Greetings CNM members!

I can hardly believe the 2013 – 2014 membership year is coming to an end. I recall writing the incoming chair message as though it was yesterday. I guess it is true time flies when you are having fun. And what fun we’ve had!

Following are selected accomplishments of your Executive Committee (EC) since the last publication of Future Dimensions.

• The CNM DPG’s first webinar on competencies was successful thanks to Kelly Danis, Professional Development Committee Chair. The webinar was free to all members and 173 participated.

• The strategic plan for FY 2015-2017 was completed thanks to all the hard work of Marsha Schofield, Janel Welch and the EC members. The mission, vision and goals were revised as follows:
  ◦ **Mission**: Empowering and supporting leaders to advance nutrition practices in healthcare
  ◦ **Vision**: Optimizing leadership skills to equip members to positively influence healthcare
  ◦ **Goals**: 1) Advance nutrition practices consistent with healthcare reform 2) Provide opportunities and resources to members to develop and/or enhance multidimensional skill for leadership and management 3) Current and prospective members utilize the CNM DPG as key to their leadership success.

• The 2014 CNM Symposium was held in beautiful Asheville, NC. Once again, the Symposium was a huge success thanks to all the hard work of Kathy Allen and the

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Professional Development Committee.

• The staffing and productivity study is well underway thanks to the Research Committee.

• The new Quality Process Improvement (QPI) Subunit was successfully launched thanks to the hard work of Sherri Jones and Cindy Hamilton. Over 40 members joined the QPI EML already and a wealth of information is available on our website. If you have not visited the website or joined the EML, please consider taking advantage of this new member benefit.

The Academy and DPG elections took place in February. I know Kathy Allen, Incoming Chair, will lead this awesome DPG to much bigger successes. Please help me in congratulating our incoming officers:

Chair Elect: Caroline Steele, MS, RD, CSP, IBCLC
Secretary: Jennifer Wilson, MS, RD, LDN
Nominating Committee Chair Elect: Wendy Phillips, MS, RD, CNSC, CLE
Nominating Committee: Kelly Danis, RDN, LDN, RD, LD

It would take too much space and time to thank everyone individually for all that was accomplished during the past year, however, every member of the EC worked tirelessly to improve and bring innovation to the CNM DPG. Moreover, a huge thanks goes out to CNM DPG members for your participation. Your willingness to share and mentor makes our EML one of the best member benefits.

I am honored to have served as your Chair this past year. I learned much from you and the EC. Thank you!

Best regards,

Young Hee

Young Hee Kim, MS, RD, LDN, CNSC
Chair, CNM DPG 2013-2014

Visit us at the CNM DPG website—cnmdpg.org. Available resources include:

• Searchable member directory
• Resource library
• The DPG’s guiding principles and strategic plan
• The Standards of Professional Performance for Dietitians in Clinical Nutrition Management
• Newsletter archives
• CNM annual report to members
• Eblast archives
• Information on the Informatics and Quality and Process Improvement (QPI) subunits
• Sign up for the CNM electronic mailing list (EML)
• Sign up for the QPI EML—in the members only section, click on the Subunits tab, then QPI
• Update your CNM profile—click on Edit Your Profile in the Member Info section

For additional information, contact us at: ClinicalNutritionMgtDPG@gmail.com
“It is the distinctive knowledge base of the clinical dietitian that makes her/him the qualified individual responsible for informing the physician of a client’s unique nutrient needs.”

- Mary Ann Kight, PhD, RD

What does this mean to you? As one of my favorite quotes, the simplest meaning is that the registered dietitian nutritionist’s (RDN’s) knowledge base is unique. No other healthcare professional looks at nutrition-specific information in the same manner as the RDN, nor understands how to thoroughly interpret it. Pharmacy looks at medications, labs and hydration; physicians look at hydration and perhaps oral intake; nursing documents oral intake, diet tolerance, anthropometrics, and gastrointestinal function, but RDN’s are the specialists that pull it all together.

By analyzing patient nutrient intake and interaction with disease pathology, medication kinetics, functional status, nutrient-depleting medications and nutrition-focused physical exam (NFPE) findings, RDNs are able to identify specific nutrition-related problems.\(^2\) If we do not elevate our level of practice to include the NFPE, nutrition-specific problems will be overlooked and left unidentified and untreated. The Academy’s Standards of Practice (SOPs) for RDNs include the NFPE as part of the overall nutrition assessment.\(^3\)

One primary responsibility of a clinical nutrition manager (CNM) is to assess the clinical competency of her/his RDN team members. Many questions surround the appropriate method to assess clinical competency. What determines clinical competency? How is it measured? What should be included in chart audits/reviews? A survey was sent to the CNM listServ, as well as local dietetic associations, to gather information regarding current practice for assessing clinical competency.

When asked how clinical competency was assessed, ninety percent of CNM respondents indicated utilizing a chart audit process that may or may not be combined with another form of competency assessment (i.e. discussion, testing or peer reviews). Clearly, elevating dietitian practice level involves more than comprehensive chart audits, but this is a great place to start. The next question is: What else can CNMs do besides chart audits to assess competency?

When discussing clinical competency, we must begin with the basics of nutritional assessment and the RDN skill of putting together a puzzle. Our puzzle pieces include 1) diet information, 2) interpretation of laboratory values, 3) NFPE, 4) review of home and current medications, including nutrient-depleting medications, and 5) weight/anthropometric interpretation. Dr. Kight referred to these as the 5 Axes of Evidence essential for nutrition assessment.\(^4\) Table 1 outlines the axes in more detail.

