Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

PROMISE HOSPITAL OF ASCENSION INCORRECTLY BILLED MEDICARE INPATIENT CLAIMS WITH KWASHIORKOR

Inquiries about this report may be addressed to the Office of Public Affairs at Public.Affairs@oig.hhs.gov.

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Acting Regional Inspector General for Audit Services

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Office of Inspector General

http://oig.hhs.gov

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OFFICE OF AUDIT SERVICES FINDINGS AND OPINIONS

The designation of financial or management practices as questionable, a recommendation for the disallowance of costs incurred or claimed, and any other conclusions and recommendations in this report represent the findings and opinions of OAS. Authorized officials of the HHS operating divisions will make final determination on these matters.

Promise Hospital of Ascension incorrectly billed Medicare inpatient claims with Kwashiorkor, resulting in overpayments of over $465,000 over 4 years.

INTRODUCTION

WHY WE DID THIS REVIEW

Kwashiorkor is a form of severe protein malnutrition. It generally affects children living in tropical and subtropical parts of the world during periods of famine or insufficient food supply. Cases in the United States are rare. The Medicare program provides health insurance coverage primarily to people aged 65 or older; however, for calendar years (CYs) 2010 and 2011, Medicare paid hospitals $711 million for claims that included a diagnosis code for Kwashiorkor. Therefore, we are conducting a series of reviews of hospitals with claims that include this diagnosis code.

OBJECTIVE

Our objective was to determine whether Promise Hospital of Ascension (the Hospital) complied with Medicare billing requirements for Kwashiorkor.

BACKGROUND

The Medicare Program

Medicare Part A provides inpatient hospital insurance benefits and coverage of extended care services for patients after hospital discharge. The Centers for Medicare & Medicaid Services (CMS) administers the Medicare program. CMS contracts with Medicare contractors to, among other things, process and pay claims submitted by hospitals, including long-term care hospitals.

Hospital Inpatient Prospective Payment System

Long-term care hospitals provide care for clinically complex patients who require long stays (more than 25 days) with hospital-level care. CMS pays predetermined rates for these patient discharges under the inpatient prospective payment system for long-term care hospitals. The rates vary according to the diagnosis-related group (DRG) to which a beneficiary's stay is assigned and the severity level of the patient's diagnosis. DRGs for long-term care hospitals are weighted to reflect the resources that patients in long-term care require.

The DRG payment is, with certain exceptions, intended to be payment in full to the hospital for all inpatient costs associated with the beneficiary's stay. The DRG and severity level are determined according to diagnoses codes established by the *International Classification of Diseases, Ninth Revision, Clinical Modification* (ICD-9 coding guidelines). The ICD-9 coding guidelines establish diagnosis code 260 for Kwashiorkor. Because Kwashiorkor is considered a high-severity diagnosis, using diagnosis code 260 may increase the DRG payment.

Promise Hospital of Ascension

The Hospital, which is part of Promise Healthcare, was a 54-bed transitional care hospital located in Gonzales, Louisiana. The Hospital closed prior to the start of our audit work. The Hospital received $5,760,038 in Medicare payments for inpatient hospital claims that included diagnosis code 260 for Kwashiorkor during our audit period (CYs 2010 through 2013) based on CMS's National Claims History data.

HOW WE CONDUCTED THIS REVIEW

Our audit covered $2,137,016 of $5,760,038 in Medicare payments to the Hospital for 62 of the 163 inpatient hospital claims that contained diagnosis code 260 for Kwashiorkor. We did not review the remaining claims because removing diagnosis code 260 did not change the Medicare payment. We also did not review managed care claims or claims that were under separate review. We evaluated compliance with selected Medicare billing requirements but did not use medical review to determine whether the services were medically necessary. This report does not represent an overall assessment of all claims submitted by the Hospital for Medicare reimbursement.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

See Appendix A for the details of our scope and methodology.

FINDING

The Hospital did not comply with Medicare requirements for billing Kwashiorkor on any of the 62 claims that we reviewed. The Hospital used diagnosis code 260 for Kwashiorkor but should have used codes for other forms of malnutrition or no malnutrition code at all. For four of the inpatient claims, substituting a more appropriate diagnosis code produced no change in the DRG or payment amount. However, for the remaining 58 inpatient claims, the errors resulted in overpayments of $465,079. Promise Healthcare believes that all claims identified by the Office of Inspector General were appropriately submitted for payment.

FEDERAL REQUIREMENTS AND GUIDANCE

Medicare payments may not be made for items and services that "are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member" (The Social Security Act, § 1862(a)(1)(A)). Federal regulations state that the provider must furnish to the Medicare contractor sufficient information to determine whether payment is due and the amount of the payment (42 CFR § 424.5(a)(6)). In addition, the *Medicare Claims Processing Manual* requires providers to complete claims accurately so that

Medicare contractors may process them correctly and promptly (Pub. No. 100-04, chapter 1, § 80.3.2.2).

The ICD-9 coding guidelines establish diagnosis code 260 for Kwashiorkor. In addition, the Medicare Contractor Beneficiary and Provider Communications Manual states that ICD-9 related questions are handled by the American Hospital Association's (AHA) Coding Clinic. The Third Quarter 2009 AHA Coding Clinic stated that code 260 is only appropriate when the provider specifically documents Kwashiorkor.

