



Complex medical nutritional therapy according to OPS code 8-98j – a unique feature of the German DRG system

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Abstract

Complex therapies belong to the highly specialized forms of therapy, the contents and conditions for implementation of which are defined in the catalog of operation and procedure codes (OPS). The procedure defined since 2019 with OPS code 8-98j describes the complex medical nutritional therapy (CMNT), which requires a specialist-led nutrition team with at least one nutritional therapy specialist (e.g., dietitian or ecotrophologist) as a mandatory structural feature. Process features include screening of nutritional status within the first 48 h of inpatient admission, body composition determinations, and needs assessments for energy and nutrient requirements. In addition, an individual treatment plan is developed and, if necessary, adjusted during follow-ups. CMNT is suitable for all patients who have a differentiated nutritional problem. The clear structure and process features of this therapy reflect internationally required criteria for quality assurance in nutritional therapy. Implementation of this complex therapy with a uniform financial assessment could provide an additional basis for funding nutritionists in nutrition teams and thus increase the presence and acceptance of nutritional medicine and its services.

Keywords: Inpatient nutritional therapy, revenue relevance, malnutrition, hospital, nutrition team, nutritional medicine, nutritional support, complex medical nutritional therapy

Citation

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Introduction

Nutritional support is the “provision of food or nutrients [...] for the purpose of improving or maintaining nutritional status and quality of life and improving clinical outcomes” [1]. The body of evidence shows that implementation of nutritional support in the hospital can positively affect mortality and quality of life, particularly in malnourished patients [2–6].

In international studies, the prevalence of malnutrition according to the criteria of the Global Leadership Initiative on Malnutrition (GLIM) [7] ranges from 23% to 47% depending on the patient population [8–13]. Comparable data was also collected in German hospitals. About 20% of the patients are severely malnourished; another 15% have been diagnosed with moderate malnutrition [14].

Although malnutrition is associated with a longer hospitalization, a higher risk of complications and mortality, and considerable costs [15, 16], screening patients for a risk of malnutrition (far from any treatment approach) on admission has so far not been mandatory in German hospitals.

Nutritional support has also not yet been implemented to the necessary extent. Hospitals in Germany do not have professional nutrition teams throughout the country nor are nutritional medical measures consistently designed in accordance with guidelines [17, 18]. In addition, there are structural challenges (e.g., in the organization of work processes and responsibilities) [17, 18]. In some cases, there is a lack of acceptance of nutritional therapy and its necessity by other professional groups [18]. At the level of health policy, the downgrading of malnutrition diagnoses [19, 20] in the flat-rate payment system German Diagnosis related groups (G-DRG), which has been going on for years, further reinforces this

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situation. This ultimately leads to any investment being opposed based on economic rationale.

The relatively recent introduction of complex treatments in nutritional medicine [21] could be a first step to promote and support aspects such as quality assurance, increased acceptance, and the appropriate monetary representation of nutritional medicine services.

Complex therapies belong to the highly specialized forms of therapy (Section “Definition of complex therapy”), the contents and conditions for implementation of which are defined in the catalog of operation and procedure codes (OPS codes). The services listed in this catalog represent the medical therapy measures taken in the hospital [21].

Complex therapy, which represents the comprehensive care of nutritionally relevant cases, did not exist until now. Consequently, the possibility of a financial evaluation of nutritional medical services was also insufficient. Under the initiative of PD Dr. Michael Adolph, the OPS code 8-98j Complex Medical Nutritional Therapy was developed in cooperation with the German Society for Nutritional Medicine (DGEM), which closes precisely this gap [22].

OPS code 8-98j describes Complex Medical Nutritional Therapy (CMNT) and is intended to contribute to an increase in the quality of care in everyday clinical practice through defined quality criteria and present nutritional medicine transparently in the billing system. This may also provide an incentive to establish nutrition teams in additional hospitals. CMNT became feasible on January 1, 2019 and is thus codeable. It is currently used mainly for patients at risk of malnutrition [23]. In addition, CMNT is applicable to other complex nutritional problems.

Background

Definition of complex therapy

“Complex therapy” refers to the combination of different procedures for the diagnosis and treatment of specific diseases [24]. Their contents are defined in the OPS catalog.