Understanding disease pathology, the effect of medications in micronutrient nutriokinetics, the ability to gather, interpret and analyze a diet history for macro and micronutrient intakes and
losses, and an understanding of the inflammatory process should all be included in nutrition assessment, as each is important in conducting and interpreting a comprehensive NFPE. Nutriokinetics describes how the body processes certain ingested nutrients, and is a term similar to pharmacokinetics.¹

Combined, these pieces are essential to form an accurate nutrition diagnostic statement. Dr. Kight’s 5 Axes of Evidence are comparable to the Academy of Nutrition and Dietetics Nutrition Care Process (NCP) domains of assessment: food or nutrition-related history, biochemical data, medical tests and procedures, anthropometric measurements, nutrition-focused physical findings and client history.⁵ A thorough review of both models challenges the practitioner to expand upon critical thinking skills and take a more in-depth look at overall nutritional status.

There is an array of educational backgrounds and experiences among practicing RDNs. Surprisingly, many were not trained to conduct a hands-on NFPE. Thus, this is an essential component of the NCP and IDNT (International Dietetics and Nutrition Terminology) resources, and the importance and inclusion of the NFPE is evident.

The NFPE can be quite intimidating to those clinicians new to the process, and does require critical thinking skills, consistent implementation, ongoing training, and monitoring. Essentially, the NFPE is conducted to identify physical manifestations of macro and/or micronutrient excesses or deficiencies, including nutrient-based lesions. It should be conducted with a head to toe approach, and include examination of various structures such as hair, eyes, tongue, skin, etc.

The development of nutrient-based lesions is complex and may arise from alterations in nutrient acquisition, absorption, distribution, metabolism, storage and/or excretion. As clinicians, we must be familiar with normal nutriokinetics and aware of how disease processes and medications alter the body’s normal functions in

Table 1. Five Axes of Evidence for Nutritional Assessment

<table>
<thead>
<tr>
<th>5 Axes of Evidence</th>
<th>Items to Assess</th>
<th>Potential Chart Audit Evaluation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diet / Alimentation</td>
<td>Current diet and estimated protein &amp; calorie intake (not just % of meal consumed) Diet history – including breakdown of macro / micronutrient intakes</td>
<td>Diet History completed with minimum requirements of a food frequency documented.</td>
</tr>
<tr>
<td>Weight &amp; Anthropometrics</td>
<td>Current weight, weight history and BMI Disease pathology, inflammation process Functional status changes</td>
<td>Weight history, percent weight change with time frame and functional status changes documented.</td>
</tr>
<tr>
<td>Laboratory</td>
<td>Accurate interpretation considering: Effect of inflammation Effect of medications</td>
<td>Hepatic proteins are not identified as nutrition problems and not utilized as nutrition goals i.e. “albumin WNL”</td>
</tr>
<tr>
<td>Medication</td>
<td>Nutrient-depleting medications Home medications</td>
<td>Home and current nutrient-depleting medications identified.</td>
</tr>
<tr>
<td>NFPE</td>
<td>Muscle &amp; fat loss Micronutrient lesions Functional status changes</td>
<td>Comprehensive NFPE performed, including all 3 groups (see Table 2). Accurate interpretation of findings with supporting evidence.</td>
</tr>
</tbody>
</table>
conjunction with a patient’s/client’s diet history. Please refer to Table 2 for a brief overview of physical groups evaluated during a NFPE, signs and symptoms, and contributing factors and concepts the RDN should understand.

Dr. Kight has divided the body into three groups, which may lessen the learning curve for many practitioners in applying the practice of NFPE. Lesions found in Oral/Perioral Structures (Group 1) tend to be primarily micronutrient related, Skin & Related Structures (Group 2) may be a combination of micro and macronutrient abnormalities, and Other Body Systems (Group 3) tend to be macronutrient related. Group 1 consists of the tongue, gums, and teeth; Group 2 consists of the skin, eyes, hair and nails; and Group 3 consists of overall body systems.¹

In order to effectively implement the NFPE into daily clinical practice, one must first analyze the clinical team’s current practices and identify areas of improvement regarding information gathering and interpretation skills. As part of the NFPE implementation, I implemented a peer review process to expand critical thinking skills and encourage constant evaluation and discussion of the team’s documentation.

The ability to accurately gather and interpret information can drastically change a nutrition assessment, diagnosis, goals and interventions. The following case study serves as a comparison of how a detailed diet history, full review of medications, and NFPE can significantly change the nutrition diagnosis.

