent. To avoid multiple responses from the same health care institution, IP addresses were reviewed and duplicate sites were deleted.

### **CURRENT MALNUTRITION DIAGNOSIS AND DOCUMENTATION PRACTICES**

In total, 652 Dietitians in Nutrition Support RDN members completed the survey (24% response rate). The information presented here includes only nutrition and dietetics practitioners working in the adult setting ( $n=542$ , 66% adult and 25% combination of adult and pediatric). Survey responses are presented in [Table 2](#). The majority of RDNs were diagnosing malnutrition (79%). This group of practitioners was more likely to work in an academic/tertiary health care setting compared with RDNs not diagnosing malnutrition (86% vs 75%). Years of professional practice did not influence the likelihood of diagnosing malnutrition. Only 44% of RDNs were consistently performing nutrition-focused physical examinations. The routine conduction of nutrition-focused physical examinations differed by years of experience and practice setting. RDNs with 10 or less years of experience were more likely to always perform nutrition-focused physical examinations compared with those with more than 10 years of experience (43% vs 34%). In addition, RDNs working in academic/tertiary settings were more likely to always perform nutrition-focused physical examinations

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