Established examples of complex therapy (CT) include early rehabilitation and geriatric CT, CT for stroke, CT for Parkinson’s disease, and CT for difficult-to-treat epilepsy.

New therapy definitions as well as changes to existing characteristics can be applied for at the German Federal Institute for Drugs and Medical Devices (BfArM) [25]. Each procedure contains specific requirements for delivery [25]. This can provide a standardized basis for determining effort. In addition, electronic communication and statistical recording of medical services is made possible. Complex therapies are named such because of their scope of treatment and differentiated requirements for implementation. Among other things, the qualifications of the medical staff, structural, and equipment facilities as well as the content and duration of treatment are specified. Complex therapies thus not only provide frameworks for the comprehensive treatment of various medical conditions but also define the conditions of the more complex procedures.

Structural features	
1.	Nutrition team with treatment management by a specialist with the structured curricular training or the additional designation nutritional medicine and with a dietitian or ecotrophologist
2.	Weekdays (from Monday to Friday) at least seven-hour availability of the nutrition team
Process features	
1.	Standardized screening of nutritional status within the first 48 h after inpatient admission
2.	Standardized baseline nutritional assessment at the beginning of treatment by a member of the nutrition team consisting of:
2.1	Nutritional history, including current food intake
2.2	Grip strength measurement
2.3	Bioelectrical impedance analysis (BIA) or determination of the energy metabolism by indirect calorimetry
2.4	Determination of energy and nutrient requirements, taking into account compatibility and overall balance
2.5	Preparation of an individual treatment plan (oral, sip feed, enteral and/or parenteral according to a graduated feeding scheme) at the beginning of treatment
3.	At least twice per complete week: Progress and target monitoring of documented dietary intake (oral, sip, enteral, and/or parenteral); of this, once weekly with performance of the following procedures:
3.1	Grip strength measurement or BIA or indirect calorimetry
3.2	Recording of weight/body mass index (BMI)
4.	Weekly team meeting
5.	Indication-dependent recommendations for the physician providing further care and/or home care service providers

Tab. 1: **Structural and process features of complex medical nutritional therapy** (own representation according to the German Federal Institute for Drugs and Medical Devices [25])



Structural requirements of complex medical nutritional therapy

Various basic requirements must be met for CMNT to be provided and coded (♦ Tables 1 and 2).

OPS code	Treatment days
8-98j.0	up to 6
8-98j.1	Minimum 7 to maximum 13
8-98j.2	Minimum 14 to maximum 20
8-98j.3	At least 21

Tab. 2: **Differentiation according to treatment days**
(own presentation according to German Federal Institute for Drugs and Medical Devices [25])

As of January 1, 2022, further differentiation of coding by treatment days is possible. As shown in ♦ Table 2, treatment duration can be divided into four categories ranging from a maximum of six days to a minimum of 21 days.

Possible applications of complex medical nutritional therapy

Because there is no specific differentiation in the structure and process characteristics with regard to the indications, CMNT is basically suitable for all patients who have a differentiated nutrition problem. The ICD codes shown in the ♦ box can be used to indicate nutrition-related diagnoses, among others.

As described at the outset, the current focus is still on patients with an increased risk of malnutrition or diagnosed malnutrition. The etiology-based diagnoses of malnutrition are presented in the 2017 consensus-based guideline on the definition and terminology of clinical nutrition published by the European Society for Clinical Nutrition and Metabolism (ESPEN) [26]. They provide indications for potential uses of CMNT. A distinction can be made between disease-specific malnutrition – both without and with inflammation – and disease-independent malnutrition. Causes of malnutrition without inflammation may include dysphagia, neurological diseases and strokes, gastroenterological diseases (e.g., short bowel syndrome), and psychological disorders [26]. Chronic diseases and thus an increased risk of malnutrition may be present in patients with inflammatory bowel disease (IBD), chronic kidney dis-

ease, chronic obstructive pulmonary disease (COPD), and heart failure as well as other advanced organ diseases. Affected persons with oncological diseases can also be included in this group. Both disease-related malnutrition diagnosis groups could include patients with an indication for treatment by CMNT.