Table 2. Nutrition Focused Physical Exam Review¹

<table>
<thead>
<tr>
<th></th>
<th>Group 1 – Oral/Perioral Structures</th>
<th>Group 2 – Skin &amp; Related Structures</th>
<th>Group 3 – Other Body Systems</th>
</tr>
</thead>
<tbody>
<tr>
<td>What the RDN may identify</td>
<td>Nutrient-based lesions: physical manifestations of nutrient deficit or excess</td>
<td>Nutrient-based lesions: physical manifestations of nutrient deficit or excess</td>
<td>Protein/calorie malnutrition, Muscle and fat loss/wasting</td>
</tr>
<tr>
<td><strong>Signs</strong></td>
<td><strong>Tongue</strong> – baldness, filiform atrophy, fissuring, edema</td>
<td><strong>Skin</strong> – poor turgor, poor elasticity, flakiness or dryness, pitting edema, petechiae</td>
<td><strong>Lean Body Mass Stores</strong> – upper arm, lower extremity, interosseous wasting; functional status changes</td>
</tr>
<tr>
<td></td>
<td><strong>Gums</strong> – color, bleeding, tenderness</td>
<td><strong>Eyes</strong> – Bitot’s spots, keratomalacia, pallor of everted lower eyelids</td>
<td><strong>Fat stores</strong> – upper arm and back fat loss, sunken eyes</td>
</tr>
<tr>
<td></td>
<td><strong>Lips</strong> – vertical fissuring, dry/cracked, paleness</td>
<td><strong>Nails</strong> – spooning, ridging, dry/brittle, white spotting</td>
<td><strong>Hair</strong> – easily pluckable, increase in hair loss, dry and brittle, dull</td>
</tr>
<tr>
<td></td>
<td><strong>Teeth</strong> – missing, hypoplastic line across front incisors, caries</td>
<td></td>
<td><strong>Stress</strong> – physical and emotional</td>
</tr>
<tr>
<td><strong>Contributing Factors</strong></td>
<td>Inadequate micronutrient intake, including amount and duration</td>
<td>Inadequate micronutrient intakes, including amount and duration</td>
<td>Inadequate intake</td>
</tr>
<tr>
<td></td>
<td>Nutrient-depleting medications, including length of time on medication</td>
<td>Nutrient-depleting medications, including length of time on medication</td>
<td>Disease process and inflammation effects on normal nutriokinetics</td>
</tr>
<tr>
<td></td>
<td>Disease process and inflammation effects on normal nutriokinetics</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

¹ Future Dimensions in Clinical Nutrition Practice
Scenario one shows a limited assessment, but an appropriate nutrition diagnosis based on the information obtained. In the second scenario, the NFPE, and a more thorough diet history and medication review were used in the assessment: investigation of medications, and a NFPE which revealed muscle wasting and a suspected zinc deficiency. Among other interventions, the RDN recommended checking serum zinc levels. The recommendations were accepted, and the patient was found to be zinc-deficient and was started on appropriate supplementation.

A clinician’s diagnosis statement, goals and interventions can only be as good as the RDN’s information-gathering and interpretation skills. For instance, in an acute care setting, simply looking at the acute problem is not sufficient to identify true nutrition-related problems. The whole patient must be assessed, including weight history, diet history, and functional status changes in order to identify potential underlying nutrition problems.

The NFPE should be in every RDN’s toolkit. By obtaining and analyzing comprehensive information from the patient and record, the RDN should be able to identify potential macro and/or micro-nutrient deficiencies and then focus the NFPE on these specific areas. While the NFPE can be overwhelming and uncomfortable for clinicians not accustomed to performing this task, study, gradual training with consistent feedback and competency evaluation is key to moving this process forward.
It is impossible to assess clinical competency by chart audits alone. Building the electronic medical record to include an area specifically for NFPE documentation can trigger the RDN to complete the nutritional assessment thoroughly and critically and can serve as a way for the CNM to ensure that the NFPE is consistently conducted. Monthly or quarterly chart reviews which include review of the NFPE, in conjunction with shadowing or direct observation, can serve as a great clinical competency tool.

Several resources exist to aid in development of skills related to conducting an NFPE; visit www.eatright.org and/or http://anhi.org/ for webinars and articles. Implementation of the NFPE takes commitment, consistent and constant evaluation, and will elevate the RDN’s level of practice.

References

Marie’s passion for clinical practice began during her Dietetic Internship at Cox College of Nursing and Health Sciences in Springfield, MO. Marie is a member of the Morrison Healthcare family and recently accepted a position as Director of Food and Nutrition Services at Texas Spine & Joint Hospital in Tyler, TX. She served as Clinical Nutrition Manager at Good Shepherd Medical Center in Longview, TX for the past 3.5 years, and Regional Clinical Nutrition Manager for Morrison for the past two years.

One free CPEU available to CNM DPG members!

1. Read the article titled “Nutrition Focused Physical Exam: An Essential Piece in Evaluation of Clinical Competency” by Marie Mahon, RD, LD
2. Log on to the CNM DPG website at cnmdpg.org
3. Go to the member’s only section and click on the link for the CPE Exam
4. Take the exam; your CPE certificate will be emailed to you within one week

This article has been approved for 1 CPE, Level 2; Learning Needs Codes 3000, 6080, and 5280. The test will remain available for three years after the publication date of this edition of Future Dimensions in Clinical Nutrition Practice (May 5th, 2014).
Introduction
Consider the following nutrition diagnostic statements: “278.01 as evidenced by V85.41” or “263.0 related to limited access to food as evidenced by V85.0”. Registered Dietitian Nutritionists (RDNs), like other healthcare providers, do not document in medical records using numbers and codes as in these examples. Rather, the first statement would be written as “morbid obesity related to excess calories as evidenced by a BMI of 41” (any BMI 40-44.9 would use the V85.41 code) and the second statement would be written as “moderate protein-calorie malnutrition related to limited access to food as evidenced by BMI less than 19”. However, translating medical diagnoses and procedures into numerical codes serves several purposes. This article explains the reasons for using the International Classification of Diseases (ICD), as developed by the World Health Organization, throughout the world as a standard classification of disease, injuries, and causes of death.¹

