Key coding considerations for malnutrition

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News & Insights

A review 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%. According to research on older adults with acute hospitalization, up to 71% are at nutritional risk or are malnourished. The elderly are at greater risk due to increased comorbidities; related organ system compromise; and the reduced ability to access, prepare, and ingest food.

Documentation of underweight or abnormal weight loss will not impact DRG [diagnosis-related group] assignment as a comorbidity, but these diagnoses do impact hospital quality metrics and rankings.

Abnormal weight loss, cachexia, and protein-calorie malnutrition are equally weighted and significantly impact publicly reported hospital rankings and PSI [patient safety indicator] metrics. Underweight is not included. Documentation should demonstrate reportability as a significant diagnosis.

Cachexia provides a CC [complication or comorbidity] as a secondary diagnosis and will continue to impact CMS-HCC [hierarchical condition category] risk adjustment until version 28 is fully phased in in 2026. Documentation should identify the underlying chronic illness and disease processes contributing to the compromised state.

Codes E40, E41, and E42 (kwashiorkor, nutritional marasmus, and marasmic kwashiorkor, respectively) rarely should be seen in the United States. The presence of these codes on a claim likely will trigger an audit; if they are used, the documentation should demonstrate clear support of their presence.

Coders should be alert to all comorbidities often accompanying malnutrition, including the presence of chronic illness, malignancies, depression, non-healing wounds, prolonged ventilation time, functional quadriplegia, or substance abuse/dependence.

Malnutrition may be overlooked in the obese population because weight loss may not be as apparent and/or may be assumed to be intentional when it wasn't so. The physician must still apply diagnostic criteria to the patient. A statement of weight loss from the physician is not enough; specification of how much weight loss over what period of time is needed. Physicians should also document whether the weight loss was intentional.

Vitamin deficiencies are very common after a gastric bypass, especially if the patient does not take all of the vitamin and mineral supplements as ordered. Documentation of noncompliance is needed as well as the specific deficiencies. The documentation should identify the deficits related to micronutrients (Vitamins B1, B6, and B12; folic acid; vitamins C, A, D, and E; zinc; chromium; and selenium).

Documentation should indicate the primary source of calories as well as an education plan related to diet choices.

Social determinants of health influence a patient's health status and should be considered in both assessment and treatment plans. Review records with consideration of challenges such as housing insecurity, food insecurity, low income, and material hardship.

Editor's note: *This article is an excerpt from the "2025 JustCoding Pocket Guide" by Laurie Prescott, RN, MSN, CCDS, CDIP, CRC, CCDS-O, and Shannon E. McCall, RHIA, CCS, CCS-P, CPC, CPC-I, CEMC, CRC, CCDS.*

Related Topics:
Coding, Documentation improvement

Best practices for documenting bacterial culture lab tests

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News & Insights

CMS determined the improper payment rate for bacterial culture lab tests was 15.1% in 2023, with a projected improper payment amount of $9.6 million. Insufficient documentation accounted for 100% of improper payments for these tests during this reporting period, according to the agency. Revenue cycle professionals should review CMS' provider compliance tip to better understand lab test order requirements and prevent denials.

The physician, practitioner, or non-physician practitioner who is treating the patient must order the test(s). The provider must be consulting or treating the patient for a specific medical problem and use the results to manage it.

Medical necessity must be documented in the medical record when ordering the service, according to CMS. The entity submitting the claim must have the following:

- Documentation of the order for the service billed, including the provider's contact information
- Documentation showing correct order processing and claim submission
- Diagnostic or other medical information provided to the lab

Diagnostic lab test orders require one of the following:

- Signed order or prescription listing the specific test
- Unsigned order or lab prescription listing specific tests done
- Authenticated medical record supporting the intent to order specific tests

Providers can deliver orders via phone, email, or a written and signed document that is hand-delivered, mailed, or faxed to the testing facility, according to CMS. The agency does not need the provider's signature on orders for clinical diagnostic tests paid based on the clinical lab fee schedule, based on the physician fee schedule, or for physician pathology services.

Revenue cycle professionals can read Chapter 6 of the *Medicare Program Integrity Manual* for more information on order requirements, as well as Chapter 15 of the *Medicare Benefit Policy Manual* for more information on delivery requirements. Access CMS' fact sheets on medical record documentation requirements and Medicare signature requirements for additional guidance.

Editor's note: *A version of this article originally appeared in* Revenue Integrity Insider*, NAHRI's weekly e-newsletter.*

Related Topics:
Billing and reimbursement, Documentation improvement, Medicare news

CMS issues 2026 IPPS proposed rule

April 16, 2025
News & Insights

On April 11, CMS published a draft copy of the fiscal year (FY) 2026 Inpatient Prospective Payment System (IPPS) final rule to detail potential changes to Medicare inpatient coding and billing.

CMS is proposing a 2.4% increase in operating payments for acute care hospitals, which reflects a projected FY 2026 hospital market basket percentage increase of 3.2%, reduced by a 0.8 percentage point productivity adjustment. The agency expects the proposed changes to operating and capital IPPS payment rates to boost hospital payments by $4 billion.

CMS also detailed its proposed transition plan for the discontinuation of the low-wage index policy for FY 2026 and subsequent years. This proposal stems from a recent court order to vacate certain policies and budget neutrality adjustments. The agency is proposing to adopt a budget-neutral narrow transitional exception to the calculation of 2026 IPPS payments for low-wage index hospitals that would be significantly impacted throughout the transition.

