

Department of Health and Human Services

**OFFICE OF  
INSPECTOR GENERAL**

**NORTHSIDE MEDICAL CENTER  
INCORRECTLY BILLED MEDICARE  
INPATIENT CLAIMS WITH SEVERE  
MALNUTRITION**

*Inquiries about this report may be addressed to the Office of Public Affairs at  
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Assistant Inspector General  
for Audit Services

December 2016  
A-03-15-00012

# *Office of Inspector General*

<https://oig.hhs.gov>

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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.

## EXECUTIVE SUMMARY

*Northside Medical Center incorrectly billed inpatient claims with severe malnutrition, resulting in overpayments of approximately \$1.3 million over 2 and a half years.*

### WHY WE DID THIS REVIEW

There are three types of severe malnutrition listed in *the International Classification of Diseases, Ninth Revision, Clinical Modification* (ICD-9 coding guidelines): Kwashiorkor (diagnosis code 260), Nutritional Marasmus (diagnosis code 261), and other severe protein-calorie malnutrition (diagnosis code 262). Previous Office of Inspector General reviews determined that hospitals incorrectly billed for Kwashiorkor, a disease that is rarely found in developed countries.

Nutritional Marasmus is a form of serious protein-energy malnutrition that is caused by a deficiency in calories and energy and is found primarily in children. Similar to Kwashiorkor, diagnosis codes 261 and 262 are each classified as a type of major complication or comorbidity (MCC). Adding MCCs to a Medicare claim can result in a higher Medicare payment.

The Medicare program provides health insurance coverage primarily to people aged 65 or older. For calendar years (CYs) 2011 through 2014, Medicare paid hospitals over \$20 billion for claims that included diagnosis code 261 or 262.

Our objective was to determine whether Northside Medical Center (the Hospital) complied with Medicare billing requirements when assigning diagnosis code 261 or 262 to inpatient hospital claims.

### BACKGROUND

Medicare Part A provides inpatient hospital insurance benefits and extended care services coverage 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. Under the inpatient prospective payment system (IPPS), CMS pays inpatient hospital costs at predetermined rates for patient discharges. 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. 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 diagnosis codes established by the ICD-9 coding guidelines.

Under section 1128J(d) of the Social Security Act and 42 CFR part 401 subpart D (the 60-day rule), upon receiving credible information of a potential overpayment, providers must: (1) exercise reasonable diligence to investigate the potential overpayment, (2) quantify the overpayment amount over a 6-year lookback period, and (3) report and return any overpayments within 60 days of identifying those overpayments (42 CFR 401.305(a)(2), (f) and 81 Fed. Reg. 7654, 7663 (Feb. 12, 2016)). OIG believes that this audit report constitutes credible information of potential overpayments.

The Hospital is a 398-bed university-affiliated hospital located in Youngstown, Ohio, that offers

a wide range of inpatient, outpatient, emergency, diagnostic, and therapeutic services. The Hospital received \$11,076,498 in Medicare payments for 699 inpatient hospital claims that included a diagnosis code for a severe type of malnutrition from January 1, 2013, through June 30, 2015. For 302 of the 699 claims, removing diagnosis code 261 or 262 changed the DRG. Of these 302 claims, we reviewed a random sample of 100 claims totaling \$1,154,023.

## **WHAT WE FOUND**

The Hospital complied with Medicare billing requirements for diagnosis codes 261 and 262 for 2 of the 100 claims that we reviewed. However, the Hospital did not comply with Medicare billing requirements for the remaining 98 claims. For two of these claims, the medical record documentation supported a secondary diagnosis code other than 261 or 262, but the error resulted in no change to the DRG or payment. For the remaining 96 claims, the billing errors resulted in net overpayments of \$463,619. These errors occurred because the Hospital used diagnosis code 261 or 262 when it should have used codes for other forms of malnutrition or no malnutrition diagnosis code at all.

On the basis of our sample results, we estimated that the Hospital received overpayments of at least \$1,280,761 for the audit period.

## **WHAT WE RECOMMEND**

We recommend that the Hospital:

- refund to the Medicare program \$1,280,761 for the incorrectly coded claims;
- exercise reasonable diligence to identify and return any additional similar overpayments outside of our audit period, in accordance with the 60-day rule, and identify any returned overpayments as having been made in accordance with this recommendation; and
- strengthen controls to ensure full compliance with Medicare billing requirements.

## **HOSPITAL COMMENTS AND OUR RESPONSE**

In written comments on our draft report, the Hospital partially disagreed with our first recommendation and agreed with the remaining two recommendations. For 26 of the 98 claims, the Hospital agreed that using diagnosis code 261 or 262 resulted in billing errors. However, the Hospital did not agree with our determination that the other 72 claims incorrectly used diagnosis code 261 or 262. The Hospital stated that for each of these 72 claims, there was a diagnostic statement of malnutrition in addition to other clinical indicators. The Hospital also believes that diagnosis code 261 or 262 on each of these claims meets the definition of a secondary diagnosis and that there is adequate documentation to support the assignment of diagnosis code 261 or 262.

After reviewing the Hospital's comments, we maintain that our findings and recommendations are valid for all 98 claims in error. We subjected the 98 claims to medical review and stand by those medical necessity and coding determinations.