The ICD code set allows clinicians, statisticians, politicians, health planners, and others to speak a common language, both in the United States and internationally. Most healthcare workers are familiar with the ninth edition of this classification set, commonly known as ICD-9. Although originally planned for October 1, 2014, the ICD-9 system will be replaced by the tenth edition, also known as ICD-10, in the United States in 2015.¹ The system that is used to describe diagnoses for billing purposes is the Clinical Modification of ICD, or ICD-CM. While the ICD-CM codes are used for diagnoses, the PCS, Procedure Classification System, is used to describe the procedure or surgery performed. Both of these systems will change when the 10th edition is implemented in 2015. ICD-10 will affect diagnosis and inpatient procedure coding for everyone covered by the Health Insurance Portability and Accountability Act (HIPAA), not just those who submit Medicare or Medicaid claims.²

Other billing and coding terms with which RDNs may be familiar are the CPT and HCPCS codes. The CPT, or Current Procedural Terminology, is used by providers to code for both inpatient and outpatient services and procedures, and includes the billing codes for medical nutrition therapy. These codes are also used by facilities for services and procedures for outpatients. For services and procedures not included in the CPT system, a HCPCS code is assigned, which stands for Health Care Procedural Coding System. Neither of these systems will be affected by the transition to ICD-10.³

Why Change to ICD-10?
The Centers for Medicare and Medicaid Services (CMS) requires this switch to the 10th edition for

Table 1. Example of ICD-9 to ICD-10 Code Conversion

<table>
<thead>
<tr>
<th>ICD-9 Code</th>
<th>Possible Corresponding ICD-10 Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>250.61 - Diabetes mellitus with neurological manifestations type 1 not stated as uncontrolled</td>
<td>E10.40 - Type 1 diabetes mellitus with diabetic neuropathy, unspecified E10.41 - Type 1 diabetes mellitus with diabetic mononeuropathy E10.44 - Type 1 diabetes mellitus with diabetic amyotrophy E10.49 - Type 1 diabetes mellitus with other diabetic neurological complication</td>
</tr>
</tbody>
</table>
many reasons. Coding using ICD-10 requires more specific documentation of the disease or procedure, thereby improving accuracy and enhancing specificity of the diagnosis itself. Most other countries already use the newer edition, so switching to ICD-10 will help with communication between medical record systems internationally. The ICD-9 code sets are outdated and incomplete, as they do not include new procedures and diagnoses that have been developed as a result of innovations in technology and treatment.

Because the coding system is used for billing, enhanced coding accuracy will allow for more accurate billing and quicker reimbursement. Further, a higher quality of care can be delivered because of the improved communication between healthcare providers and facilities. The transition to ICD-10 will also allow electronic monitoring of specific codes, which will help CMS implement performance-based payment systems. In addition, CMS and other healthcare payors will have a greater ability to detect fraud and abuse.

Due to improved specificity in coding of diagnoses, research and epidemiological trials will be able to track cases more efficiently and accurately, and resource utilization for specific disease states can be more closely monitored. For example, under the ICD-9 system “diabetes mellitus with neurological manifestations type I not stated as uncontrolled” is code 250.61. This code cannot be directly mapped to any one new code in the ICD-10 system, because the newer system requires more information about the diagnosis itself. There are four codes in ICD-10 that could correspond to this one ICD-9 code (see Table 1).

Nutrition research, especially epidemiological research, may be enhanced with the introduction of ICD-10 due to the ability to more accurately track diagnoses with increased specificity. Because of more precise coding, disease prevalence can be more accurately monitored, and better decisions can be made regarding healthcare resource utilization.

How Does ICD-10 Differ From ICD-9?
Due to the increased specificity associated with ICD-10, the new codes are usually longer than the ICD-9 codes. Each digit in the ICD-10 code is used to designate a certain aspect of the diagnosis. The three digits before the decimal in an ICD-10-CM code define the category of the diagnosis, while the three digits after the decimal describe the etiology, anatomic site, and severity of the disease. In the PCS codes, each number before and after the decimal refers to a specific part of the procedure (see Table 2).

Because of the expansion and demand for more specificity in ICD-10, medical record documentation will need to be enhanced in some instances to be sure accurate codes can be assigned. Documentation has always been used to support the medical services provided, and needs to indicate the level of service. This is especially true for physicians who make the medical diagnoses and perform the procedures under the PCT codes. It is also a good reminder for RDNs to be sure that documentation matches the care provided.
The ICD-10-CM system has a tabular list of possible diagnostic codes. All of the ICD-10 codes, with additional information, can be found on the CMS website at www.cms.gov/ICD-10. Nutrition-related codes are found in Chapter 4. The same malnutrition diagnoses are still available in ICD-10 that were available in ICD-9 (Figure 1). CMS does not identify criteria used to define malnutrition, and there is no universally accepted approach to its diagnosis. The Academy of Nutrition and Dietetics and the American Society for Parenteral and Enteral Nutrition published a consensus statement in 2012 with recommended criteria for the classification of malnutrition, but this has not been officially accepted by CMS.

In addition to the malnutrition diagnosis codes, a group of codes in E64 describe sequelae related to malnutrition and other nutritional deficiencies. This category is used to indicate conditions resulting from the types of malnutrition listed in categories E43, E44, E46 and E50-E63, if the malnutrition itself is no longer present. In other words, these codes describe conditions that result from a patient being malnourished or having micronutrient deficiencies. Figure 2 lists the specific codes in E64.