The proposed rule includes several modifications to various quality and reporting programs, including adjustments to certain Hospital Inpatient Quality Reporting (IQ) Program measures. CMS is proposing to change the risk adjustment methodology, shorten the performance period, and add Medicare Advantage patients to the current cohort for the following IQR measures:

- Hospital-Level, Risk-Standardized Complication Rate Following Elective Primary Total Hip Arthroplasty and/or Total Knee Arthroplasty
- Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate Following Acute Ischemic Stroke Hospitalization with Claims-Based Risk Adjustment for Stroke Severity

Along with other IQR measure modifications, CMS is proposing to remove the following measures:

- Hospital Commitment to Health Equity beginning with the CY 2024 reporting period/FY 2026 payment determination
- COVID-19 Vaccination Coverage among Health Care Personnel measure, beginning with the CY 2024 reporting period/FY 2026 payment determination
- Screening for Social Drivers of Health and Screen Positive Rate for Social Drivers of Health measures, beginning with the CY 2024 reporting period/FY 2026 payment determination

CMS is also proposing changes to the Medicare Promoting Interoperability Program, Hospital Readmissions Reduction Program, Hospital-Acquired Condition Reduction Program, and more. In addition, the agency is proposing to update current Extraordinary Circumstances Exception (ECE) policy to clarify that it has the discretion to grant an extension rather than only a full exception in response to ECE requests.

The rule includes nearly 500 new ICD-10-CM codes that would take effect on October 1, if finalized. The proposals include a new code for type 2 diabetes mellitus in remission, as well as more than 100 new codes to capture non-pressure chronic ulcers in various stages. Revenue cycle professionals can view Part B News' analysis of the code proposals for more information.

Finalized in the 2025 IPPS final rule, the Transforming Episode Accountability Model (TEAM) is a bundled payment model scheduled to run from January 2026 to December 2030. CMS is proposing several changes to TEAM, including a limited deferment period for certain hospitals and removing health equity plans.

The proposed rule is expected to be published in the *Federal Register* on April 30. The agency is seeking feedback on several proposals in the rule, and comments are due on June 10. Revenue cycle professionals can read CMS' fact sheet and press release for more information on the proposed changes.

Related Topics:
Billing and reimbursement, Coding, IPPS, Medicare news

CMS issues CY 2026 MA and Part D final rule

April 23, 2025
News & Insights

CMS recently issued a final rule to detail policy and technical changes to Medicare Advantage (MA) and Part D programs for contract year (CY) 2026. The rule finalized proposals related to the MA appeals process, implementation of the Medicare Prescription Payment Plan program, and more.

CMS finalized several proposals aimed at closing loopholes in MA appeals processes that adversely affect providers and enrollees. The agency clarified that the definition of an "organization determination" includes an MA plan's decision made concurrently with the enrollee's receipt of services. Other steps taken include codifying existing guidance on provider and enrollee notifications, as well as modifying existing regulations to clarify enrollees' liability.

CMS finalized its proposal to restrict MA plans' ability to reopen and modify a previously approved inpatient hospital decision based on information gathered after the approval. Moving forward, these plans can only reopen an approved admission for obvious error or fraud, according to the agency.

The final rule codifies several Inflation Reduction Act (IRA) provisions, including certain vaccine and insulin cost-sharing requirements that were set to expire at the end of CY 2025. CMS finalized its proposal to codify parts one and two of final guidance released in 2025 for the Medicare Prescription Payment Plan, with minor modifications. The agency finalized a requirement for an automatic election renewal process that would continue a Part D enrollee's participation in the program until they opt out.

The final rule also includes provisions related to special supplemental benefits for the chronically ill, risk adjustment data updates, dual eligible special needs plans, and more. Of note, CMS opted not to finalize the Biden administration's proposals to expand Part D coverage of anti-obesity medications, require an annual health equity analysis of utilization management policies, and add new artificial intelligence guardrails in the MA program.

CMS also released the 2026 MA and Part D rate announcement to detail new MA payment factors and changes to the Part D benefit that reflect IRA provisions taking effect on January 1, 2026. The updates include the 2026 out-of-pocket threshold, liability changes related to the Medicare Drug Price Negotiation Program, and the establishment of the selected drug subsidy program.

These regulations take effect on June 3. Read CMS' fact sheets on the final rule, rate announcement, and redesign program instructions for more information.

Editor's note: This article originally appeared in Revenue Integrity Insider*, NAHRI's weekly e-newsletter.*

Related Topics:
Billing and reimbursement, Medicare news

Dissecting expanded Part B coverage of hepatitis B vaccines

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News & Insights

CMS recently expanded coverage of hepatitis B vaccines and their administration, enabling mass immunizers to submit these claims under the same roster billing system used for the flu, pneumococcal, and COVID-19 vaccines.

The agency revised 42 *CFR* § 410.63(a)(2) to expand the list of individuals who are at a high or intermediate risk of contracting hepatitis B and qualify for Part B coverage. Effective January 1, 2025, patients who have not previously received a completed hepatitis B vaccination series or have an unknown vaccination history also fall within the intermediate-risk group.

CMS clarified that a doctor's order is no longer necessary to administer the hepatitis B vaccine under Part B. Revenue cycle professionals can find more information on place of service codes, simplified roster claims, and more in *Medicare Claims Processing Transmittal 13091*.

CMS pays roster bills for hepatitis B vaccine and administration claims in the same way it does for other Part B vaccines. The products are paid at 95% of their average wholesale price, and the administration is paid according to the Part B vaccine administration fee schedule.

Organizations that administer hepatitis B vaccines must ensure staff are aware of the updated coverage criteria, and mass immunizers should review the related roster billing processes. Learn more about roster billing here.

Editor's note: This article originally appeared in Revenue Integrity Insider*, NAHRI's weekly e-newsletter.*

Related Topics:
Billing and reimbursement, Coding, Medicare news

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