



EFFECTIVE USE OF THE GLIM CRITERIA FOR DIAGNOSING MALNUTRITION IN ADULTS

THE PROBLEM:

- Because Medical Coding of Malnutrition often *significantly* raises case value in the inpatient and outpatient arenas, claims including a diagnosis of Malnutrition are frequently denied and are frequently the focus of crippling regulatory fines.¹
- Medical Coders correctly code the following diagnostic codes when they see the physician's diagnoses documented in the medical chart. The Malnutrition codes provide MCCs or CCs as indicated, often significantly increasing case value to reflect the increased costs and morbidity of patients suffering from Malnutrition.²
 - ICD-10-CM:

▪ E43: Severe Protein-Calorie Malnutrition	MCC	SOI/ROM 4/3
▪ E44.o: Moderate Protein-Calorie Malnutrition	CC	SOI/ROM 3/2
▪ E44.1.: Mild Protein-Calorie Malnutrition	CC	SOI/ROM 2/1
▪ E46: Unspecified Protein Calorie Malnutrition	CC	SOI/ROM 3/2
▪ Z68.1 Adult BMI < 19	CC	
▪ R64 Cachexia or "Wasting Syndrome"	CC	SOI/ROM 2/1
 - CMS-HCC 21 Protein Calorie Malnutrition
 - HHS-HCC 023 Protein Calorie Malnutrition
- The Medical Definition of Malnutrition is broad. It is "the result of any condition in which the body does not receive enough nutrients for proper function."³ It is rare for an insurer to accept a claim for Malnutrition supported only by the medical definition of Malnutrition.
- To further complicate things, until 2018 American and World Health definitions have not been standardized or consistent or easy to follow. Hypoalbuminemia and Hypoproteinemia can no longer be used *alone* to substantiate Malnutrition, and the ASPEN criteria can no longer be used *alone* to substantiate malnutrition.⁴

¹ "The diagnosis of severe protein calorie malnutrition is under high scrutiny from the Centers for Medicare & Medicaid Services (CMS) and the U.S. Department of Health and Human Services (HHS) Office of Inspector General (OIG)." Corazzo, M. [ICD-10monitor](https://www.icd10monitor.com/severe-protein-calories-malnutrition-in-the-oig-crosshairs) August 20, 2018 **reported at** <https://www.icd10monitor.com/severe-protein-calories-malnutrition-in-the-oig-crosshairs>

² E40, 41, 42 Kwashiorkor, Marasmus are also MCC but in the US are mostly unusable codes indicating very severe malnutrition and may not be used unless these specific diagnoses are documented. See AHA Coding Clinic Third Quarter 2017 p. 25)

³ Hickson, M *Malnutrition Postgrad Med J* 2006 Jan; 82 (963)2-8

⁴ *RAC Monitor*, October 26, 2017 **Novitas Guidelines for Malnutrition reported to be Outdated, not Useful for Physicians, reported at** <https://www.racmonitor.com/novitas-guidelines-for-malnutrition-reported-to-be-outdated-not-useful-for-physicians>



THE SOLUTION: The **GLIM Criteria** became the accepted medical standard in the United States and most of the world for **diagnosing malnutrition** in September 2018 .⁵

- Under the GLIM Standard, documentation of **ONE of the Phenotypic** Criteria **and ONE of the Etiologic** Criteria supports a diagnosis of Malnutrition. Severity of the Malnutrition is supported within the specifics of the Phenotypic Criteria. These criteria can be documented by a Registered Dietician.

PHENOTYPIC CRITERIA	ETIOLOGIC CRITERIA
<i>NON</i>WOLITIONAL WEIGHT LOSS: <u>Moderate:</u> 5% in less than 6 months 10% in > 6 months <u>Severe:</u> 10% in < 6 months 20% in >6 months	REDUCED FOOD INTAKE or ABSORPTION <u>Reduced Intake:</u> < 50% of normal intake > 1 week months or any > 2 weeks <u>Reduced Assimilation/Absorption:</u> ex. SBO Gastroparesis, Pancreatic Conditions, Ostomies, etc.
LOW BMI (in kg/m ²) <u>Moderate:</u> BMI < 20 under 70 yrs. or < 22 <u>Severe:</u> BMI < 18.5 under 70 yrs. or < 20	INFLAMMATION/DISEASE BURDEN: ex. COPD, CHF, CKD, Malignancies, “Inflammatory conditions, elevated CRP (> 3.0 mg/L)”
REDUCED MUSCLE MASS¹ <u>Moderate:</u> Mild to moderate deficit <u>Severe:</u> Severe Deficit	

- The GLIM criteria and Consensus recommend that patients with anorexia, weakness, visible weight loss, biochemical alterations measured by laboratory testing and/or known intake reduction or absorption due to medical conditions and/or procedures be identified as “at risk” and evaluated for Malnutrition.⁷
- If the Physician’s Diagnosis or the Physician’s or Nutritionist’s supporting documentation of GLIM clinical indicators are not documented, CDI can query for the presence of either to insure the documentation supports the increased utilization of resources that comes with the diagnosis of Malnutrition and to prevent *successful* denial of the coded Malnutrition diagnosis.

⁵ In September 2018 the Global Leadership Initiative on Malnutrition (GLIM) agreed by Consensus to use the GLIM Criteria to diagnose Malnutrition consistently world-wide. This included ASPEN (USA), ESPN (Europe) FELANPE (Latin America), PENZA (Asia) doi.org/10.1002/jpen 1440 **and also reported at** Cederholm, T. et al *GLIM criteria for the Diagnosis of Malnutrition Clinical Nutrition* February 2019 Volume 38 Issue 1, p. 1-9 reported at [https://www.clinicalnutritionjournal.com/article/S0261-5614\(18\)31344-X/fulltext](https://www.clinicalnutritionjournal.com/article/S0261-5614(18)31344-X/fulltext)

⁶ As measured by hand grip strength, Calf/Arm circumference Differentials, Anthropometric studies, Measurements Dual energy absorptiometry, FFMI, BIA, US, CT, MRI comparisons

⁷ Cederholm, T. et al *GLIM criteria for the Diagnosis of Malnutrition Clinical Nutrition* February 2019 Volume 38 Issue 1, p. 1-9 reported at [https://www.clinicalnutritionjournal.com/article/S0261-5614\(18\)31344-X/fulltext](https://www.clinicalnutritionjournal.com/article/S0261-5614(18)31344-X/fulltext)