PRACTICE TIPS: Inpatient Payment and the Role of the RDN

The Centers for Medicare and Medicaid Services (CMS) utilize a payment system for acute care, inpatient hospital admissions based on the diagnoses and comorbidities of patients. The inpatient prospective payment system (IPPS) categorizes patient admissions into a diagnosis-related group (DRG) with an assigned payment weight based on typical resource utilization[1]. DRG payment weights account for a patient's condition, complexity of expected interventions, and any complications or comorbidities that make care more complex and costly and assign relative weights based on these factors. A higher relative weight indicates a more complex patient and higher expected costs.

In addition to the base DRG, patients are eligible for additional complications/comorbidities (CC) and/or major complications/comorbidities (MCC). The addition of CCs and MCCs represents a more medically complex payment, therefore resulting in increased relative weight and payment. The CC, MCC and non-CC are classified as types of Medicare Severity – DRG (MS-DRG).

Currently, malnutrition has been designated as a CC/MCC under the MS-DRG payment system, as listed below:

Code Number	Code Description	CC/MCC
E44.0	Moderate protein-calorie malnutrition	CC
E44.1	Mild protein-calorie malnutrition	CC
E45	Retarded development following protein-calorie malnutrition	CC
E46	Unspecified protein-calorie malnutrition	CC
E43	Unspecified severe protein-calorie malnutrition	MCC

While DRGs are critical to determining individual patient reimbursement rates, they also contribute to the facility's case mix index (CMI). The CMI accounts for the overall average severity of illness of patients admitted to the facility to provide payment more accurately to facilities that care for more medically complex patients. It utilizes the relative reight calculation, which reflects the average cost to provide care for the diagnosis relative to the average cost to provide care to all patients. The CMI is calculated by adding all the DRG weights for all Medicare discharges and dividing by the number of discharges[2]. Therefore, accurate diagnosis and documentation of malnutrition could impact reimbursement for individual patients, as well as the facility.

A hypothetical example of the impact of CCs and MCCs on the relative weight and estimated facility reimbursement is listed below[3]:

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[1] https://www.cms.gov/medicare/payment/prospective-payment-systems/acute-inpatient-pps#:~:text=This%20payment%20system%20is%20referred,Medicare%20patients%20in%20that%20DRG.
[2] https://www.cms.gov/medicare/medicare-fee-for-service-payment/acuteinpatientpps/acute-inpatient-files-for-download-items/cms022630
[3] https://webpricer.cms.gov/#/pricer/ipps

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DRG Number	DRG Name	Relative Weight	Estimated Reimbursement
370	Major Esophageal disorders	0.7487	$10,939.77
369	Major Esophageal disorders with CC (Moderate Malnutrition)	1.0221	$13,703.29
368	Major Esophageal Disorders with MCC (Severe Malnutrition)	1.7542	$21,103.40

Documentation of the presence and severity of malnutrition by the physician or eligible provider is essential to coding and billing for the condition. While the RDN provides valuable supporting evidence and is likely to determine interventions related to malnutrition, RDN documentation alone cannot be used for coding and billing purposes.

How should I diagnose and document malnutrition?

In July 2020, the US Department of Health and Human Services' Office of the Inspector General (OIG) issued a report related to incorrect billing of severe malnutrition, resulting in $1 billion in overpayments[4]. As a result, many facilities and the RDN staff approach malnutrition documentation, coding, and billing with significantly more caution. To ensure accurate and adequate documentation of malnutrition, RDNs should utilize the Nutrition Care Process (NCP), along with a valid and reliable nutrition assessment tool. While no one specific tool is recommended for nutrition assessment, examples of well-validated adult nutrition assessment tools include:

- Subjective Global Assessment[5]

- Mini Nutrition Assessment (MNA)[6]

Relying solely on biochemical data, such as albumin or pre-albumin, is not recommended. Components critical to coding and billing include the etiology of malnutrition, its severity, necessary interventions provided during the hospitalization, and recommendations for follow-up care post-discharge, if appropriate. Completing documentation utilizing the NCP helps to ensure each of these components is adequately and uniformly addressed, minimizing variation between clinicians, and improving continuity of care.

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[4] https://oig.hhs.gov/oas/reports/region3/31700010.asp

[5] Detsky, Allan S., et al. "What is subjective global assessment of nutritional status?." *Journal of parenteral and enteral nutrition* 11.1 (1987): 8-13.

[6] Guigoz, Yves, Bruno Vellas, and Philip J. Garry. "Assessing the nutritional status of the elderly: The Mini Nutritional Assessment as part of the geriatric evaluation." *Nutrition reviews* 54.1 (1996): S59.