



Applicable To:

- Medicare
- Medicaid – excluding AZ, FL, HI, KY, NC

**Claims and Payment Policy:
Incorrect Billing for Severe
Malnutrition**

Policy Number: CPP-145

Original Effective Date: 8/1/2020

Revised Date(s): N/A

BACKGROUND

The World Health Organization (WHO) defines **malnutrition** as deficiencies, excesses, or imbalances in a person's intake of energy and/or nutrients. The term malnutrition addresses 3 broad groups of conditions: undernutrition, which includes wasting (low weight-for-height), stunting (low height-for-age) and underweight (low weight-for-age). **Severe malnutrition** can be defined as a very low weight to height ratio, visible severe wasting, or by the presence of nutritional oedema (abnormal fluid retention in the tissues). Severe malnutrition is responsible, directly or indirectly, for 35% of deaths among children under five worldwide.

The three major types of malnutrition are **kwashiorkor, nutritional marasmus, and marasmic kwashiorkor**. Kwashiorkor is a nutritional disorder most often seen in regions experiencing famine. It is a form of malnutrition caused by a lack of protein in the diet. Kwashiorkor is also known as "edematous malnutrition" because of its association with edema (fluid retention). Nutritional marasmus is a form of severe malnutrition characterized by energy deficiency. It can be distinguished from kwashiorkor in that kwashiorkor is a protein deficiency with adequate energy intake, whereas marasmus is inadequate energy intake in all forms, including protein. Marasmic kwashiorkor is the most severe form of protein-energy malnutrition in children, with a weight for height ratio less than 60% of that expected, and with oedema as well as other symptoms of kwashiorkor

The Academy of Nutrition and Dietetics (Academy) and the American Society for Enteral and Parenteral Nutrition (A.S.P.E.N.) developed consensus recommendations for diagnosis of malnutrition in adults (2012) and children (2013). The ASPEN consensus statement for malnutrition in children pertain to infants and neonates who are older than 37 weeks corrected gestational age (CGA) and 30 days of age and older.

In 2013, the American Society for Parenteral and Enteral Nutrition (ASPEN) group defined **pediatric malnutrition** (undernutrition) as an imbalance between nutrient requirement and intake, resulting in cumulative deficits of energy, protein, or micronutrients that may negatively affect growth, development, and other relevant outcomes. Based on its etiology, malnutrition is either **(1)** illness related (1 or more diseases/injuries directly result in nutrient imbalance) or **(2)** caused by environmental/ behavioral factors associated with decreased nutrient intake/ delivery (or both).

In 2018, in order to address the lack of criteria for malnutrition in neonates, Goldberg et al.(2018), published criteria for malnutrition in preterm neonates up to 1 month of age (or 28 days of age) in the Journal of the Academy of Nutrition and Dietetics Preterm neonates are defined as having been born earlier than 37 weeks of gestation. The Goldberg Criteria defines mild to severe malnutrition in full-term, post-term neonates and preterm neonates based on deficits in nutrient intake and growth.

Those adults who lack adequate calories, protein, or other nutrients needed for tissue maintenance and repair experience undernutrition. In acute, chronic, and transitional care settings, recognition and treatment of adult undernutrition are a primary concern.

Malnutrition is classified as either **acute** (fewer than 3 months in duration) or **chronic** (duration of 3 months or more) based on the National Center for Health Statistics' (NCHS) definition of "chronic" as a disease or condition that lasts three months or longer. Chronic malnutrition may manifest with growth deficits, especially diminished height velocity (stunting), which is a hallmark of this condition that may be observed earlier than 3 months in the course of malnutrition.

