Priority Health	BILLING POLICY No. 016
MALNUTRITION	
Date of origin: July 2024	**Review dates: 2/2025, 02/2026**

DEFINITION

The International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) includes the following types of severe malnutrition (listed by diagnosis code):

- **E40**: is a **billable diagnosis code** used to specify a medical diagnosis of kwashiorkor.
- **E41**: Nutritional marasmus – a form of serious protein-energy malnutrition caused by a deficiency in calories and energy and is found primarily in children
- **E42**: Is a **billable diagnosis code** used to specify a medical diagnosis of marasmic kwashiorkor.
- **E43**: Unspecified severe protein-calorie malnutrition – also known as starvation edema

These four diagnosis codes impact DRG reimbursement as they are classified as major complications or co-morbidities. It's essential to appropriately document all elements to diagnose severe malnutrition and select the appropriate malnutrition diagnosis to avoid overpayments.

A review of the results of the Mini Nutritional Assessment (MNA) across settings and countries in Europe, the United States and South Africa found the prevalence of malnutrition among 4,507 older adults (mean age 82.3, 75.2% female) was 22.8%. Rates were higher in the rehabilitation setting (50.5%) and lowest among community dwellers (5.8%). Over one-third of hospitalized older adults (38.7%) in this study met the criteria for malnutrition.

POLICY SPECIFIC INFORMATION

Criteria for diagnosing / identifying malnutrition severity

To accurately diagnosis and report severe malnutrition on a claim, start by confirming the presence of malnutrition and then validate to the level of severity.

Identifying the malnutrition severity through the following documentation will allow for coding to the highest level of specificity:

- Treatment protocols must match the severity reported on the claim.
- Clinical indicators such as contributing factors, nutritional support during hospital encounter, planned nutritional support post discharge must be defined within the medical record.
- A treatment plan for underlying etiology must be present.
- Any additional increased patient complexities or contributing etiologies should be detailed

The American Society for Parenteral and Enteral Nutrition (ASPEN) and the Global Leadership Initiative on Malnutrition (GLIM) have created criteria for use in diagnosing malnutrition along with scoring the severity.

Below is an overview of elements expected within the medical documentation for accurate coding of severe malnutrition. For the most up to date criteria, reference the links shared below.

ASPEN

The Guidelines & Standards - ASPEN speaks to a continuum of inadequate nutritional intake as well as increased requirements, impaired absorption, altered transport and altered nutrient use as contributing factors to malnutrition.

ASPEN defines situations where severe malnutrition occurs which includes acute illness injury, chronic illness and social or environmental circumstances. Documentation must define patient-specific situations and contributing factors to accurate coding for severe malnutrition.

The following criteria for the diagnosis of malnutrition have been recommended in a consensus statement from the Academy of Nutrition and Dietetics (Academy) and the American Society for Parenteral and Enteral Nutrition (ASPEN) in 2012:

Two or more of the following six characteristics:

- Insufficient energy intake
- Weight loss
- Loss of muscle mass
- Loss of subcutaneous fat
- Localized or generalized fluid accumulation that may mask weight loss
- Diminished functional status as measured by handgrip strength

GLIM

Additional criteria were introduced in 2018 from GLIM, established to develop a global consensus on the identification and diagnostic criteria for malnutrition to facilitate comparison of malnutrition prevalence, treatment and outcomes.

The FINAL factsheet_GLIM speak to the same contributing factors as ASPEN but also identify disease associated with inflammatory mechanisms, especially those related to chronic disease as a factor.
The new criteria include an appreciation of the role of acute and chronic inflammation, which is not represented in the International Classifications of Diseases 10th revision (ICD-10) codes.

The diagnosis requires the combination of at least one phenotype and one etiologic criteria:

- **Phenotype criteria**: Nonvolitional weight loss, low body mass index (BMI), or reduced muscle mass
- **Etiologic criteria**: Reduced food intake or absorption, or underlying inflammation due to acute disease/injury or chronic disease

Additional criteria

- **Acute illness/injury is present for less than three months**. Examples include multi-trauma, surgery, prolonged intubation, or hospitalization.
- **Chronic illness is present for three months or longer**. Examples include metastatic disease, chronic lung disease, or HIV disease.
- **Social and environmental circumstances** limit access or ability to self-care.

Lab parameters

Lab parameters used to support or indicate severe malnutrition include:

- Albumin < 2.0 gm/dL and/or pre-albumin < 5 mg/dL
- Usual body weight < 75 % with Unintended weight loss of >5% in one month
- Unintended weight loss of >7.5% in three months
- Unintended weight loss of >10% in six months OR
- Unintended weight loss of >20% in one year

Albumin and prealbumin levels are highly nonspecific for malnutrition, but when malnutrition is known to be present, they may be useful indicators of severity.

Reference to the most up to date criteria as defined by ASPEN and GLIM as they may provide updates before this Priority Health policy reflects them.

DISCLAIMER

CMS and/or MDHHS guidelines apply unless otherwise specified in this policy or provider manual. Where such guidance is absent, this policy applies. Priority Health's billing policies outline our guidelines to assist providers in accurate claim submissions and define reimbursement or coding requirements if the service is covered by a Priority Health member's benefit plan. The determination of visits, procedures, DME, supplies and other services or items for coverage under a member's benefit plan or authorization isn't being determined for reimbursement. Authorization requirements and medical necessity requirements are appropriate to procedure; diagnosis and frequency are still required. We use Current Procedural Terminology (CPT), Centers for Medicare and Medicaid Services (CMS), Michigan Department of Health and Human Services (MDHHS), and other defined medical coding guidelines for coding accuracy.

An authorization isn't a guarantee of payment when proper billing and coding requirements or adherence to our policies aren't followed. Proper billing and submission guidelines must be followed. We require industry standards, compliant codes defined by CPT, HCPCS, and revenue codes for all claim submissions. CPT, HCPCPS, revenue codes, etc., can be reported only when the service has been performed and fully documented in the medical record to the highest level of specificity. Failure to document services rendered or items supplied will result in denial. To validate billing and coding accuracy, payment integrity pre- or post-claim reviews may be performed to prevent fraud, waste and abuse. Unless otherwise detailed in the policy, our billing policies apply to both participating and non-participating providers and facilities.

If guidelines detailed in government program regulations, defined in policies and contractual requirements aren't followed, Priority Health may:

- Reject or deny the claim
- Recover or recoup claim payment

An authorization on file for an item or services doesn't supersede coding, billing or reimbursement requirements.

These policies may be superseded by mandates defined in provider contracts or state, federal or CMS contracts or requirements. We make every effort to update our policies in a timely manner to align these requirements or contracts. If there's a delay in implementation of a policy or requirement defined by state or federal law, as well as contract language, we reserve the right to recoup and/or recover claim payments to the effective dates per our policy. We reserve the right to update policies when necessary. Our most current policy will be made available in our Provider Manual.

CHANGE / REVIEW HISTORY

Date	Revisions made
Feb. 5, 2025	Added "Disclaimer" section
02/2026	Additions of diagnosis E40 and E42. Updated links to ASPEN and GLIM criteria