Payment Policy: Malnutrition

Reference Number: CC.PP.145
Product Types: All
Last Review Date: 07/25

Coding Implications
Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Policy Overview
Acute care hospitalizations for malnutrition require the most appropriate and most specific level of diagnosis coding. The medical record documentation supporting the diagnosis should be clearly documented by the physician or a licensed independent practitioner.

The cost difference between a Diagnosis Related Group (DRG) billed *with* malnutrition as a major complication or comorbidity (MCC) (in a position other than as the primary diagnosis code position) and a DRG billed without malnutrition as an MCC (in a position other than as the primary diagnosis code position) will be denied reimbursement unless meeting the documentation requirements described in this policy.

The purpose of this policy is to support a retrospective review of inpatient claims billed with the diagnosis of malnutrition.

Application
Inpatient facility claims
Medicare

Documentation Requirements

I. For purposes of reimbursement of inpatient claims for treatment of non-severe (moderate) malnutrition diagnoses in members/enrollees ≥ 18 years of age malnutrition, ALL of the following need to be clearly documented in the inpatient hospital records by the physician or licensed independent practitioner.
   A. One of the following:
      1. Non-severe (moderate) malnutrition secondary to acute illness or injury when meeting two or more of the following[1]:
         a. Energy intake < 75% for > seven days;
         b. Weight loss, any of the following:
            i. 1% to 2% in one week;
            ii. 5% in one month;
            iii. 7.5% in three months;
         c. Mild body fat loss*;
         d. Mild muscle mass loss**;
         e. Mild fluid accumulation;
      2. Non-severe (moderate) malnutrition secondary to chronic disease when meeting two or more of the following[1]:
         a. Energy intake < 75% for ≥ one month;
         b. Weight loss, any of the following:
            i. 5% in one month;

ii. 7.5% in three months;
iii. 10% in six months;
iv. 20% in one year;
c. Mild body fat loss*;
d. Mild muscle mass loss**;
e. Mild fluid accumulation;

3. Non-severe (moderate) malnutrition secondary to social or environmental circumstances when meeting two or more of the following[1]:
a. Energy intake < 75% for ≥ three months;
b. Weight loss, any of the following:
i. 5% in one month;
ii. 7.5% in three months;
iii. 10% in six months;
iv. 20% in one year;
c. Mild body fat loss*;
d. Mild Muscle mass loss**;
e. Mild fluid accumulation;

B. Treatment plan provided in the hospital that meets all of the following[2]:
1. Nutrition assessment and care plan implementation to include all of the following:
a. Provide least restrictive, medically appropriate diet;
b. Determine need for nutrition supplementation;
c. Treat medical issues impacting nutrition intake and utilization;
d. Review medications regarding impact on nutrition intake;
2. Nutrition care plan monitoring and evaluation to include the following:
a. Follow-up within three days;
b. Monitor the following parameters:
i. Tolerance of nutrient intake;
ii. Oral intake including supplements, vitamins, and minerals;
iii. Enteral/Parenteral intake;
iv. Anthropometric measures (e.g., height and weight for BMI);
v. Functional status;
c. Discharge planning to include follow up care as appropriate (e.g., home health, follow-up appointments for ongoing nutritional assessment).

II. For purposes of reimbursement of inpatient claims for treatment of severe malnutrition diagnoses in members/enrollees ≥ 18 years of age malnutrition, ALL of the following need to be clearly documented in the inpatient hospital records by the physician or licensed independent practitioner.

A. One of the following:
1. Severe malnutrition secondary to acute illness or injury when meeting two or more of the following[1,3]:
a. Energy intake < 50% for ≥ 5 days;
b. Weight loss, any of the following:
i. > 2% in one week;
ii. > 5% in one month;
iii. > 7.5% in three months;

c. Moderate body fat loss*;
d. Moderate muscle mass loss**;
e. Moderate to severe fluid accumulation;
f. Grip strength measurably reduced (not recommended in intensive care unit);