The diseases can also be diagnosed in patients receiving intensive care; CMNT is thus applicable here as well [25]. Similarly, there may be an increased risk of malnutrition here as a result of systemic infections, burns, injuries, or major surgery. In addition to medical factors, social and economic influences as well as advancing age may increase the risk of malnutrition [26]. In addition to malnourished patients, bariatric surgery patients and patients with epilepsy could also benefit from CMNT. Consequently, patients from oncological, surgical, gastroenterological, and geriatric departments as well as internal medicine may be particularly indicated for CMNT because they have a high prevalence of malnutrition. It should be noted that nutritional therapy must be coded separately if it is used as the main medical treatment or as an ancillary treatment in patients who are not receiving intensive care [25]. CMNT does not preclude the use in pediatrics. However, it does pose challenges because the specified malnutrition screenings and use of BMI for under 18-year-olds have not been validated. Nevertheless, outpatient nutritional therapy following discharge should generally be considered reasonable.

Expected costs of complex medical nutritional therapy

A distinction can be made between investment costs and follow-up costs in terms of the costs that can be expected to be incurred in order to create and maintain the basic structural conditions. These depend on the existing equipment of the hospital and may consist of medical technology and/or appropriate accessories, space for the nutrition team, and continuing education as appropriate. The implementation initially involves an organizational effort (in terms of time) to plan, set up, and consolidate the newly introduced structures. ♦ Table 3 provides an overview of possible expenses without taking into account personnel resources.

Furthermore, ongoing costs for maintenance, replacement purchases, and consumables (e.g., electrodes) must be calculated. In the CMNT specifications, in contrast to the widespread nutritional therapy with one-time patient

ICD codes that may justify complex medical nutritional therapy (examples)

E40–E46 (malnutrition)

R63.3 (Feeding difficulties and mismanagement)

R63.4 (Abnormal weight loss)

R63.6 (Insufficient intake of food and water)

R63.8 (Other symptoms and signs concerning food and fluid intake)

M62.50 (Muscle wasting and atrophy, not elsewhere classified)



contact, a larger time window is provided for working with patients. The scope of the assessment as well as the follow-ups and the stronger monitoring aspect intensifies the contact between patients and the nutrition team, especially the nutritionists. The implementation of a CMNT is accompanied by continuous documentation of the services provided. This could be the basis for an expense calculation by the costing hospitals and subsequently enable an evaluation by the Institute for the Hospital Remuneration System (InEK). It would thus be possible to remunerate the additional expenditure accordingly.

In the qualification work of Kray 2021 on the “[...] evaluation of the feasibility and outcome of complex medical nutritional therapy according to OPS code 8-98j” [27] in a maximum care hospital, the Dietrich-Bonhoefer-Klinikum (DBK) Neubrandenburg, initial information on the costs incurred in implementing CMNT were collected using the example of four treated patients. The working time of the nutrition team with and without patient contact as well as the use of oral nutritional supplements were considered. On average, the four patients generated costs of €5 29.70 (€5 78.53; €8 04.23; €3 36.49; € 392.94) over the course of the CMNT. These costs were influenced by different treatment periods (III next section) and different needs for oral nutritional supplements.

Implementation and execution of the CMNT – Practical experience to date

As shown in ♦ Figure 1, a standardized nutritional screening is necessary before starting CMNT; this should be performed by the care staff. Further diagnostics as well as intervention needs, which are taken over exclusively by the nutrition team, result from the positive result of the screening and are the beginning of the CMNT. Possible screening instruments include the Nutritional Risk Score 2002 (NRS 2002), the Mini Nutritional Assessment (MNA), and the Nutrition Risk in Critically ill (NUTRIC) score.

After a positive screening result, the energy and nutrient requirements are determined in the course of a basic assessment for nutritional medical diagnostics. An individual therapy plan is then drawn up according to the current Guidelines for Nutritional Therapy for Clinics and Practices (LEKuP) and the stage scheme of nutrition according to the DGEM terminology [1]. Both the performance of the basic assessment and the determination of needs and therapy planning are carried out by the nutritionists in consultation with the respective physicians of the nutrition team. The course of treatment is monitored twice a week, and therapy is adjusted if necessary [25]. In addition to food intake, either weight and BMI are recorded or a grip strength measurement, BIA, or indirect calorimetry is performed in alternation. In addition, interdisciplinary weekly case discussions of the nutrition team are scheduled under the direction of the nutritionally trained medical specialist or nutritionist.

