

Department of Health and Human Services

**OFFICE OF  
INSPECTOR GENERAL**

**CORNERSTONE HOSPITAL OF AUSTIN  
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](mailto:Public.Affairs@oig.hhs.gov).*



**Brian P. Ritchie**  
Assistant Inspector General  
for Audit Services

August 2016  
A-03-15-00009

# *Office of Inspector General*

<http://oig.hhs.gov>

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# *Notices*

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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.

***Cornerstone Hospital of Austin incorrectly billed Medicare inpatient claims with Kwashiorkor, resulting in overpayments of \$358,000 over 5 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 Cornerstone Hospital of Austin (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.

## **Cornerstone Hospital of Austin**

The Hospital, which is part of Cornerstone Healthcare Group, is a 118-bed long-term acute-care hospital located in Austin, Texas. The Hospital received \$3,739,115 in Medicare payments for inpatient hospital claims that included diagnosis code 260 for Kwashiorkor during our audit period (CYs 2010 through 2014) based on CMS's National Claims History data.

### **HOW WE CONDUCTED THIS REVIEW**

Our audit covered \$1,863,855 of \$3,739,115 in Medicare payments to the Hospital for 54 of the 118 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 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 54 claims that we reviewed. The Hospital used diagnosis code 260 for Kwashiorkor but should have used codes for other forms of malnutrition. The 54 inpatient claims that were coded incorrectly resulted in overpayments of \$357,516. Hospital officials believe 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 54 claims that we reviewed. The ICD-9 coding guidelines establish diagnosis code 260 for Kwashiorkor. The Hospital used diagnosis code 260 for Kwashiorkor but should have used codes for other forms of malnutrition. The 54 inpatient claims that were coded incorrectly resulted in overpayments of \$357,516. Hospital officials believe that all claims identified by the Office of Inspector General were appropriately submitted for payment.

### **RECOMMENDATIONS**

We recommend that the Hospital:

- refund to the Medicare program \$357,516 for the incorrectly coded claims and
- strengthen controls to ensure full compliance with Medicare billing requirements.

### **CORNERSTONE HOSPITAL OF AUSTIN COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE**

In written comments, the Hospital agreed that none of the patients were correctly coded for Kwashiorkor; however, Hospital officials believe that in all cases the medical record documentation supported some level of protein malnutrition. In addition, Hospital officials indicated that the coding requirements for protein malnutrition were confusing when these claims were submitted. Based on their interpretation of the ICD-9 coding guidelines, Hospital officials believe that all claims identified by the Office of Inspector General were appropriately submitted for payment.

The Hospital's comments are included as Appendix B. We did not include the attachment because it contained personally identifiable information.

The Office of Inspector General maintains that the 54 claims reviewed were coded incorrectly resulting in overpayments of \$357,516. We agree that the claims documented protein malnutrition and that ICD-9 coding requirements for protein malnutrition could be confusing. However, the Third Quarter 2009 AHA Coding Clinic clarified that code 260 is only appropriate when the provider specifically documents Kwashiorkor. All 54 claims were submitted after this clarification. Therefore, 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 \$1,863,855 in Medicare payments to the Hospital for 54 inpatient claims that contained diagnosis code 260 for Kwashiorkor during the period January 1, 2010, through December 31, 2014. We reviewed only claims for which removing the diagnosis code 260 changed the Medicare payment.

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 June 2015 through April 2016.

### **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 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 54 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: CORNERSTONE HOSPITAL OF AUSTIN COMMENTS**

# **CHG Hospital Austin, LLC**

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2200 Ross Avenue, Suite 5400, Dallas, Texas 75201  
dsmith@chghospitals.com  
469-621-6761 (direct)

April 29, 2016

*Via HHSIOIG Delivery Server*

OIG Office of Audit Services  
Attn: Stephen Virbitsky  
Regional Inspector General for Audit Services  
Office of Audit Services, Region III  
Public Ledger Building, Suite 316  
150 S. Independence Mall West  
Philadelphia, PA 19106

Re: Cornerstone Hospital Austin Long Term Care

Mr. Virbitsky:

We have investigated the claims that the Office of Inspector General (OIG) identified in its June 9, 2015 letter. Cornerstone Hospital Austin (Cornerstone) takes accurate coding very seriously and appreciates the opportunity to respond to this inquiry. To investigate the claims, we took the following steps:

OIG identified 54 Medicare inpatient hospital claims submitted by Cornerstone during calendar years 2010 through 2013 with Kwashiorkor (diagnosis code 260) as a primary or secondary diagnosis. The full patient records for each of these claims were retrieved from Medical Records and a team consisting of the Corporate Chief Clinical Officer, Facility CEO and CNO, Centralized Coding Manager/Auditor, our Clinical Documentation Integrity Physician Advisors and Corporate Director of Case Management reviewed the medical records for each of these claims. Physician documentation as well as lab results and the Registered Dietitian notes, where applicable were reviewed. Supportive documentation of malnutrition was copied and highlighted for submission to the OIG. The Severity of the malnutrition documented was recorded and added to the attached spreadsheets, supporting documents were copied and reference to malnutrition was highlighted.

Based on our investigation and clinical review of the patient's needs, as reflected in their documentation, we determined that the medical record documentation that was available and reviewed, in all cases did support some level of Protein Malnutrition. As you know the HHS-OIG review is limited to only a surface review and only a plain language reading of the documentation and cannot review the documents for actual clinical and medical determinations of present conditions in the records that result in billing and coding. In our review we used licensed physicians and medical personnel to perform the review. As such the review maintains the requirements under the Yellow Book to have qualified personnel performing the review. Based on our clinical documentation review using medical personnel we believe the attached results bear the greatest weight of reliability under the performance review standards and we

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**OIG Office of Audit Services**  
**Attn: Stephen Virbitsky**  
**Regional Inspector General for Audit Services**  
**Office of Audit Services, Region III**  
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request the offsets we have documented to be applied properly to the contested amounts. As you will see the information attached clearly shows the levels and offsets that are applicable to the fifty-four (54) claims based upon the medical and clinical standards we applied in our review.

While none of the patients were correctly coded for "Kwashiorkor" based on subsequent clarifications in the guidance, they were billed due to indicated Protein Malnutrition according to the ICD publication in effect at the time the coding occurred. At that time the tabular coding index indicated documentation of "Protein Malnutrition" and pointed to code 260. Adding to the confusion, the ICD-9 manual's indexed entries for coding "Malnutrition ... Protein," and lack of clarity in AHA Coding Clinic (3rd Quarter 2009) was acknowledged as confusing and likely caused coders confusion for identifying when a query was necessary. The National Center for Health Care Statistics recognized this issue and in the third quarter of 2009 stated, "NCHS was considering a proposal to revise the index entries under mild and moderate Protein Malnutrition in order to provide clearer direction to the coder." The revisions to the ICD-9-CM Coding Manual index entries did not occur until October 1, 2012, (v30.0) leaving hospitals at risk for generating a 260 diagnosis code for Protein Malnutrition prior to this update. In addition, the official coding guideline state in Section I. Conventions, General Coding Guidelines and Chapter Specific Guidelines:

*The conventions, general guidelines and chapter-specific guidelines are applicable to all health care settings unless otherwise indicated. The conventions and instructions of the classification take precedence over guidelines. (ICD-9-CM Official Guidelines for Coding and Reporting, pg. 6)*

As we have discussed and you are aware there was no other option listed for "Protein Malnutrition" in the earlier guidance. The code book applicable at the time this began also did not provide another clear option related to the severity of the malnutrition. This has been highlighted by other providers as the below referenced response submitted to the OIG in January 2014 indicated:

*Given this lack of clarity in the code book, the specific question was asked by a York Hospital coder of the AHA Central Office on JCD-9-CM. On March 27, 2009, AHA answered that it was appropriate to code 260 when the physician documents only "proteinmalnutrition."*

(WellSpan York Hospital (A-03-13-00015), Department of Health and Human Services OFFICE OF INSPECTOR GENERAL, February, 2014).

