Documentation of hospital patients' malnutrition helps maximize care and reimbursement

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Nutrition support professionals who are well-versed in proper documentation of malnutrition diagnoses in hospital patients can help ensure that hospitals receive maximum funding for patient care according to a new review.

The review, recently published in *Nutrition in Clinical Practice* (*NCP*), a peer-reviewed, interdisciplinary journal of the American Society for Parenteral and Enteral Nutrition (A.S.P.E.N.) that publishes articles about the scientific basis and clinical application of nutrition and nutrition support, found that proper documentation and coding of malnutrition can increase the payments the hospital receives for care.

Medicare is the major source of funding for many hospitals in the United States. Hospitals receive payments using the Acute Care Hospital Inpatient Prospective Payment System, which classifies patients into Medical Severity Diagnosis-Related Groups (MS-DRGs) to determine payment amounts. Documentation of comorbidities and complications can increase the payment hospitals receive to offset patient care costs.

The development of a valid and reliable program to identify, document, intervene, and code malnutrition is one of the ways the nutrition support clinician can contribute to the financial stability of the hospital and enhance the potential for adequate clinical resources to care for malnourished patients. In addition, classifying a patient's degree of malnutrition can help the healthcare team determine how frequently to reassess the patient and his or her response to care to provide the best possible outcomes.

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