Upon discharge, there should be an orderly transition to continuing care providers and the continuation of nutritional therapy interventions as needed. For this purpose, it is important to include the nutritional therapy recommendations in the discharge report [28]. This is the task of physicians. In general, care should be taken to ensure that all CMNT content is documented in detail. To date, only a few scientific papers have been published on the implementation of CMNT. In the qualification work of Kray [27],

Material expenses	Price, including VAT, in €	Possible providers
BIA devices used while standing	€ 6,200–11,000	Tanita Seca
Mobile BIA	€ 2,970–5,000	Seca, Data Input, Medi Cal
Indirect calorimetry	€ 14,000–16,000	Cosmed
Floor scales/stand scales	€ 400–1,050	ADE Medical, Seca, Kern, Soehnle
Chair scales	€ 1,325–1,770	Seca, Kern, Soehnle
Hand dynamometer (Attention: should be approved as a medical device)	€ 150–€ 650	Jamar, Kern
Initial equipment consumables	approx. € 200	various providers
Non-material expenses	Price, including VAT, in €	Provider
Further education for additional qualification in nutritional medicine	Advanced training in nutritional medicine € 1,980–2,700 plus case seminars (5, each approx. € 500) or six-month continuing education in an authorized clinic	MemoMed, German Academy for Nutritional Medicine (DAEM)
	Examination at the respective state medical associations in order to have the additional training in nutritional medicine recognized	

Tab. 3: Overview of possible material and non-material expenses (source: compiled according to manufacturer’s specifications and market situation at the time of manuscript preparation as of February 2023)

BIA: Bioelectrical impedance analysis

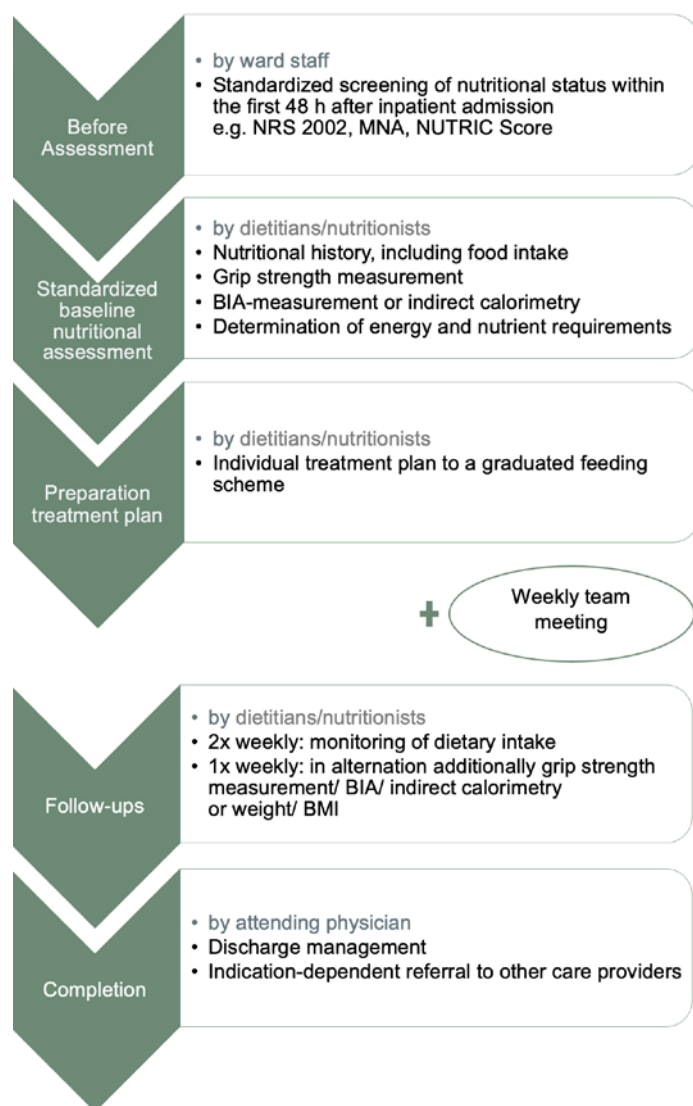


Fig. 1: Systematic procedure of complex medical nutritional therapy (own representation according to the German Federal Institute for Drugs and Medical Devices [26])