CLINICAL CRITERIA

ASPEN Malnutrition Criteria for Children and Adults

For malnutrition in children, the 2013 ASPEN (American Society for Parental and Enteral Nutrition) Criteria for pediatric suggested 5 domains as consensus recommendations defining pediatric malnutrition:

- Anthropomorphic parameters (Z-scores)
- Growth
- Chronicity of malnutrition (Acute or Chronic)
- Etiology and pathogenesis (Illness v. Non-Related)
- Developmental/functional outcomes

These consensus recommendations broadly divided malnutrition based on etiology: non-illness related v. illness-related (socio-economic, starvation) and acute v. chronic illness and inflammation. This classification also highlighted various etiologic mechanisms such as starvation, malabsorption, nutrient loss, inflammatory state, nutrient imbalance, hypermetabolism leading to malnutrition and functional loss such as lean body mass loss, weakness, developmental delay, immunocompromised state, poor wound healing and prolonged hospital stay. Severity of malnutrition was only indicated under chronic malnutrition.

Measurements include, Z-scores for weight-for-height/length, Body Mass Index (BMI), Head Circumference (HC) and Mid-Upper Arm Circumference (MUAC) which is an important proxy for weight. MUAC is an important indicator of clinically significant malnutrition because this measurement changes little in childhood, and with values less than 11.0 cm can be a predictor of mortality within 6 months. MUAC can also be used as an independent indicator of malnutrition in the setting of increased body fluid such as ascites and steroid-induced edema where presence of edema could confound any underlying weight loss due to malnutrition. Hence, MUAC has been recommended as an important criteria alone or in combination with other criteria for diagnosing severe malnutrition by the American Academy of Pediatrics.

BMI in children is compared with sex- and age-specific reference values. A BMI of 17 kg/m² approximates the -2 SD cutoff for a diagnosis of wasting. Wasting is defined as a weight-for-age less than -2 SD (z score). Chronic undernutrition or stunting is defined by WHO as having a height-for-age (or length-for-age) that is less than -2 SD (z

score) of the median of the NCHS/WHO international reference. Wasting or stunted growth indicates chronic undernutrition that is significant yet may not reach the threshold of a diagnosis of severe malnutrition as defined by ASPEN criteria.

Wasting and stunting are to be differentiated from severe malnutrition which is defined in part by BMI Z-scores less than -3 SD and predicted hospital mortality in one international study. Hence, Z-scores greater than -3 standard deviations is an additional valuable marker to diagnose significant malnutrition.

The 2012 ASPEN Criteria redefined malnutrition in adults as “undernutrition” classified in three distinct contexts: acute, chronic, and social environmental. The distinction between acute and chronic illness is based on the National Center for Health Statistics' (NCHS) definition of “chronic” as a disease or condition that lasts three months or longer. The ASPEN criteria do not specifically define “social-environmental,” but is intended for those whose nutrition is chronically deficient because of such factors as living environment, debility, non-adherence, lack of social support, and similar circumstances. Once a patient meets the criteria for “undernutrition,” the term “malnutrition” is to be used in documentation.

According to the ASPEN Criteria malnutrition should be diagnosed when there are at least *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 sometimes mask weight loss and 6. Diminished functional status as measured by hand grip strength

It should be noted that the ASPEN Criteria only distinguish severe from non-severe malnutrition and does not specifically identify mild or moderate malnutrition.

Other established lab parameters indicating 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.

“In 2018, an international group published another classification for malnutrition known as the Global Leadership Initiative on Malnutrition (GLIM) based on consensus recommendations using a criteria set of five nutritional factors and which can complement other definitions for malnutrition.”

The criteria set includes 3 phenotypic (clinical assessment) criteria such as non-volitional weight loss, low body mass index, and reduced muscle mass and 2 etiologic criteria (including reduced food intake or assimilation, and inflammation or disease burden).

The GLIM Criteria requires that at least 1 phenotypic criterion and 1 etiologic criterion should be present for a diagnosis of malnutrition.

However, severe malnutrition is linked solely to the phenotypic (clinical assessment) and requires 1 phenotypic criterion (such as 10% -20% weight loss, low BMI or muscle wasting).