Overweight, obesity, and other hyperalimentation is another section of the ICD-10-CM tabular list. The code E65 describes localized adiposity, and overweight and obesity are described in E66 (Figure 3). The specific body mass index (BMI) is now coded with Z codes instead of the V codes used with ICD-9, and these Z codes, if known, are used to complement the E66 codes. RDNs should always document the BMI when known to help ensure that a complete diagnosis is documented.

**What Does The RDN Need To Know?**

ICD codes are used in both outpatient and inpatient settings. In the inpatient setting, diagnosis of malnutrition is key to defining the care plan for that patient. While clinical documentation specialists cannot use the RDN’s diagnosis alone to code for malnutrition, once the physician has concurred with the RDN and documented the malnutrition diagnosis, the inpatient RDN can work with the clinical documentation specialists in the coding department to ensure the accurate ICD-10-CM code for malnutrition is assigned to reflect the level of care provided. Although there are no universally accepted definitions for malnutrition, each facility should adopt evidence-based guidelines for malnutrition diagnosis, which then need to be consistently applied to all patients.

RDNs regularly provide medical nutrition therapy (MNT) in the ambulatory care setting, and therefore must be able to convert currently used ICD-9-CM codes to the ICD-10-CM codes. While the physician makes the medical diagnosis, the referral the RDN receives does not typically include an ICD code. If the RDN bills Medicare directly, i.e. as in private practice, she or he will need to know how to assign an ICD-10-CM code.

### Figure 1. Malnutrition Codes

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>E40</td>
<td>Kwashiorkor</td>
</tr>
<tr>
<td>E41</td>
<td>Nutritional marasmus</td>
</tr>
<tr>
<td>E42</td>
<td>Marasmic kwashiorkor</td>
</tr>
<tr>
<td>E43</td>
<td>Unspecified severe protein-calorie malnutrition</td>
</tr>
<tr>
<td>E44</td>
<td>Protein-calorie malnutrition of moderate and mild degree</td>
</tr>
<tr>
<td>E45</td>
<td>Retarded development following protein-calorie malnutrition</td>
</tr>
<tr>
<td>E46</td>
<td>Unspecified protein-calorie malnutrition</td>
</tr>
</tbody>
</table>

### Figure 2: E64: Sequelae of Malnutrition Codes

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>E64.0</td>
<td>Sequelae of protein-calorie malnutrition (excludes E45)</td>
</tr>
<tr>
<td>E64.1</td>
<td>Sequelae of vitamin A deficiency</td>
</tr>
<tr>
<td>E64.2</td>
<td>Sequelae of vitamin C deficiency</td>
</tr>
<tr>
<td>E64.3</td>
<td>Sequelae of rickets</td>
</tr>
<tr>
<td>E64.8</td>
<td>Sequelae of other nutritional deficiencies</td>
</tr>
<tr>
<td>E64.9</td>
<td>Sequelae of unspecified nutritional deficiency</td>
</tr>
</tbody>
</table>
Future Dimensions in Clinical Nutrition Practice

For ambulatory care provided in healthcare facilities, coders and documentation specialists typically assign the code; however, because ICD-10-CM codes are much more specific, it is still helpful for clinicians to be familiar with ICD-10 so that they know what to document to ensure that the correct codes are assigned. Diagnoses for which the RDN commonly provides MNT are listed in Table 3, and include the ICD-9-CM codes with the recommended corresponding ICD-10-CM codes. An online resource for converting more codes to the new system can be found at www.icd10data.com.

While it is important for RDNs to know about coding diagnoses using ICD-10, the extensive details of the system should be handled by the facility’s coding and billing departments. The most important thing RDNs need to understand is that if a nutrition diagnosis is documented, such as malnutrition, an intervention must be in place to treat that diagnosis, and the patient should be monitored for his/her response to care. RDNs should check with the coding department at the hospital or healthcare facility with questions specific to that facility.

References

Table 3: Conversion of commonly used codes for providing Medical Nutrition Therapy

<table>
<thead>
<tr>
<th>Diabetes Mellitus – ICD-9</th>
<th>Diabetes Mellitus – ICD-10</th>
</tr>
</thead>
<tbody>
<tr>
<td>250.00 Type II or unspecified type, not stated as uncontrolled</td>
<td>E11.9 Type 2 diabetes mellitus without complications</td>
</tr>
<tr>
<td>250.01 Type I [juvenile type], not stated as uncontrolled</td>
<td>E10.9 Type 1 diabetes mellitus without complications</td>
</tr>
<tr>
<td>250.02 Type II or unspecified type, uncontrolled</td>
<td>E11.65 Type 2 diabetes mellitus with hyperglycemia</td>
</tr>
<tr>
<td>250.03 Type I [juvenile type], uncontrolled</td>
<td>E10.65 Type 1 diabetes mellitus with hyperglycemia</td>
</tr>
<tr>
<td>Chronic Kidney Disease – ICD-9</td>
<td>Chronic Kidney Disease – ICD-10</td>
</tr>
<tr>
<td>585.3 Chronic kidney disease, stage III (moderate) [kidney damage with moderate decrease in GFR (30-50)]</td>
<td>N18.3 Chronic kidney disease, stage 3 (moderate)</td>
</tr>
<tr>
<td>585.4 Chronic kidney disease, Stage IV (severe) [kidney damage with severe decrease in GFR (15-29)]</td>
<td>N18.4 Chronic kidney disease, stage 4 (severe)</td>
</tr>
<tr>
<td>585.5 Chronic kidney disease, Stage V [Excludes chronic kidney disease, Stage V requiring chronic dialysis; kidney failure with GFR of &lt; 15]</td>
<td>N18.5 Chronic kidney disease, stage 5</td>
</tr>
<tr>
<td>E66.0 Obesity due to excess calories</td>
<td>E66.01 Morbid (severe) obesity due to excess calories</td>
</tr>
<tr>
<td>E66.09 Other obesity due to excess calories</td>
<td>E66.1 Drug-induced obesity</td>
</tr>
<tr>
<td>E66.3 Overweight</td>
<td>E66.8 Other obesity</td>
</tr>
<tr>
<td>E66.9 Obesity, unspecified</td>
<td></td>
</tr>
</tbody>
</table>