in 2021, initial experience was gained on the implementation and practical execution of CMNT at the Dietrich-Bonhoeffer-Klinikum Neubrandenburg (DBKN). In order to facilitate the implementation of CMNT, it was initially limited to the surgical ward. Because CMNT influences the treatment processes, a continuous exchange with all professional groups involved, especially the ward staff, proved to be essential throughout both the introduction phase and implementation phase. The introduction of CMNT was discussed in the nutrition team of DBKN. This consisted of dietitians, a nutritionist, a care specialist, a diabetes consultant, speech therapist, and a pharmacist. The information was passed on to the physicians of the surgical ward via the head nutritionist (Prof. Dr. J.-P. Keil). Verbal and written information to the care staff was provided by the nutrition team, especially by the dietitians. Similar experiences with the implementation of CMNT were also

described by Müller and Weimann (Klinikum St. Georg Leipzig) [23] and Hausen et al. (University Hospital Bonn) [29]. At University Hospital Bonn, the introduction of the CMNT was supervised and evaluated by a newly established nutrition commission consisting of medical and care management, pharmacy and kitchen management, and contact persons from purchasing and controlling [29]. Again, the advance information provided by medical and care ward staff as well as the relevant IT and coding departments were described as supportive factors [23, 29].

In all clinics, it also proved positive to implement CMNT initially on a ward that was already familiar with the work of the nutrition team [23, 27, 29]. For example, in the DBK Neubrandenburg [27], initially only patients of a surgical ward were provided with CMNT. According to Müller and Weimann [23], the intensified collaboration with the ward staff enabled continual consultation in order to record food intake and adjust nutritional therapy if necessary.

Through interaction with ward staff, the nutrition team at DBK Neubrandenburg was informed of patients with a potential need for CMNT/nutritional intervention the day before their scheduled hospital admission. This was made possible because the ward had an overview of the planned new admissions, including the main diagnosis and the planned intervention. For example, patients with a potential need were treated surgically for inflammatory bowel disease or oncological disease in the gastrointestinal tract.

After the nutritional screening, it was made possible to perform the assessment on the day of admission. The treatment period was thus maximally utilized [27]. The overall treatment duration of the four CMNTs performed at DBK Neubrandenburg averaged 3.6 h (individual treatment durations of 2.8 h, 3.6 h, 3.7 h, and 4.3 h over the entire treatment period).

Of these, an average of 1.8 h (1.7, 1.8, 1.8, and 1.9 h) was spent on the baseline assessment, and an average of 0.4–0.8 h per follow-up per week. Additional working hours resulted from nutrition team meetings (0.5 h per week) and interdisciplinary consultations [27]. At University Hospital Bonn, it was possible to link the digital implementation of malnutrition screening with the automatic request for a nutrition consultation and reduce process steps [29].

Furthermore, the preparation and further development of electronic and printed templates



for the documentation of the assessment and course proved to be advantageous in the DBK Neubrandenburg. This included information for ongoing care after hospitalization [27, 28]. Specifically, a distinction was made between documentation templates for assessment and follow-ups. They included anamnestic and diagnostic information (e.g., anthropometric data, relevant diseases, the results of nutritional screening and grip strength measurement) on the treated person as well as a final assessment. Furthermore, a nutritional history, including the recording of food intake, was performed by means of a 24-h recall. After determining individual energy and nutrient needs, the recommended nutritional therapy was documented. The results of the respective examinations were recorded in the follow-ups. In addition to food intake, the course of nutritional therapy, other laboratory chemistry findings, information from the nutrition team meeting, and possible changes in therapy were documented. A similar compact documentation template was developed at Klinikum St. Georg [23]. It is divided into three parts that are completed at different times. Within the first 48 h after admission, the first part must be completed. This includes the screening result and anthropometric data as well as individual needs and a treatment plan. In the second part, the follow-ups are recorded. The last part is for discharge management. In addition, guidance on coding is provided.

Regular exchange within the nutrition team allowed for renewed discussion and, if necessary, adjustment of nutritional therapy decisions in all hospitals presented [23, 27, 29]. Here, the expertise of the different professions of the nutrition team proved to be beneficial and enabled the use of “collective intelligence” [1, 23]. Possible bases for discussion may include treatment planning and goals, difficulties encountered with food intake and tolerability of the nutritional support used, and recommendations for continuing care after discharge.