GLIM Phenotypic Criteria:

- Non-volitional weight loss
- Low body mass index
- Reduced muscle mass

GLIM Etiologic Criteria:

- Reduced food intake/assimilation
- Inflammation/disease burden

The GLIM criteria offer some advantages over the 2012 ASPEN Malnutrition Consensus criteria. While the ASPEN criteria is effective for diagnosing malnutrition, it was less so for defining severe malnutrition. The GLIM criteria are less subjective, more clinically intuitive and include weight loss, muscle mass, and BMI parameters that are more consistent with the traditional concepts of non-severe and severe malnutrition.

The GLIM criteria can only be used to identify moderate malnutrition (E 46-unspecified malnutrition) or severe malnutrition (ICD-10: E43- unspecified severe protein-calorie malnutrition) (see section on [Summary of Criteria Sets for Severe Malnutrition in Adults and Children and Group A Criteria](#)).

Hence, BMI ranges given in the GLIM classification is not universally accepted for malnutrition. According to the GLIM classification the phenotypic (clinical) determination of severe malnutrition can be established with a BMI < 18.5. However, the authors of GLIM also indicate that there is substantial regional variation in the use of low BMI as a phenotypic (that is, clinical criteria) for malnutrition diagnosis.

The experience from the current U.S. population is that people are often overweight or obese and would need to lose substantial weight before low BMI designation could be assigned by their provider. In other words, if the BMI cut off < 18.5 is used to diagnose severe malnutrition it would not accurately identify severe malnutrition due to a high prevalence of obesity. **Hence, although the GLIM criteria suggests a diagnosis of severe malnutrition is indicated by a BMI < 18.5, it does not appear to be universally applicable.**

BMI and Malnutrition Criteria

Body Mass Index (BMI) is a person's weight in kilograms divided by the square of height in meters. A high BMI can be an indicator of unhealthy weight gain (referred to by the WHO and CDS as fatness or obesity). Overweight and obesity are defined as abnormal or excessive fat accumulation that may impair health according to the World Health Organization (WHO). BMI can be used to screen for weight categories that may lead to health problems but it is not diagnostic of the body fatness or health of an individual. However, it should be considered a rough guide because it may not correspond to the same degree of (unhealthy weight gain or fatness or obesity) fatness in different individuals. BMI provides the most useful population-level measure of overweight and obesity as it is the same for both sexes and for all ages of adults.

According to the CDC,

- If your BMI is less than 18.5, it falls within the underweight range.
- If your BMI is 18.5 to <25, it falls within the normal.
- If your BMI is 25.0 to <30, it falls within the overweight range.
- If your BMI is 30.0 or higher, it falls within the obese range.

Given that the CDC range of normal BMI is 18.5-24.9, a BMI < 18.5 would not be sufficient to establish a diagnosis of severe malnutrition. Instead, a BMI < 18.5 indicates a state of undernutrition or being underweight.

Table 1: BMI Classification of Malnutrition

Classification	BMI Principal Cut-off Points
<i>Underweight</i>	<18.50
Severe Malnutrition	<16.00
Moderate Malnutrition	16.00–16.99
Mild Malnutrition	17.00–18.49
Normal Range	18.50–24.99
<i>Overweight</i>	>25.00
Pre-Obese	25.00–29.99
<i>Obese</i>	>30.00
Obese Class I	30.00–34.99
Obese Class II	35.00–39.99
Obese Class III (Morbid Obesity)	>40.00

A patient’s body mass index (BMI) is one of the most important indicators of malnutrition and severity of malnutrition. BMI may also be used to determine the degree of malnutrition, with normal values as defined by the Center for Disease Control and Prevention Body Mass Index. Center for Disease Control and Prevention.

Malnutrition & Obesity Body Mass Index (BMI) is a reportable HEDIS/Star healthcare quality measurement BMI can provide sound clinical information on a person’s nutritional status. In order to determine that patients are at a healthy weight, the provider should record their height and weight, calculate the BMI, and document the BMI in the chart at least once or twice a year.

