Risk Adjustment Coding for Morbid Obesity and Malnutrition

Rob Janett, MD FACP
Medical Director for Accountable Care
Care New England
HCC Risk Coding

• General Concept Review:
  – Parent/Child codes
  – MEAT for documentation (manage, evaluate, assess, or treat
  – Focus on SCREENING at-risk patients for complicating conditions
  – Code every patient every year for chronic conditions
Risk adjustment success factors

Key is to capture the disease burden of the patients – payment depends on accurate diagnosis coding.

Codes need to be entered at least once a year.

Codes need to be specific and supported by documentation.

**Interventions:** Awareness, Education, Process Improvement, Maximizing Opportunities.

Problem list management and staff work flows can make accurate coding significantly easier.
Morbid Obesity--Tips

- Very common and often overlooked in coding
- We should always measure BMI on a yearly basis and during/after acute exacerbations of chronic illness
- Morbid Obesity = \( \text{BMI} \geq 40 \)
  - RAF score .365
  - ICD9 code 278.01
  - Don’t forget the “child code” of hypoventilation if the patient is also Pickwickian
  - Don’t forget the “child code” if there is venous stasis ulceration, heart failure, protein malnutrition
“All these years, and you haven’t listened to a damn thing I’ve said, have you?”
Protein Calorie Malnutrition

- Rarely coded in practice. Often overlooked.
- Lost clinical opportunity and lost HCC risk adjustment coding opportunity.
- Common: Prevalence 4% in community, 22% in SNF, 27% to 38% in hospitalized elders
- BMI < 18.5. Or low albumen, or significant recent weight loss, etc.
- RAF score .713
Values Commonly Used to Grade the Severity of Protein Calorie Nutrition

<table>
<thead>
<tr>
<th></th>
<th>Normal weight (%)</th>
<th>Body Mass Index</th>
<th>Serum Albumin (g/dL)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Normal</td>
<td>90% - 110%</td>
<td>19 - 24*</td>
<td>3.5 - 5.0</td>
</tr>
<tr>
<td>Mild Undernutrition</td>
<td>85% - 90%</td>
<td>18 - 18.9</td>
<td>3.1 - 3.4</td>
</tr>
<tr>
<td>Moderate Undernutrition</td>
<td>75% - 85%</td>
<td>16 - 17.9</td>
<td>2.4 - 3.0</td>
</tr>
<tr>
<td>Severe Undernutrition</td>
<td>&lt; 75%</td>
<td>&lt; 16</td>
<td>&lt; 2.4</td>
</tr>
</tbody>
</table>

*In the elderly, BMI <21 is associated with increased mortality risk.

Suggested parameters for evaluating significance of unplanned and undesired weight loss are:

<table>
<thead>
<tr>
<th>Interval</th>
<th>Significant Loss</th>
<th>Severe Loss</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 month</td>
<td>5%</td>
<td>&gt; 5%</td>
</tr>
<tr>
<td>3 months</td>
<td>7.5%</td>
<td>&gt; 7.5%</td>
</tr>
<tr>
<td>6 months</td>
<td>10%</td>
<td>&gt; 10%</td>
</tr>
</tbody>
</table>
Malnutrition

ICD 9 codes

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>260</td>
<td>Kwashiorkor</td>
</tr>
<tr>
<td>261</td>
<td>Nutritional marasmus</td>
</tr>
<tr>
<td>262</td>
<td>Oth severe malnutrition</td>
</tr>
<tr>
<td>2630</td>
<td>Malnutrition mod degree</td>
</tr>
<tr>
<td>2631</td>
<td>Malnutrition mild degree</td>
</tr>
<tr>
<td>2632</td>
<td>Arrest devel d/t malnutr</td>
</tr>
<tr>
<td>2638</td>
<td>Protein-cal malnutr NEC</td>
</tr>
<tr>
<td>2639</td>
<td>Protein-cal malnutr NOS</td>
</tr>
<tr>
<td>7994</td>
<td>Cachexia</td>
</tr>
</tbody>
</table>

Protein-calorie malnutrition commonly accompanies illnesses such as:

- Cancer
- Pancreatitis
- Alcohol Abuse and/or Dependence
- Obesity
- Celiac Disease
- ESRD
- Alcoholic Hepatitis
- Cirrhosis
- Anemia
- COPD
Take Home Messages

• Screen patients with BMI.
• For patients at risk for protein calorie malnutrition because of underlying medical illness or social/psychological problems: note the weight trajectory, screen with albumin or pre-albumin labs
• Treat malnutrition to prevent other complications
• For patient who are morbidly obese (BMI $\geq 40$) treat the obesity and screen for common complications of morbid obesity (sleep apnea, CHF, venous stasis, etc.)
• Document and code these important chronic conditions