Sustaining Malnutrition Hospital Reimbursement From Dietitian-Led Interventions

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Background

- 20-60% of hospitalized patients are malnourished [1-12]
- Malnutrition is associated with impaired wound healing, increased length of stay, morality rates, and treatment costs [1-3, 6-7, 13-22]
- Hospitals struggle to capture appropriate reimbursement for malnourished patients due to under and improper documentation [7, 23-24]
- American Society of Parenteral and Enteral Nutrition and the Academy of Nutrition and Dietetics guidelines for identifying malnutrition require 2 of 6 criteria to be present: reduced energy intake, weight loss, loss of body fat, loss of muscle mass, fluid accumulation, or reduced hand grip strength [2-5,7]
- Dietitians perform Nutrition Focused Physical Exams (NFPE) that include a hands-on physical assessment and patient interview to screen for and identify these criteria [2-5, 7]
- Dietitian documentation alone does not directly impact medical diagnoses or reimbursement [6]
- Diagnoses and reimbursement can only be captured from physician or other authorized licensed practitioner documentation [6]
- Incongruence between physician and dietitian documentation can lead to insurance claim denials

Learning Objectives

- Explain the dietitian's role in identifying malnutrition
- Describe the importance of congruent documentation between dietitian and provider on hospital reimbursement values for malnutrition

Methods

- January 2017, dietitians were trained on the NFPE process
- April 2017, physicians and advanced providers were educated on the NFPE process and best practices for documentation and diagnosis of malnutrition

Methods

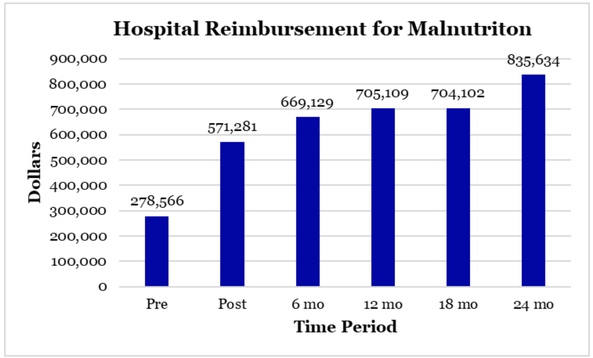
- Following IRB approval, electronic medical records were queried from October 1, 2016 through January 31, 2018
- Surgical patients were grouped into pre-intervention (October 1, 2016 – March 31, 2017) and post-intervention cohorts (August 1, 2017- January 31, 2018)
- ICD-10 codes were used to identify patients from each cohort with unspecified, mild, moderate, and severe malnutrition
- Records were analyzed to determine percentage of patients with congruent degree of malnutrition documentation between the dietitian and physician
- Using UKHC specific Medicare and Medicaid weighted DRG multipliers, estimated reimbursement outcomes attributed to malnutrition documentation were calculated
- Reimbursement was followed at 6-, 12-, 18-, and 24 months post-intervention

Results

- Diagnosing
  - 528 patients were included for analysis
  - Pre-intervention: 194 patients
  - Post-intervention: 334 patients
    - 72% increase in malnutrition diagnosing in the post-intervention period
- Concordance
  - Pre-intervention: 8.64%
  - Post-intervention: 46.3%
    - 436% increase in concordance rates in the post-intervention period
- Reimbursement
  - Pre-intervention: $278,566
  - Post-intervention: $571, 281
    - 105% increase in reimbursement in the post-intervention period

Results

- Sustained Reimbursement
  - 6 months: $669,129
  - 12 months: $705, 109
  - 18 months: $704, 102
  - 24 months: $835,634



Conclusions

- Following an educational quality improvement initiative, malnutrition diagnosing, diagnosis congruency, and hospital reimbursement improved
- Reimbursement has been sustained for 2 years post-intervention
- Further quality improvement initiatives are needed to improve clinical outcomes and therefore reduce treatment costs

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Takeaways, Barriers & Challenges

- Hospital reimbursement for malnutrition can improve when using standardized exams and documentation methods
- Encourage dietitians to be trained on performing Nutrition Focused Physical Exams
- Educate providers on the American Society for Parenteral and Enteral Nutrition's criteria for diagnosing malnutrition
- Continue to improve concordance rates in degree of malnutrition between provider and dietitian
- Improving concordance rates can decrease time and money spent fighting insurance claim denials for malnutrition