Severe malnutrition requires the most appropriate and most specific level of coding as well as specific and clear documentation in hospital medical records by the attending physician to support criteria.

Due to variability in applicability of various criteria and the lack of a single defining criteria, the Criteria A, B and C are a compilation of various classifications, including criteria from ASPEN, GLIM and American College of Physicians (ACP) Hospitalist criteria, thereby providing a comprehensive criteria set that is clinically relevant to physicians.

For purposes of reimbursement of inpatient claims for severe malnutrition, ALL the following criteria need to be clearly documented in the inpatient hospital records by the physician or licensed independent practitioner (LIP):

Summary of Criteria Sets for Severe Malnutrition in Adults and Children:

Severe malnutrition is indicated if at least 2 criteria are met from criteria Group A, **OR**, if at least 2 criteria are met from criteria Group B **OR** if at least ONE criteria is met for Group C:

Group A Criteria (Includes GLIM Criteria for Adults and ASPEN Criteria for Children):

1. BMI < 16 Kg/m² (if age > 18 years) or (BMI-for-Age Z-score or Length/Ht for Age Z-score or Weight-for-Height Z-score (WHZ) or length Z-scores > 3 standard deviations below median OR mid-upper arm circumference ((MUAC) < 11.5 cm or > 3 standard deviations below median (if age < 18 years), **OR**
2. Inadequate weight gain or nutrient intake as indicated by 1 or more of the following:
 - a. Age 23 months or younger and gaining less than 25% of expected weight (reduced weight gain velocity) **OR**
 - b. Age 2 to 18 years and unintentional loss of 10% or more of his or her usual body weight **OR**
 - c. Deceleration in weight for ht/length-Z-scores > 3 standard deviations below median
3. Albumin < 2.4 gm/dL and/or Prealbumin < 5 mg/dL **OR**
4. Current body weight < 70% of usual body weight **OR**
5. Unintended weight loss indicate by at least 1 or more of the following :
 - a. >5% in one month, **OR**
 - b. >7.5% in three months, **OR**
 - c. >10% in six months, **OR**
 - d. >20% in one year **OR**
 - e. Current body weight is < 70 % Ideal Body Weight (IBW) **OR**

Group B Criteria: (Aspen Criteria for Adults) :

1. Unintended weight loss indicate by at least 1 or more of the following :
 - a. >5% in one month, **OR**
 - b. >7.5% in three months, **OR**
 - c. >10% in six months, **OR**
 - d. >20% in one year **OR**
 - e. Current body weight is < 70 % Ideal Body Weight (IBW) **OR**
2. Decreased energy intake: ≤75% of estimated energy requirement for up to 3 months, **OR**
3. Documented severe muscle wasting **OR**
4. Documented severe loss of subcutaneous fat, **OR**

5. Measurably and reproducible reduced grip strength, **OR**
6. Documented severe fluid accumulation (edema)

Group C Criteria: Goldberg Criteria for Neonatal Malnutrition (use for neonates up to age of 1 month or 28 days of life):

1. For age > 2 weeks of life:
 - a. Decline in weight-for-age Z score: decline of >2 SD (standard deviations) **OR**
 - b. Weight gain velocity: < 25% of expected rate of weight gain to maintain growth rate **OR**
 - c. Nutrient intake: ≥ 7 consecutive days of protein/energy intake provides ≤75% of estimated needs **OR**
 - d. Linear growth velocity: < 25% of expected rate of linear gain to maintain expected growth rate **OR**
 - e. Decline in length-for-age Z score: Decline of > 2 SD (standard deviations) **OR**
 - f. Days to regain birthweight: > 21 days AND Use in conjunction with nutrient intake : ≥7 consecutive days of protein/energy intake provides ≤ 75% of estimated needs
2. For Neonatal age < 2 weeks of life:
 - a. Nutrient intake: ≥7 consecutive days of protein/energy intake provides ≤ 75% of estimated needs

POSITION STATEMENT

In accordance with CMS and ICD-10 CM Coding Guidelines, WellCare may retrospectively audit providers regarding diagnosis assignment of severe malnutrition. Wellcare will perform a lookback of claims and medical records for appropriate coding and medical necessity of severe malnutrition codes that are not submitted as the primary diagnosis. If the severe malnutrition diagnosis was inappropriately used, Wellcare will recover the difference in the payment amount.