2. Severe malnutrition secondary to chronic disease when meeting two or more of the following[1,3]:
   a. Energy intake < 75% for ≥ one month;
   b. Weight loss, any of the following:
      i. > 5 % in one month;
      ii. > 7.5% in three months;
      iii. > 10% in six months;
      iv. > 20% in one year;
   c. Severe body fat loss*;
   d. Severe muscle mass loss**;
   e. Severe fluid accumulation;
   f. Grip strength measurably reduced;
3. Severe malnutrition secondary to social or environmental circumstances when meeting two or more of the following[1,3]:
   a. Energy intake < 50% for ≥ one month;
   b. Weight loss, any of the following:
      i. > 5% in one month;
      ii. > 7.5% in three months;
      iii. > 10% in six months;
      iv. > 20% in one year;
   c. Severe body fat loss*;
   d. Severe muscle mass loss**;
   e. Severe fluid accumulation;
   f. Grip strength measurably reduced;

Note: Height and weight should be measured rather than estimated and should not be self-reported. Body fat and muscle mass cannot be self-reported and should be accurately documented and in alignment with physical exam findings of other providers.

*Areas of body fat wasting include but are not limited to any of the following[1,4]:

- Orbital areas;
- Triceps;
- Iliac crest;

**Areas of muscle mass wasting include but are not limited to the following[1,4]:

- Temples (temporalis muscle);
- Clavicles (pectoralis and deltoids);
- Shoulders (deltoids);
- Interosseous muscles;
- Scapula (latissimus dorsi, trapezius, deltoids);
- Thigh (quadriceps);
- Patellar region;

- Calf (gastrocnemius);

B. Treatment plan provided in the hospital that meets all of the following[2,5]:
   1. Nutrition assessment and care plan implementation to include at least two of the following:
      a. Medically appropriate supervised nutritional diet;
      b. Daily calorie counts;
      c. Minimum of two to three daily liquid nutritional supplements;
      d. Appetite stimulants (e.g., Megestrol or Remeron);
      e. Frequent nutritional follow-ups;
      f. Weekly weights;
      g. Enteral feedings and/or total parenteral nutrition (TPN);
   2. Treat medical issues impacting nutrition intake and utilization;
   3. Review medications regarding impact on nutrition intake;
   4. Discharge planning to include follow up care as appropriate (e.g., home health, follow-up appointments for ongoing nutritional assessment).

   Note: Minimal or no treatment may be recommended for severe malnutrition for members/enrollees on hospice.

Reimbursement Guidelines

- The Health Plan uses paid claims data and a proprietary clinical algorithm to identify severe malnutrition claims for retrospective audit.
- When a potential billing error is identified, the Health Plan will request medical records to validate the diagnosis and procedure codes billed on the claim.
- Once the medical record is received, certified professional coders and registered nurses will clinically validate the documentation to ensure:
  a. The medical record contains the necessary information;
  b. The diagnosis code on the claim matches the diagnosis code in the medical record
  c. The diagnosis billed on the claim is supported by the clinical information in the medical record.
- Medical record reviews are overseen by the health plan Medical Director.
- After review of the medical record, the Health Plan will issue an audit determination letter to the provider. The letter will provide a thorough explanation of the determination as well as details for the provider to submit a dispute if they disagree with the determination.
- The clinical validation review will be completed within 30 days from receipt of medical records.
- The following explanation codes will be sent to the provider on the Explanation of Payment (EOP) at the conclusion of the review.

Explanation Code	Description
iA	Deny: Medical records not received per previous request
iB	Pay: DRG payment increase after review of medical records
iC	Pay: DRG payment adjustment after review of medical records

iE	Deny: DRG inpatient payment denied after review of records. Observation claim
iF	Pay: Reinstate payment after review of medical records

Coding and Modifier Information

This payment policy references Current Procedural Terminology (CPT®). CPT® is a registered trademark of the American Medical Association. All CPT codes and descriptions are copyrighted 2024, American Medical Association. All rights reserved. CPT codes and CPT descriptions are from current manuals and those included herein are not intended to be all-inclusive and are included for informational purposes only. Codes referenced in this payment policy are for informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

CPT/HCPCS Code	Descriptor
N/A	N/A

Modifier	Descriptor
NA	NA

ICD 10 Codes	Descriptor
E43	Unspecified severe protein-calorie malnutrition
E44.0	Moderate protein-calorie malnutrition
E44.1	Mild protein-calorie malnutrition

Definitions

Diagnosis Related Groups (DRG)

Patient classification scheme that relates the type of patients a hospital treats (case mix) to the costs incurred by the hospital. The case mix consists of 1) severity of illness, 2) prognosis, 3) treatment difficulty, 4) need for intervention; and 5) resource intensity.

