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Deconstructing OIG Malnutrition Denials

By Nina Youngstrom

Here's an analysis by James Kennedy, M.D., president of CDIMD in Nashville, and compliance professional Paul Belton, of two malnutrition cases from the HHS Office of Inspector General's \$1 billion audit report on malnutrition.^[1] Contact Kennedy at jkennedy@cdimd.com and Belton at 1paulbelton@gmail.com.

Case 1 – Facts

- A review of the record indicates that the patient is a female Medicare enrollee with a medical history including *chronic obstructive pulmonary disease (COPD) and oxygen-dependence, hypertension, and non-Hodgkin's lymphoma*. The patient presented to the hospital on 12/18/2016 for increasing shortness of breath and brown phlegm. The patient was treated as an inpatient over the period 12/18/2016–1/3/2017.
- The patient's History and Physical (H&P) by the *emergency physician documented the patient's appearance as well-developed and well-nourished*, with moist oropharynx. The patient was in respiratory distress with diffuse wheezes but was afebrile and alert and oriented. Her abdomen was soft.
- A chest X-ray showed no acute findings. The patient's lab results showed elevated white blood cells (WBC), glucose level, and blood urea nitrogen (BUN) and low hemoglobin and hematocrit. The patient was admitted for medical management and was started on a cardiac diet.
- *Active problems included obesity, with BMI 30–34.9kg/m².*
- A nutrition assessment on 12/23/2016 documented that the patient's weight was 82.4kg and body mass index (BMI) was 35.5kg/m².
- *The assessment noted that, per chart review, the patient had not had recent weight loss*. Inadequate oral intake related to decreased appetite, and illness as evidenced by patient eating 25%–75% of meals, was documented.
- *The intervention was to trial Carnation Instant Breakfast (CIB) with lunch and monitor meal and supplement intakes; follow-up was planned in 3–4 days due to the holiday. The goal was for oral intake >= 50% of meals and consumption of nutrition supplement.*
- On 12/24/2016, the nurse documented encouraging adequate intake. *Albumin level was low (2.9) on 12/27/2016*. Ensure pudding was added with lunch and dinner in place of CIB due to fluid restriction, per dietitian note on 12/27/2016; the patient was eating 75% of meals. By 1/2/2017, the patient was consuming 50–75% of meals and 100% of CIB at breakfast.

Clinical Factors for Review	Support in Record
Nutritional Marasmus or Other Severe Protein-Calorie Malnutrition Hospital Claims	
<p>Did the patient medically have Nutritional Marasmus or suffer from severe malnutrition of any type?</p> <p>SSA § 1862, 42 C.F.R. § 424.5(a)(6)</p>	No
<p>Was the assignment of diagnosis code E41 (Nutritional Marasmus) and/or E43 (Unspecified Severe Protein-Calorie Malnutrition) adequately supported by the documentation contained in the medical record? If not, what malnutrition diagnosis code, if any, was supported by the medical records?</p> <p>CMS Publication 100-02, <i>Medicare Benefit Policy Manual</i>, Chapter 1, § 10 Covered Inpatient Hospital Services; <i>Journal of the Academy of Nutrition and Dietetics</i>. May 2012; Volume 112, Issue 5: Pages 730-738. 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).</p>	<p>No</p> <p>None</p>
<p>Is the DRG assignment substantiated by the patient's diagnoses and procedures?</p> <p>CMS Publication 100-08, <i>Medicare Program Integrity Manual</i>, Chapter 6, § 6.5.3 DRG Validation Review. CMS Publication 100-04, <i>Medicare Claims Processing Manual</i>, Chapter 1, § 80.3.2.2.</p>	No

Rationale

- Review of the medical records found that there was no weight loss documented.
- The patient was obese. It is difficult to establish malnutrition with modest weight loss in an obese person. Patients whose BMIs are in the obese or very obese range can be deficient in micronutrients. However, no documentation of micronutrient deficiency was provided in this patient's record.
- The patient was eating; there is no evidence of inadequate intake.
- This patient's serum albumin was noted to be 2.9, below the normal range. However, this patient was given prednisone to treat an acute COPD exacerbation. Prednisone is known to depress serum albumin levels in proportion to dosage level. In the setting of steroid dosing, serum albumin is not a reliable measure for determining malnutrition risk.
- The dietary interventions were more consistent with prevention of malnutrition. There was no specific medical management of malnutrition; the dietary interventions were nonspecific; there were no complications from malnutrition, and malnutrition did not complicate the clinical course. No specific

malnutrition diagnosis is evident.

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