CODING & BILLING

MS-DRG Classification

Medicare uses a classification system titled Medicare Severity Diagnosis Related Groups (MS-DRGs), and most state Medicaid programs use a similar classification system titled All Patient Refined DRGs (APR-DRGs).

The principal diagnosis necessitating hospital admission decides the diagnosis related group (DRG) to which the patient's stay is assigned. Secondary diagnoses, known as comorbidities or complications (CCs) and major comorbidities or complications (MCCs), can increase the cost of care above that required if the patient only suffered from the principal diagnosis.

When these secondary diagnoses are coded, the patient may be assigned to a different DRG with a higher severity level. Each MS-DRG has an associated relative weight (RW) that is multiplied by the hospital's base rate (also known as the Medicare standardized payment rate) to determine the amount of reimbursement due to the hospital.

An MCC reflects the highest level of severity for a secondary diagnosis, and results in increased use of hospital resources. MCCs for nutrition include severe malnutrition, protein malnutrition and emaciation. CCs result in increased hospital resource use as well, but to a lesser extent than MCCs. CC diagnoses include unspecified malnutrition, protein-energy undernutrition, cachexia, and body mass index less than 19 kg/m².

The ICD-10 Classification for Malnutrition includes the following definitions that are considered severe and assignment of a higher weight for MS-DRG as a MCC condition is permissible.

Unless Kwashiorkor or Nutritional Marasmus are specifically documented by the physician in the medical record, these conditions **should not** be substituted for unspecified severe protein-calorie-malnutrition (E-43) (Kwashiorkor (E-40) and Marasmic kwashiorkor (E42).

Nutritional edema with “dyspigmentation of skin and hair” should **rarely** be used in the U.S.

Nutritional Marasmus is described in ICD-10 as “nutritional atrophy, severe malnutrition otherwise stated; severe energy deficiency” and should **rarely** be used in the U.S.

Severe malnutrition is described in ICD-10 as “Unspecified severe protein-calorie; Other severe protein calorie malnutrition; Nutritional edema without mention of dyspigmentation of skin and hair.”

Emaciation (due to malnutrition) is tabulated as Nutritional Marasmus and **should not** be used when the physician only describes thin appearance without diagnosis of malnutrition.

Emaciation is a descriptive term and by itself **cannot** be used to document or code Nutritional Marasmus (E41).

Medical Record Audit Support

The Office of the Inspector General (OIG) reviewed medical records at the University of Wisconsin and revealed that physicians were billing severe malnutrition diagnosis codes when codes for other forms of malnutrition were supported through medical record documentation. In some cases, documentation did not even support a malnutrition diagnosis. In accordance with the OIG findings, Wellcare Health Plans will post-pay retrospectively review medical records when a severe malnutrition diagnosis code (E40, E41, E42, and E43) is not billed as the primary diagnosis in order to determine if a more appropriate diagnosis should apply.

ICD-10 Codes

E40	Kwashiorkor
E41	Nutritional marasmus
E42	Marasmic kwashiorkor
E43	Unspecified severe protein-calorie malnutrition

Coding information is provided for informational purposes only. The inclusion or omission of a CPT, HCPCS, or ICD-10 code does not imply member coverage or provider reimbursement. Consult the member's benefits that are in place at time of service to determine coverage (or non-coverage) as well as applicable federal/ state laws.