Through our investigation, we identified aggravating reasons for the Kwashiorkor miscoding. Cornerstone determined that claims billed with the diagnosis code 260 (Kwashiorkor) were coded erroneously, due to the guidance previously referenced and aggravated by a corresponding programmed decision path within our coding software, 3M Encoder. The

Encoder software is supposed to generate a warning message when a coder reaches a 260 diagnosis code to allow for verification of the type of malnutrition (Severe Protein Malnutrition vs. Kwashiorkor). However, at the time the software did not properly display these warnings. These decision paths and warning messages are programmed into the software by 3M with no ability for Cornerstone driven edits to change the programmed functionality.

Based on multiple requests from clients, 3M implemented a software update in October 2010, to revise the Encoder product to include consistent warnings with diagnosis code 260, regardless of what path a coder follows to reach that diagnosis. As is apparent in the claims lists provided by the OIG, claims for 2012 were not at issue.

Cornerstone has implemented internal controls to verify all claims with a 260 diagnosis code have supportive documentation of Protein Malnutrition. Since the time of these claims, Cornerstone has taken a number of significant steps both in training and investments to ensure the accuracy of its coding and its claims. Cornerstone took immediate action to ensure malnutrition-related claims are billed correctly and in accordance with Medicare requirements. In April of 2011, Cornerstone hired a lead coding resource, and further invested in a Manager of Coding, Health Information Management position. As a result, Cornerstone implemented internal controls to verify all claims with a 260 diagnosis code. Education was also provided to Cornerstone regarding the term Kwashiorkor vs. Protein Malnutrition. On August 30, 2011, Cornerstone hosted a three day coding conference for the Case Management Director, Coders, Coding Manager, and the outside Coding Auditor. This workshop reviewed coding best practices and offered specific examples and recommendations of when clarification is needed. Also in 2011, three full quarter coding audits were completed. Continuing education requirements have also been strengthened and include:

- Ongoing education through AHIMA and or CEU recognized companies for coding certification;
- Educational offerings through our external auditing company every year;
- Compliance training and current coding certification required through either AHIMA and or AAPC;
- Internal audits are routinely completed, with ongoing education both in one on one and group settings;
- Compliant Queries being completed and sent out for conflicting and incomplete documentation;
- PEPPER reports are pulled to identify areas of risk and action plans needed to monitor; and
- Ongoing presentations are held for the coding groups that are developed by the coding manager and or different disciplines.

In addition, Cornerstone has developed an enhanced audit process to ensure all appropriate documents are sent to the coder and the coder is reviewing critical areas for

**OIG Office of Audit Services**  
**Attn: Stephen Virbitsky**  
**Regional Inspector General for Audit Services**  
**Office of Audit Services, Region III**  
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documentation related to the primary and supporting diagnoses. In addition, all 260 diagnosis codes in our prior CPSI system and our HMS system accounts have been pulled from September 15, 2009 through April 30, 2015, for review by the corporate clinical operations and coding teams.

Cornerstone has discussed these items at length with you and appreciates your consideration of the misdirection that existed in the industry at the time and the application of the proper offsets to the indicated levels of documentation.

The attached spreadsheet indicates the medically indicated levels and severity of the malnutrition that was documented for each patient. The spreadsheet is segregated into five tabs based on the severity of the protein malnutrition: (1) Consolidated Claims List; (2) severe Protein Malnutrition; (3) moderate Protein Malnutrition; (4) mild Protein Malnutrition; and (5) unspecified Protein Malnutrition. For your convenience and application of the appropriate offsets we have included in this submission the portion of the medical record indicating Protein Malnutrition and highlighting the documentation supporting our current clinical determinations of the patient's needs as supported by reading the entirety of the medical record.

Cornerstone appreciates the guidance, professionalism and collegiality of the OIG audit team throughout the review process, as well as the opportunity to respond to the OIG's audit findings. Please do not hesitate to contact me if you have any questions or need additional information at information at 512-706-1900.

Respectfully submitted,

**/David F. Smith/** | President

Cornerstone Hospitals of Austin and Round Rock | 4207 Burnet Road | Austin, TX 78756  
dsmith@chghospitals.com