Major Complication or Comorbidity

Diagnosis code(s) used by Medicare to assign individual cases to MS-DRGs based on severity of illness.

Medicare Severity Related Diagnosis Groups (MS-DRGs)

Classification of diagnoses according to severity for payment under the Inpatient Prospective Payment System (IPPS). This classification is based on information reported from the hospital: 1) the principal diagnosis, 2) up to 24 additional diagnoses; and 3) up to 25 procedures performed during the hospitalization.

Inpatient Prospective Payment System

A method of reimbursement in which Medicare payments are based on a predetermined, fixed amount. The payment amount for a specific service is based on how that service is classified, for example, diagnosis related groups (DRG) for inpatient services.

Additional Information
NA

Related Documents or Resources
NA

References
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Revision History	
02/01/2020	Policy CPP-145 developed. Approved by MPC.
04/30/2021	Transferred to Centene template and renumbered policy from CPP-145 to CP.MP.212. Minor rewording of criteria with no clinical significance. Condensed background. References reviewed and updated. Approved by CPC.

Revision History	
05/31/2021	In I.A.5.a and I.B.1.a, added >5% weight loss in one week as a criteria option. In I.B.4, added severe muscle wasting or loss of subcutaneous fat as criteria option. In I.B.5, added severe edema as an option. Deleted I.C.6 as if I.C.3 is met, the neonate doesn't also have to take >21 days to regain birthweight. Approved by CPC.
06/07/2021	Transferred to Centene template and renumbered from CPP-145 to WC.PP.145, changed LOB in header from "ALL" to "Medicare."
08/01/2021	Added all post pay audit details in the "Reimbursement Guidelines" section
02/16/2022	Removed error in revision log entry from 06/21. Clarified the location of the post pay audit details in the 8/21 revision log entry
04/2022	References reviewed, updated and reformatted. Updated time criteria I.B.2. from "for up to 3 months" to "≥ 1 month."
03/2023	Annual review completed. References reviewed and updated. External specialist reviewed.
10/2023	Updated policy number from WC.PP.145 to CC.PP.145. Changed I.A.1.a from 16 kg/m^2 to 18.5 kg/m^2. Changed I.A.5.a and I.B.1.a to > 2% weight loss in one week as a criteria option. Removed "albumin <2.4 gm/dL and/or prealbumin <5 mg/dL" from I.A. Added ICD-10 code E43 to coding table. Replaced all instances of "members" with "members/enrollees." References reviewed and updated. Reviewed by external specialist.
01/2024	Corrected applicable products from "Medicare" to "All."
09/2024	Annual review. References reviewed and updated.
07/2025	Annual review. Updated title of policy from Severe Malnutrition to Malnutrition. Removed "severe" verbiage from policy overview. Removed pediatric criteria from policy. Updated Criteria I. to include non-severe (moderate) malnutrition diagnosis criteria guidelines and treatment. Added Criteria II. to include severe malnutrition diagnosis criteria guidelines and treatment. Coding and descriptions reviewed. Added ICD-10 codes E44.0 and E44.1. References reviewed and updated. Reviewed by internal specialist.

Important Reminder

For the purposes of this payment policy, "Health Plan" means a health plan that has adopted this payment policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any other of such health plan's affiliates, as applicable.

The purpose of this payment policy is to provide a guide to payment, which is a component of the guidelines used to assist in making coverage and payment determinations and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage and payment determinations and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable plan-level administrative policies and procedures.

This payment policy is effective as of the date determined by Health Plan. The date of posting may not be the effective date of this payment policy. This payment policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this payment policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. Health Plan retains the right to change, amend or withdraw this payment policy, and additional payment policies may be developed and adopted as needed, at any time.

This payment policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care and are solely responsible for the medical advice and treatment of members/enrollees. This payment policy is not intended to recommend treatment for members/enrollees. Members/enrollees should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this policy are independent contractors who exercise independent judgment and over whom Health Plan has no control or right of control. Providers are not agents or employees of Health Plan.

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Note: For Medicaid members/enrollees, when state Medicaid coverage provisions conflict with the coverage provisions in this payment policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this payment policy.

Note: For Medicare members/enrollees, to ensure consistency with the Medicare National Coverage Determinations (NCD) and Local Coverage Determinations (LCD), all applicable NCDs and LCDs should be reviewed prior to applying the criteria set forth in this payment policy. Refer to the CMS website at http://www.cms.gov for additional information.