DEFINITIONS

Cachexia	General weight loss and wasting, as occurs in the course of chronic disease or emotional disturbance.
Emaciation	Excessive leanness caused by disease or lack of nutrition, and characterized by an extreme loss of subcutaneous fat that results in an abnormally lean body.
Kwashiorkor	Also known as “edematous malnutrition” because of its association with edema (fluid retention), is a nutritional disorder most often seen in regions experiencing famine. It is a form of malnutrition caused by a lack of protein in the diet. People who have kwashiorkor typically have an extremely emaciated appearance in all body parts except their ankles, feet, and belly, which swell with fluid.
Nutritional marasmus	A form of severe malnutrition characterized by energy deficiency. It can be distinguished from kwashiorkor in that kwashiorkor is protein deficiency with adequate energy intake whereas marasmus is inadequate energy intake in all forms, including protein.
Marasmic kwashiorkor	The most severe form of protein-energy malnutrition in children, with weight for height less than 60% of that expected, and with oedema and other symptoms of kwashiorkor.
Protein-energy undernutrition (PEU)	Formerly called protein-energy malnutrition, PEU can be gradual, or sudden and total. Severity ranges from subclinical deficiencies to obvious wasting (with edema, hair loss and skin atrophy) to starvation. Multiple organ systems are often impaired, and diagnosis usually involves lab testing, including serum albumin. PEU is common among the institutionalized elderly, and among patients with disorders that decrease appetite or impair nutrient digestion, absorption or metabolism.
Protein malnutrition	Undernutrition resulting from inadequate intake of protein.

Severe malnutrition	Values of patients who are severely malnourished include being less than 75% of normal weight, having a BMI of less than 16 kg/m ² , serum albumin level less than 2.4 g/dL, serum transferrin level less than 150 mg/dL, and total lymphocyte count less than 800 cells/mm ³ .
Unspecified malnutrition	Used in the absence of further descriptive terminology, such as the severity or type of malnutrition, in the physician's documentation
Unspecified severe protein-calorie malnutrition	Is a form of malnutrition that is defined as a range of pathological conditions arising from coincident lack of dietary protein and/or energy (calories) in varying proportions. The condition has mild, moderate, and severe degrees.

REFERENCES

1. AAP Pediatric Nutrition Handbook. 6th ed. Elk Grove Village, IL: American Academy of Pediatrics; 200.
2. ACP Hospitalist. CODING CORNER | AUGUST 2009 Reporting malnutrition. Accessed on December 9, 2019
3. Acute Care Hospital Inpatient Prospective Payment System. Medicare Learning Network website. Available at <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/acutepaymntssysfctst.pdf> Accessed 9 December, 2019.
4. AHA Coding Clinic. Third Quarter ICD-10 2017. Pages 25-26.
5. Body Mass Index. Center for Disease Control and Prevention Retrieved from: [Body Mass Index \(BMI\) | Healthy Weight | CDC](https://www.cdc.gov/healthyweight/assessing/bmi/healthyweight/whowebster/index.html) Updated July 16, 2014. Accessed December.
6. Consensus Statement of the Academy of Nutrition and Dietetics/American Society for Parenteral and Enteral Nutrition: Indicators Recommended for the Identification and Documentation of Pediatric Malnutrition (Undernutrition) Nutrition in Clinical Practice Volume 30 Number 1 February 2015 147–161 © 2014.
7. Department of Health and Human Services Office of the Inspector General: Retrieved from: https://wellcareportal.wellcare.com/Operations/WPMO/PPT/Shared%20Documents/QA/IS/2019PHS_3.181%20IN CORRECTLY%20BILLED%20CLAIMS%20FOR%20SEVERE%20MALNUTRITION/VALUATION-IDEATION/Research/OIG%20Article%20on%20Providers%20incorrectly%20billing%20severe%20malnutrition.pdf Accessed December 6, 2019.
8. HealthLine. Retrieved from: <https://www.healthline.com/health/kwashiorkor> Accessed December 6, 2019.
9. Healthline. Retrieved from: <https://www.healthline.com/health/marasmus#overview1> Accessed December 6, 2019.
10. Journal of the Academy of Nutrition and Dietetics, Goldberg DL, Becker PJ, Brigham K, et al. Author(s), Identifying Malnutrition in Preterm and Neonatal Populations: Recommended Indicators. Article in Press <https://doi.org/10.1016/j.jand.2017.10.006> Pages 1-11, 2018.
11. Mehta, N. L. et al. Defining Pediatric Malnutrition: A Paradigm Shift toward Etiology-Related Definitions. JPEN J Parenter Enteral Nutrition 2013 37: 460 originally published online 25 March 2013 (A.S.P.E.N.)
12. Mehta, N. L. et al. Defining Pediatric Malnutrition: A Paradigm Shift Toward Etiology-Related Definitions. JPEN J Parenter Enteral Nutrition 2013 37: 460 originally published online 25 March 2013 (A.S.P.E.N.)
13. Pinson & Tang. Sep 10, 2018. CDI+ Newsletter, Clinical & Coding New Global Malnutrition Definition (GLIM) and (GLIM Criteria for the Diagnosis of Malnutrition: A Consensus Report from the Global Clinical Nutrition Community. Journal of Parenteral and Enteral Nutrition Volume 43 Number 1 January 2019 32–40).
14. Sturgeon, J. APR-DRGs in the Medicaid Population. *For the Record*. Available at <http://www.fortherecordmag.com/archives/0313p6.shtml>. Accessed 9 December, 2019.