Use additional codes to identify BMI, if known (Z68.-)
Wendy Phillips is the Director of Nutrition Systems at the University of Virginia Health System, and a Regional Clinical Nutrition Manager with Morrison Management Specialists. She can be reached at wendyphillips@iammorrison.com.

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Interested in contributing an article to the newsletter? Topics of interest include leadership, management, innovations in clinical practice, research and outcomes, nutrition legislation and public policy, reimbursement and coding, informatics, healthcare reform, and many others. If interested, please contact an editor.
Empowering Yourself For Success was the theme chosen for this year’s Symposium, to build on last year’s theme of Building on Success. Our goal was to provide attendees with the skills and knowledge required to demonstrate and effectively communicate the value of nutrition intervention and the importance of nutrition professionals as an integral part of healthcare reform and quality patient care. Additionally, multiple updates on the work being done and opportunities available through our DPG and The Academy of Nutrition and Dietetics were provided.

The Symposium kicked off with an inspiring and entertaining talk by Heidi Seawright who demonstrated to attendees how to communicate with strength and grace. Lynn Moore and Catherine Montgomery reminded us of the importance of empowering the dietitian to embrace challenge and become an integral part of your organization and interdisciplinary team. Attendees received an update from our Informatics Sub-Unit from Janel Welch and Will Murphy, who provided a first look at the new Academy of Nutrition and Dietetics Health Informatics Infrastructure (ANDHII). Our day wrapped up with a talk about the exciting changes coming to our Professional Development Plans and practice competencies.

Day two started with Dr. Vivek Reddy providing a thorough background on Meaningful Use with along with a glimpse of how requirements and standards will be evolving in the future. An update on the progress and future plans for our Quality and Process Improvement (QPI) Sub-Unit was given by Sherri Jones and Cindy Hamilton. Attendees were introduced to the resources available to them on the Quality page of the CNM website and were encouraged to register for the QPI listserv. The morning also provided two additional sessions “Move in the Right Direction: Malnutrition Diagnosis, Documentation and Physical Assessment” and “Empower High Performance Teams through Professional Development” by Michelle Hoppman and Susan Konek respectively. Day two ended early with the opportunity to attend this year’s tour of the beautiful house and grounds of the Biltmore Estate. It was an afternoon filled with history and touring of the grand estate house and wrapped up with a delightful wine tasting at the Biltmore Winery.

Day three was a long day jammed packed with robust sessions. Glenna McCollum, President of the Academy, started the group off on day three with a session highlighting the Top Ten Factors Impact-
ing our Careers. She reviewed information ranging from The Academy’s strategic goals, to professional development and public policy with a great deal more in between. She left attendees energized to become more active and further promote the organization and profession. Dr. Paul Wischmeyer addressed malnutrition and protein requirements in the ICU, providing attendees with strategies and evidence for program development at their own facilities. The day also included topics ranging from ethical considerations, ICU to Rehab transitions, and a quality improvement project on infant feeding presented by Caroline Steele, the incoming Chair Elect for the CNM DPG. The day also included updates from the House of Delegates, Public Policy and Political Action Committees by Mary Jane Rogalski, Julie Haase and Marty Yadrick. Lastly, attendees heard about the latest treatments options for inflammatory bowel disease from Dr. Wallace Crandall and Jennifer Smith.

The final day included a detailed review of The Academy’s latest Compensation Survey by Susan Laramee. The two following sessions highlighted additional examples of successful process improvement initiatives surrounding pressure ulcer referrals from nursing to nutrition and pediatric malnutrition diagnosis documentation from Rebecca Solomon and Susan Goolsby respectively. Finally, Jean Caton gave an inspiring talk on “How to Enhance Your Leadership Profile. Five Actions You Must Master to Communicate You are a Powerful, Persuasive and Influential Leader”. It was an inspirational day and great note on which to end the conference.

This year’s Symposium was filled with wonderful networking opportunities and robust session topics presented by engaging speakers who provided exciting new information. A big thank you goes out to all of our speakers for sharing their knowledge with us. Attendees left energized, with a long list of new ideas and projects to tackle. I encourage all members to consider sharing your success stories.

Research Committee Report
By Susan DeHoog, RD—Research Committee Co-Chair

CNM and the Dietetic Practice Based Research Network’s RDN Productivity/Staffing study is underway! In January, three 30 minute informational webinars were held and CNMs were invited to participate. The goal was to recruit 150 RDNs from 40 facilities; interest in the project was overwhelming and ultimately 426 RDNs from 86 facilities in 31 states were recruited. After attending training webinars, all participants began collecting data, which will continue through mid May. Because of the higher than expected participation rate, more time may be needed to analyze the data, however it is anticipated that aggregate data and a complete analysis will be available in June or July. The participating facilities should receive reports in August, and the study results will be presented at FNCE in Atlanta in October. Stay tuned!
Quality and Process Improvement Sub-Unit Update
By Sherri Jones, MS, MBA, RDN, LDN, FAND—QPI Sub-Unit Chair

We are approaching the one year anniversary of the inception of the CNM QPI Sub-Unit in May. We set our aim quite high and although ALL of our goals were not met, we did accomplish quite a bit in our first year. We are proud to report the new QPI Sub-Unit did manage to...