The “best practice” knowledge of all involved can benefit not only the patients but also all members of the nutrition team. In addition to the patient-specific discourse, there is the opportunity to exchange ideas about the coding of nutrition-specific secondary diagnoses as well as the organization of the CMNT in everyday clinical practice. Contemporary nutrition management leads to multiple inter-

faces through the involvement of different professional groups. At the University Hospital of Tübingen, for example, in addition to the nutrition team of the Nutrition Unit, physicians, care staff (including stoma care and care of percutaneous endoscopic gastrostomies (PEG)) and kitchen and service staff as well as physiotherapy and outpatient rehabilitation are involved in the exchange [30]. When implementing nutritional therapy and CMNT, interdisciplinary exchange is envisaged. After baseline assessment and therapy planning by the nutrition team, therapy is confirmed by a ward physician. The therapy is implemented in cooperation with the care and service staff. Multidisciplinary rounds and case discussions take place during the course of treatment [27]. A nutrition commission was established in 2019 at the University Hospital Bonn for structured interface coordination [29].

Structural challenges and opportunities

Both Kray [27] and Müller and Weimann [23] describe hospital processes as an obstacle to meeting timelines. First, the time window of 48 h after ward admission should be considered when performing the nutritional screening. Regular training on the use and importance of malnutrition screening can be helpful in establishing the approach [31]. During the implementation of the assessment and the twice-weekly scheduled follow-ups, bottlenecks sometimes occur as a result of early discharges or the absence of patients because of further examination and treatment appointments. The documentation of all process steps is essential [23, 27, 29].

The nutrition teams of Klinikum St. Georg in Leipzig [23], Bonn University Hospital [29], and DBK Neubrandenburg [27] are optimizing the process steps and collaboration as well as gradually establishing CMNT on additional wards. This should result not only in more frequent coding but also in quality assurance and enhancement. Through complex therapy, nutritional therapy gained more presence and acceptance at Klinikum St. Georg [23].

Conclusions

CMNT created a way to map the complexity and quality of advanced nutritional medicine services. The OPS definition specifies not only clear structure and process characteristics that can be applied to the introduction and expansion of nutritional medicine but also a possibility to improve and assure quality. This predetermined process, which is based on interprofessional collaboration, could also represent a great opportunity for the further development and demonstrability of the benefits of nutritional therapies because of the demonstrable and documented structure. As a result, the presence and acceptance of nutritional medicine and its services can be increased.

At this point in time, CMNT is not yet revenue-relevant. Until this is the case, hospitals would have to make an upfront investment. This can be viewed as an investment in a fundamental change in the nutritional medicine claims payment system. This also applies if the break-even point is currently neither foreseeable nor calculable and may even not be reached because of the lack of implementation. More frequent implementation, documentation, and



coding are thus necessary in order to provide the basis for evaluation that is needed to calculate the effort. If necessary, advance directives could be implemented at the expense of care resources or the reassignment of unfilled care positions as well as the definition of nutritional therapy as auxiliary care activity. Nutrition-related diagnoses and treatments could thus gain in importance. In the long term, revenue relevance may provide an additional basis for funding the nutrition team.

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Conflict of interest

The authors declare that there is no conflict of interest.

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Anerkannte Fortbildung für die Zertifikate der DGE, des VDD, des VDOE, des VFED, der RAL GEK und der Landesärztekammer Hessen

Zertifizierte Fortbildung

10 Fragen

Informationen zur Teilnahme:
www.ernaehrungs-umschau.de

Bearbeitung möglich bis:
15.08.2023

Bei allen Fragen ist jeweils
nur eine Antwort richtig.

1. Welche der folgenden Aussagen ist NICHT zutreffend?

- A Komplexbehandlungen werden über den Operations- und Prozedurenschlüssel des Bundesinstituts für Arzneimittel und Medizinprodukte (BfArM) definiert.
- B Unter „Komplexbehandlung“ versteht man die Kombination aus verschiedenen Verfahren zur Diagnose und Behandlung bestimmter Erkrankungen.
- C Komplexbehandlungen können den Behandlungsumfang, die Durchführung, personelle und apparative Voraussetzungen und Hinweise für die Kodierung vorgeben.
- D Komplexbehandlungen beziehen sich ausschließlich auf die Kombination von ambulanten und stationären Behandlungen.