15. World Health Organization (WHO)> Retrieved from: <https://www.who.int/nutrition/topics/malnutrition/en/>
 16. ICD 10-CM/PCS Coding Clinic. Third Quarter. ICD-10. 2017. Pages 24-25

IMPORTANT INFORMATION ABOUT THIS DOCUMENT

Claims and Payment Policies (CPPs) are policies regarding claims or claim line processing and/or reimbursement related to the administration of health plan benefits. They are not recommendations for treatment, nor should they be used as treatment guidelines. Providers are responsible for diagnosing, treating, and making clinical recommendations to the member. CPPs are subject to, but not limited to, the following:

- State and federal laws and regulations;
- Policies and procedures promulgated by the Centers for Medicare and Medicaid Services, including National Coverage Determinations and Local Coverage Determinations;
- The health plan’s contract with Medicare and/or a state’s Medicaid agency, as applicable;
- Other CPPs and clinical policies as applicable including, but not limited to, *Pre-Payment and Post-Payment Review*.
- The provisions of the contract between the provider and the health plan; and
- The terms of a member’s particular benefit plan, including those terms outlined in the member’s Evidence of Coverage, Certificate of Coverage, and other policy documents.

In the event of a conflict between a CPP and a member’s policy documents, the terms of a member’s benefit plan will always supersede the CPP. The use of this policy is neither a guarantee of payment, nor a prediction of how a specific claim will be adjudicated. Any coding information is for informational purposes only. No inference should be made regarding coverage or provider reimbursement as a result of the inclusion, or omission, in a CPP of a CPT, HCPCS, or ICD-10 code. Always consult the member’s benefits that are in place at time of service to determine coverage or non-coverage. Claims processing is subject to a number of factors, including the member’s eligibility and benefit coverage on the date of service, coordination of benefits, referral/authorization requirements, utilization management protocols, and the health plan’s policies. Services must be medically necessary in order to be covered. References to other sources and links provided are for general informational purposes only, and were accurate at the time of publication. CPPs are reviewed annually but may change at any time and without notice, including the lines of business for which they apply. CPPs are available at www.wellcare.com. Select the “Provider” tab, then “Tools” and then “Payment Guidelines”.

RULES, PRICING & PAYMENT COMMITTEE HISTORY AND REVISIONS

Date	Action
02/11/2020	<ul style="list-style-type: none"> • Approved by RGC