Accomplish the Following to Date:
- Present a sub-unit overview to the Academy’s Quality Management Committee (QMC)
- Institute a sub-unit name change based on recommendations of the QMC
- Implement a special QPI Electronic Mailing List (EML)
- Add a special QPI section to the CNM website – including terms, sample projects, links, etc.
- Expand the resources (+14) available in the Resource Library – Quality Improvement section
- Connect with the Academy’s staff regarding the new Academy of Nutrition and Dietetics Health Informatics Infrastructure (ANDHII) system – solicited feedback on reports during the Symposium
- Publish updates on the new QPI Sub-Unit in each quarterly newsletter
- Present a Quality/Process Improvement session at the CNM Symposium in Ashville, NC
- Initiate the development of a Quality Improvement Project Award program, with CNM Executive Committee approval – specifics under development

Proposed Quality Improvement Project Contest/Award:
We are in the process of developing guidelines and scoring criteria for a CNM Quality Improvement Project Contest. There are so many impressive projects and initiatives our CNM members have implemented. And, we want you to share your brilliance. The intent is to review the submissions and 1) select a winner who will receive a free registration to next year’s Symposium, 2) showcase the projects at the 2015 Symposium. Stay tuned, in the next several months we will be sending an announcement for QI project submissions.

Special QPI EML:
The QPI Electronic Mailing List (EML) has been up and running for a few months. I am excited and proud to report we now have ~50 QPI EML subscribers. If you are not currently subscribed and wish to do so, you can subscribe to this additional EML through the QPI Sub-Unit webpage or enter the following URL directly: [http://www.cnmdpg.org/members/page/qpi-sub-unit-member-info](http://www.cnmdpg.org/members/page/qpi-sub-unit-member-info). If you are already subscribed, please feel free to post QI related questions, or better yet, share your experience, expertise, and resources regarding quality and process improvement.

Expand the QPI Resources:
If you would like to contribute to the QPI Sub-Unit by submitting Sample Process Improvement Projects or additional Quality/Process Improvement resources and forms, feel free to reach out to Sherri and/or Cindy as the QPI Sub-Unit Chair and Vice Chair. And as always, if you have any questions or suggestions for the new Quality and Process Improvement Sub-Unit feel free to contact the sub-unit Chair and/or Vice-Chair. The sub-unit is a member benefit, and thus, we want to be sure to meet your needs and expectations. Visit the QPI Sub-Unit section of the website for updates.

QPI Sub-Unit Chair: Sherri Jones, MS, MBA, RDN, LDN, FAND jonessl@upmc.edu
QPI Sub-Unit Vice-Chair: Cindy Hamilton, MS, RD, LD hamiltoc@ccf.org
Breaking News: On April 2nd, 2014, over 400 RDNs and DTRs stormed Capitol Hill in Washington DC. Are these wild political activists? Protestors? Lobbyists? No, they are all members of the Academy of Nutrition & Dietetics who care about the future of our profession. They are one of us.

The Academy hosted the annual Public Policy Workshop from March 30th through April 2nd. Many nutrition professionals walked through the doors as public policy novices. Over the four-day workshop, attendees were equipped with the knowledge and resources to effectively communicate with their lawmakers about our priority areas.

The Academy identifies legislation of interest by focusing on issues in two priority areas:

1. Consumer & Community Issues
   - Prevention & treatment of chronic disease
   - Meeting nutrition needs through the life cycle
   - Quality food & nutrition
   - Nutrition monitoring & research
2. Professional Issues
   - Licensure
   - Workforce demand
   - Outcome driven nutrition services

With this focus, there are at least nine different bills presently in the legislature that directly impact our profession:

- 2010 Healthy Hunger Free Kids Act
- Agricultural Act of 2014 (Farm Bill)
- Ryan White CARE Act
- Affordable Care Act
- Benefits Improvement Protection Act
- Treat & Reduce Obesity Act
- HITECH Act
- Preventative Health Savings Act
- Older Americans Act

Our Hill visits focused on the Treat & Reduce Obesity Act, Preventative Health Savings Act and Older Americans Act. The Treat & Reduce Obesity Act will allow RDNs to get reimbursed when they provide MNT for obesity without limiting the location to a primary care physician office – if this passes, we can provide the right care to the right patient at the right time.

The Preventative Health Savings Act will allow the benefit of preventative services to be looked at over a 30-year window, instead of the current 10-year window. We all know it takes more than 10 years to realize the benefit of many preventative services and this bill is vital to demonstrate that fact to Congress.
The Older Americans Act is actually **three years** overdue for reauthorization, which gives true meaning to the phrase “it takes an act of congress.” Passage of this bill will allow our seniors to continue to receive community nutrition services such as home-delivered meals and community-based meals. These services have an impact on avoidable admissions, readmissions and severity of disease in this vulnerable population.

