

Insights to Coding and Data Quality

Coding Malnutrition

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Malnutrition coding has always been a little of a challenge from a coding perspective especially over the past four to five years. However, now we see a new level of importance from data mining for compliance. Let's take a closer look at this condition, the issues, some recommended action steps, and some case examples to help increase your knowledge and understanding.

Malnutrition is 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. 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 for themselves adequately. Often we see malnutrition in patients with liver disease, alcoholics, hepatitis, chronic and systemic diagnoses-cachexia (weight loss, wasting of muscle, loss of appetite, and general debility that can occur during a chronic disease).

The ICD-9-CM separates malnutrition into several specific codes to capture the degree of malnutrition and specific types of malnutrition. From the alpha index, the coder does not get to the specific mild, moderate or severe protein-calorie malnutrition ICD-9-CM code. However, coding staff should know already NOT to code from the alpha index alone, but rather from the tabular listing and to check the “*includes*” and “*excludes*” instructional notes.

The classifications for malnutrition are:

- 260 Kwashiorkor
- 261 Nutritional marasmus
- 262 Other severe protein-calorie malnutrition
- 263 Other and unspecified protein-calorie malnutrition

ICD-9-CM code 260, Kwashiorkor, represents nutritional edema with dyspigmentation of skin and hair. This is classified as a syndrome, particularly affecting children; excessive carbohydrate with inadequate protein intake, inhibited growth potential, anomalies in skin and hair pigmentation, edema and liver disease. In some inpatient cases, a diagnosis of "protein malnutrition" may be documented by the physician, which would be assigned to code 260, representing “Kwashiorkor;” but is that really correct? Under Medicare-Severity DRGs Inpatient Prospective Payment System, the ICD-9-CM code 260 is a major complication/comorbidity or MCC. Sometimes this is the only MCC and groups the MS-DRG case to a higher paying DRG. There may be a problem with the terminology the physician is using to describe the malnutrition. The term/diagnosis “protein malnutrition” indexes to 260, Kwashiorkor, while “protein-caloric malnutrition” indexes to ICD-9-CM code 263.9 (which is a CC).

For cases of 260 in the United States population, Kwashiorkor may not be what the patient actually has. Kwashiorkor is much different from other types of malnutrition that an elderly hospital patient may experience. According to the ICD-9-CM book (Ingenix) ...Kwashiorkor is a

syndrome, particularly of children; of excessive carbohydrate with inadequate intake, inhibited growth potential, anomalies in skin and hair pigmentation, edema and liver disease.

The tabular listing for code category 263 includes "other and unspecified protein-calorie malnutrition" and includes the codes for mild and moderate degrees of protein-calorie malnutrition. There also is guidance from American Hospital Association (AHA) relating to this subject, which is worth reviewing: Moderate protein malnutrition - *AHA Coding Clinic* on ICD-9-CM, Third Quarter 2009 Page: 06 Effective with discharges: September 15, 2009.

Finally a new compliance perspective to consider, there was an article in the *San Francisco Chronicle*, California Watch on February 19, 2011, titled, "Hospital chain, already under scrutiny, reports high malnutrition rates." This article discusses California state data of ICD-9-CM code 260 and hospitals with high frequencies of this code for inpatients, particularly in regards to the impact on the payment for Medicare (fee for service) patients. The article stated that: "in 2009, Shasta Regional Medical Center in Redding reported that 16.1 percent of its Medicare patients 65 and older suffered from Kwashiorkor, according to a California Watch analysis of state health data. That's 70 times the state average of 0.2 percent. At Desert Valley Hospital in Victorville, the Kwashiorkor rate among Medicare patients also was high: 9.1 percent, or about 39 times the state average. Both hospitals are owned by Prime Healthcare Services, a Southern California chain."

Considering all of the above, there are a few steps that HIM coding professionals should consider taking:

Action #1 It is recommend that you run a data report, starting with October 2007, to present, for inpatient cases (in particular Medicare) with the 260 code assigned as a secondary code. If you find cases with 260 code assigned, these should be reviewed for accuracy, not only for the documentation but the clinical components of the malnutrition.

Action #2 The review of records with code 260, should include a validation that the documentation and clinical indicators support the code assignment, and should determine whether further clarification is needed regarding the terminology being used by the physician/provider. If the documentation states only "protein malnutrition" then it is advised that a query be initiated.

Action #3 Generate a physician query explaining to the physician that documentation of the term "Protein Malnutrition" indexes within the ICD-9 classification system to Kwashiorkor, which is a rare form of malnutrition seen in children. Ask for clarification regarding whether the condition is actually Kwashiorkor as opposed to protein-calorie malnutrition (263.9); severe malnutrition NOS (261); severe protein-calorie malnutrition (262); or other malnutrition NOS (263.9) diagnosis (please specify type if known). It is best NOT to CODE 260 without clarification of actual Kwashiorkor from the physician.

Action #4 Develop or use a physician query that offers an explanation and also has some choices for the physician to help her or him understand the classification of malnutrition better. Here is some sample wording you could use in a query: "Dear Dr. XX: You have documented "protein malnutrition" which ICD-9-CM classification indexes to "Kwashiorkor," a rare syndrome occurring mostly in starving children. Please clarify whether your patient had Kwashiorkor, or whether s/he had "protein-calorie malnutrition," "malnutrition unspecified," or some other nutritional diagnosis (please specify) _____. Thank you."

Action #5 Share this information with your coding staff and your Clinical Documentation Improvement (CDI) staff who are querying or clarifying the nutritional diagnosis with the

physician. The good news is that work is being done at the national level that may lead to a revision in the classification or indexing for malnutrition in the ICD-9-CM classification.

Here are some helpful case examples to review and discuss with your coding staff.

Case Example A: A 76-year-old patient presents with moderate protein deficiency malnutrition.

Coding Answer A: 263.0, moderate malnutrition. Rationale: When both the degree of the malnutrition and the type is documented, code only the degree of the malnutrition, per *AHA Coding Clinic on ICD-9-CM*, Third Quarter 2009, page 6.

Case Example B: An 81-year-old patient presents with severe malnutrition.

Coding Answer B: 261, nutritional marasmus. Rationale: ICD9-CM tabular classifies severe malnutrition, which is not specified as protein calorie, to code 261.

Case Example C: A 68-year-old patient presents with severe protein-calorie malnutrition.

Coding Answer C: 262, severe protein-calorie malnutrition. Rationale: ICD-9-CM tabular classifies severe protein-calorie malnutrition as 262.

Case Example D: A 2-year-old patient presents with protein malnutrition. The physician is queried and answers that the patient has Kwashiorkor malnutrition.

Coding Answer D: 260, Kwashiorkor malnutrition. Rationale: Code 260, Kwashiorkor malnutrition should not be used to report protein malnutrition, without specific documentation of the condition of Kwashiorkor, per *AHA Coding Clinic on ICD-9-CM*, Third Quarter 2009, page 6.

Coding professionals should always have knowledge and competencies about disease processes in addition to their knowledge of coding. Also, making your physicians more aware of the ICD-9-CM classification and indexing will help enhance coding accuracy.

References

AHA ICD-9-CM Coding Clinic; San Francisco Chronicle, California Watch 2/19/2011; Wikipedia.com; health.nytimes.com

“Coding Malnutrition”, *CHIA Journal*, April 2011 – Vol. 62 No. 12, Page: 04