2. Welche Aussagen zum OPS-Code 8-98j für die ernährungsmedizinische Komplexbehandlung (EMKB) sind korrekt? Die EMKB...

- 1. ist bisher nicht erlösrelevant.
 - 2. soll durch definierte Qualitätskriterien die ernährungsbezogene Versorgungsleistung in Krankenhäusern verbessern.
 - 3. soll eine transparentere Abrechnung der ernährungsmedizinischen Leistungen ermöglichen.
 - 4. wurde 2015 erstmals definiert.
- A Nur die Antworten 1 und 2 sind richtig.
 - B Nur die Antworten 2 und 3 sind richtig.
 - C Nur die Antworten 1, 2 und 3 sind richtig.
 - D Nur die Antworten 2, 3 und 4 sind richtig.

3. Welche Personengruppen müssen laut OPS-Code 8-98j im Ernährungsteam mindestens vertreten sein?

- 1. FachärztIn mit der strukturierten curricularen Fortbildung oder der Zusatzbezeichnung Ernährungsmedizin
 - 2. Pflegefachkraft
 - 3. DiätassistentIn oder ÖkotrophologIn
 - 4. LogopädIn
- A Nur die Antwort 1 ist richtig.
 - B Nur die Antworten 1 und 2 sind richtig.
 - C Nur die Antworten 1 und 3 sind richtig.
 - D Nur die Antworten 1, 3 und 4 sind richtig.

4. Welche Erreichbarkeit wird dem Ernährungsteam durch den OPS-Code 8-98j vorgegeben?

- A Mindestens 7 h an allen Wochentagen (Montag–Sonntag)
- B Mindestens 7 h an den Werktagen (Montag–Freitag)
- C Mindestens 4 h an allen Werktagen (Montag–Freitag)
- D Erreichbarkeit an allen Werktagen (Montag–Freitag), ein genauer Zeitraum ist nicht definiert

5. In welchem Zeitraum, beginnend ab der stationären Aufnahme, muss das standardisierte Screening des Ernährungsstatus stattfinden?

- A Innerhalb der ersten 48 h
- B Innerhalb der ersten 24 h
- C Innerhalb von drei Tagen
- D Innerhalb von vier Tagen

6. Ein individueller Therapieplan wird erstellt nach dem aktuellen Leitfaden Ernährungstherapie für Klinik und Praxis (LEKuP) und ...

- A den für Mangelernährung relevanten ICD-Codes.
- B dem Stufenschema der Ernährung nach der DGEM-Terminologie.
- C den Referenzwerten für die Nährstoffzufuhr der Deutschen Gesellschaft für Ernährung.

- D den für die klinische Ernährung publizierten Leitlinien auf www.awmf.org/.

7. Wann sind das standardisierte ernährungsmedizinische Basisassessment und die Weiterbetreuung in der EMKB indiziert?

- A Immer wenn ein Ernährungsscreening durchgeführt wurde.
- B Wenn das Ernährungsteam entscheidet, dass eine Weiterbetreuung notwendig ist.
- C Wenn das Ernährungsscreening ein erhöhtes Mangelernährungsrisiko zeigt oder ein anderes komplexes Ernährungsproblem vorliegt.
- D Wenn der/die PatientIn länger als vier Tage stationär behandelt wird.

8. Welche der genannten Prozessschritte gehören NICHT zum standardisierten ernährungsmedizinischen Basisassessment?

- A Ernährungsanamnese inkl. aktueller Nahrungsaufnahme
- B Bioelektrische Impedanzanalyse (BIA) oder Bestimmung des Energieumsatzes mittels indirekter Kalorimetrie
- C Energie- und Nährstoff-Bedarfsermittlung
- D Vorstellung des/der PatientIn im Ernährungsteam

9. Welche Prozessschritte sind im Rahmen der Verlaufskontrolle 2-mal wöchentlich vorgesehen?

- A Handkraftmessung und BIA
- B vollständige Verlaufs- und Zielkontrolle der Nahrungsaufnahme
- C indirekte Kalorimetrie und Erfassung von Gewicht/BMI
- D Teambesprechung

10. Für welche PatientInnengruppe ist die EMKB NICHT indiziert?

- A PatientInnen mit einem erhöhtem Mangelernährungsrisiko
- B angiologische PatientInnen
- C geriatrische PatientInnen
- D onkologische PatientInnen