This is a very brief overview of a few of the bills, but you can find more detailed information at [http://www.eatright.org/Members/legislation/](http://www.eatright.org/Members/legislation/). Click on it. Get informed. I challenge each of you to take at least one step into advocacy – each of us has a voice and together we can come across loud and clear. You don’t have to travel to Washington or even to your state capitol. Here are a few ideas of how you can get involved:

1. Answer Action Alerts
2. Follow progress on govtrack.us
   - Did your legislators sign onto any of our bills?
     - No – ask them to sign on by meeting with them or sending a letter or e-mail
     - Yes – thank them!
3. Get involved locally
   - Attend Town Hall meetings
   - Connect with your state affiliate
   - Write a letter to the editor
   - Meet with your legislator
4. Read
   - Eat Right Weekly
   - Advocacy resources from the Academy: [http://www.eatright.org/advocacy/](http://www.eatright.org/advocacy/)
5. Be a leader
   - Encourage others to get involved—staff, peers, colleagues
6. Be a follower
   - #Follow on Twitter @eatrightPIA
   - Like on Facebook: eatrightANDPAC
7. Donate to ANDPAC

Please contact me with any questions about advocacy and public policy at Julie.haase@wfhc.org. Remember, if dietetics is your profession, then policy must be your passion.

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**Treasurer Report**

By Janet Barcroft, RD, LDN

- YTD Revenue: $134,673
- YTD Expenses: $63,302
- Investment Reserve: $341,672
- Total Expense Budget: $239,381
- Percentage of Reserve: 143%
In April Nancy Lewis, PhD, RDN, FADA, Speaker, House of Delegates, presented the HOD 2013-2014 Year in Review. Following is a brief synopsis of her report. The complete slide presentation can be viewed on www.eatright.org/hod under the 2014 HOD meeting materials titled Speakers Report. Reports from other Academy entities can also be viewed along with highlights following the Fall and Spring HOD Meetings.

Hunger in America: Food and Nutrition Insecurity Affect all RDNs and DTRs – Spring 2013 HOD Mega Issue
As a result of the Spring 2013 HOD meeting a Food and Nutrition Security Task Force was created to develop an action plan. The action plan will be submitted to the House Leadership Team and House of Delegates for approval in May 2014. The new Public Health/Community Nutrition Committee will provide oversight to the action plan. In addition, the activities of RDNs and DTRs to combat food insecurity have been highlighted in many venues.

Nutrition Services Delivery and Payment: The Business of Every Academy Member – Fall 2013 HOD Mega Issue
The Coding and Coverage Committee and Legislative and Public Policy Committee are developing an action plan that addresses current Academy resources available and future educational and practice resources needed for practitioners, educators, students and interns. The Academy is developing a marketing plan to showcase the worth of the RDN.

Visioning Report
The Accreditation Council for Education in Nutrition and Dietetics (ACEND) anticipates that draft standards and competency statements will be released for comment in the fall of 2014. All stakeholders will have opportunities to review and provide input on the proposed standards. After a 60-day comment period, the committee will review public comments and revise the draft standards and competencies.

The Commission on Dietetic Registrations (CDR) requirement of a minimum of a graduate degree for RDNs starts in 2024. Academy members were invited to participate in the Practice Competencies Initiative validation survey by April 30th.

Academy Positions Committee
Nutritional Genomics position paper published February 2014. The House Leadership Team approved a position paper proposal “The Role of the RDN and Nutrition Therapy in the Prevention and Treatment of Pre-Diabetes and Diabetes”. The HOD will vote to approve the paper following the Spring 2014 HOD Meeting.

Quality Management Committee
How long have you been a CNM?
I have been a member of CNM for more than one year. I joined the CNM DPG when I recognized that RDs practice differently, depending upon the management styles of various hospital and clinical settings that we work with. There is definite a need for us to get our heads together, to make efforts and to network, to improve and to standardize our practices that will promote us to be the leaders of clinical nutrition management in the complex hospital and public health environment.

Briefly describe your current job
Currently I am working at the University of Virginia Health System as a research scientist. My focus is to implement research related to Type II Diabetes and atherosclerosis. Publishing papers of my research and participate in seminars to be held at the Center to Public Health and Genomics (CVRC) are part of my duties. I volunteer giving nutrition lectures to a local Chinese Community Church at Charlottesville, Virginia.

What do you love most about your job?
I love my job for it gives me opportunities to study and perform hands-on scientific research related to human nutrition. I am at a position that I can be an advocate to apply the latest scientific findings to dietary practices that can improve clinical nutritional care processes and promote public awareness for improving human health and longevity.

What is the most challenging part of your job?
The most challenging part of my job is to be able to do thorough journal research, design laboratory procedures and produce evidenced based data for publications.

What advice do you have for new CNMs?
I gain reward and satisfaction from collecting and analyzing scientific research data, draw conclusions and apply it to nutrition care practices. I would advise that all clinical dietitians start collecting clinical data that they see daily, analyzing them and writing reports for publications; be actively involved in hands-on research, and publish findings that can support better clinical practices for preventive health and to continuously improve dietary guidelines for the general public.

Describe what you think the ideal role of the RD should be 30 years from now. What do you think we need to do as a profession to get to that point?
An ideal RD needs to be the leader of nutrition research, journal publication, and be a writer who defines dietary guidelines rules and regulations for any public funded nutrition programs. An RD shall be working at a department of preventive health care system that provides updated nutrition preventive health care practices and dietary guidelines. I see these agenda not to be a dream of RDs thirty years from now, but three years from now, if we all take initiatives, and work towards it.

If you couldn’t be a dietitian anymore, what profession would you choose?
If I can’t be a dietitian, I will be a research scientist.
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