INCORRECT USE OF THE DIAGNOSIS CODE FOR KWASHIORKOR

The Hospital did not comply with Medicare billing requirements for Kwashiorkor for any of the 62 claims that we reviewed, resulting in overpayments of $465,079. The ICD-9 coding guidelines establish diagnosis code 260 for Kwashiorkor. For four of the inpatient claims, substituting a more appropriate diagnosis code produced no change in the DRG or payment amount. However, for the remaining 58 inpatient claims, the errors resulted in overpayments of $465,079. Promise Healthcare believes that all claims identified by the Office of Inspector General were appropriately submitted for payment.

RECOMMENDATIONS

We recommend that Promise Healthcare:

- refund to the Medicare program $465,079 for the incorrectly coded claims and
- strengthen controls to ensure full compliance with Medicare billing requirements.

PROMISE HEALTHCARE COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

In written comments, Promise Healthcare stated that protein malnutrition was documented in the medical record and coded according to Promise's good faith and reasonable interpretation of the official ICD-9-CM instructions. Promise Healthcare believes that all claims identified by the Office of Inspector General were appropriately submitted for payment.

Promise Healthcare's comments are included as Appendix B.

The Office of Inspector General maintains that the 62 claims reviewed were coded incorrectly resulting in overpayments of $465,079. We agree that the claims documented protein malnutrition. However, based on the ICD-9 coding guidelines and the Third Quarter 2009 AHA Coding Clinic, the Hospital should have used diagnosis code 263.9 for unspecified protein malnutrition instead of diagnosis code 260 for Kwashiorkor.

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

Our audit covered $2,137,016 in Medicare payments to the Hospital for 62 inpatient claims that contained diagnosis code 260 for Kwashiorkor during the period January 1, 2010, through December 31, 2013. We reviewed only claims for which removing the diagnosis code 260 changed the Medicare payment. We did not review managed care claims or claims that were under separate review.

We limited our review of the Hospital's internal controls to those applicable to the coding of inpatient hospital claims because our objective did not require an understanding of all internal controls over the submission and processing of claims. We evaluated compliance with selected Medicare billing requirements, but did not use medical review to determine whether the services were medically necessary. We established reasonable assurance of the authenticity and accuracy of the data obtained from the National Claims History file, but we did not assess the completeness of the file.

This report does not represent an overall assessment of all claims submitted by the Hospital for Medicare reimbursement.

We conducted our review from February through September 2015.

METHODOLOGY

To accomplish our objective, we:

- reviewed Federal laws, regulations, and guidance;
- extracted the Hospital's inpatient paid claims data from CMS's National Claims History file for the audit period;
- selected all paid claims that included the diagnosis code for Kwashiorkor (260);
- removed all managed care claims and any claims that were previously reviewed by a Recovery Audit Contractor;
- removed all claims for which removing the diagnosis code for Kwashiorkor did not change the Medicare payment;
- reviewed available data from CMS's Common Working File for the selected claims to determine whether the claims had been cancelled or adjusted;
- repriced each selected claim in order to verify that the original payment by the CMS contractor was made correctly;

- requested that the Hospital conduct its own review of the 62 claims to determine whether the diagnosis code for Kwashiorkor was used correctly;

- reviewed the medical record documentation that the Hospital provided to support other malnutrition diagnoses;

- discussed the incorrectly coded claims with Hospital officials to determine the underlying causes of noncompliance with Medicare requirements;

- substituted a corrected diagnosis code based on the documentation provided and calculated the correct payments for those claims requiring adjustments; and

- discussed the results of our review with Hospital officials.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

APPENDIX B: PROMISE HEALTHCARE COMMENTS

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November 19, 2015

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DELIVERED VIA HHS/OIG DELIVERY SERVER

RE: Report Number A-03-15-00007

Dear Mr. Piccari:

I am writing in response to your email from November 10, 2015 regarding the pending final audit report referenced above. This audit reviews the use of International Classification of Diseases, Ninth Revision, and Clinical Modification ("ICD-9-CM") Code 260 ("Code 260") as a diagnosis code by Promise Hospital of Ascension ("Promise"). Promise appreciates the opportunities OIG has provided to submit additional information and documentation as part of the audit process. Promise is now in receipt of the OIG's final results concluding that certain claims in the sample used Code 260 incorrectly.

In sum, Promise believes protein malnutrition was documented in the medical record, supported by the treatment provided to the patient, and coded according to Promise's good faith and reasonable interpretation of the official ICD-9-CM instructions. Accordingly, Promise believes that the claims contained in the audit were appropriately submitted for payment. In addition, for some patients the medical record shows that the patient suffered from another major complication or comorbidity ("MCC"), which means that the amount of Medicare payment received for that patient would remain the same even if Code 260 was changed to another diagnosis code. OIG has informed Promise that the presence of other MCCs is outside the audit's scope, and thus was not considered by OIG.

Promise appreciates the OIG bringing this matter to our attention and stands ready to discuss the issue as soon as the MAC contacts us.

Sincerely,

/David Armstrong/

General Counsel
Chief Compliance Officer