## TABLE OF CONTENTS

INTRODUCTION .....	1
Why We Did This Review .....	1
Objective .....	1
Background .....	1
The Medicare Program .....	1
Hospital Inpatient Prospective Payment System .....	1
Northside Medical Center .....	2
How We Conducted This Review .....	2
FINDING .....	2
Federal Requirements and Guidance .....	3
Incorrect Use of Diagnosis Codes 261 and 262 .....	3
RECOMMENDATIONS .....	4
HOSPITAL COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE .....	4
APPENDIXES	
A: Audit Scope and Methodology .....	5
B: Sample Design and Methodology .....	7
C: Sample Results and Estimates .....	8
D: Hospital Comments .....	9

## INTRODUCTION

### WHY WE DID THIS REVIEW

There are three types of severe malnutrition listed in the *International Classification of Diseases, Ninth Revision, Clinical Modification* (ICD-9 coding guidelines)<sup>1</sup>: Kwashiorkor (diagnosis code 260), Nutritional Marasmus (diagnosis code 261), and other severe protein-calorie malnutrition (diagnosis code 262). Previous Office of Inspector General reviews determined that hospitals incorrectly billed for Kwashiorkor, a disease that is rarely found in developed countries. Nutritional Marasmus is a form of serious protein-energy malnutrition that is caused by a deficiency in calories and energy and is found primarily in children. Similar to Kwashiorkor, diagnosis codes 261 and 262 are each classified as a type of major complication or comorbidity (MCC). Adding MCCs to a Medicare claim can result in a higher Medicare payment.

The Medicare program provides health insurance coverage primarily to people aged 65 or older. For calendar years (CYs) 2011 through 2014, Medicare paid hospitals over \$20 billion for claims that included either diagnosis code 261 or 262.

### OBJECTIVE

Our objective was to determine whether Northside Medical Center (the Hospital) complied with Medicare billing requirements when assigning diagnosis code 261 or 262 to inpatient hospital claims.

### BACKGROUND

#### The Medicare Program

Medicare Part A provides inpatient hospital insurance benefits and extended care services coverage 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

Under the inpatient prospective payment system (IPPS), CMS pays inpatient hospital costs at predetermined rates for patient discharges. 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. 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 diagnosis codes established by the ICD-9 coding guidelines.

Under section 1128J(d) of the Social Security Act and 42 CFR part 401 subpart D (the 60-day rule), upon receiving credible information of a potential overpayment, providers must: (1) exercise reasonable diligence to investigate the potential overpayment, (2) quantify the

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<sup>1</sup> ICD-9 coding guidelines were in effect during our audit period. They were replaced with the ICD-10 coding guidelines, which went into effect October 1, 2015.

overpayment amount over a 6-year lookback period, and (3) report and return any overpayments within 60 days of identifying those overpayments (42 CFR 401.305(a)(2), (f) and 81 Fed. Reg. 7654, 7663 (Feb. 12, 2016)). OIG believes that this audit report constitutes credible information of potential overpayments.

### **Northside Medical Center**

The Hospital is a 398-bed university-affiliated hospital located in Youngstown, Ohio, that offers a wide range of inpatient, outpatient, emergency, diagnostic, and therapeutic services. The Hospital received \$11,076,498 in Medicare payments for 699 inpatient hospital claims that included a diagnosis code for a severe type of malnutrition from January 1, 2013, through June 30, 2015, based on CMS's National Claims History data.

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

Our audit covered \$3,611,647 for the 302 claims containing either diagnosis code 261 or 262 for which removing diagnosis code 261 or 262 changed the DRG. We did not review managed care claims or claims that were under separate review. We selected for review a random sample of 100 claims totaling \$1,154,023.

We evaluated compliance with selected billing requirements and subjected the 100 claims to medical and coding review to determine whether the services were medically necessary and properly coded.

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 audit scope and methodology.

### **FINDING**

The Hospital complied with Medicare billing requirements for diagnosis codes 261 and 262 for 2 of the 100 claims that we reviewed. However, the Hospital did not comply with Medicare billing requirements for the remaining 98 claims. For two of these claims, the medical record documentation supported a secondary diagnosis code other than 261 or 262, but the error resulted in no change to the DRG or payment. For the remaining 96 claims, the billing errors resulted in net overpayments of \$463,619. These errors occurred because the Hospital used diagnosis code 261 or 262 when it should have used codes for other forms of malnutrition or no malnutrition diagnosis code at all. For these claims, the Hospital-provided medical record documentation did not contain evidence that the malnutrition was severe or that it had an effect on the treatment or the length of the hospital stay.



On the basis of our sample results, we estimated that the Hospital received overpayments of at least \$1,280,761 for the audit period.<sup>2</sup>

See Appendix B for our sample design and methodology and Appendix C for our sample results and estimates.

## **FEDERAL REQUIREMENTS AND GUIDANCE**

Medicare payments may not be made for items or 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 (the Act), § 1862(a)(1)(A)). In addition, Medicare payments may not be made to any provider of services or other person without information necessary to determine the amount due to the provider (§ 1833(e)).

Federal regulations state that the provider must furnish the Medicare contractor with sufficient information to determine whether payment is due and the amount of the payment due (42 CFR § 424.5(a)(6)).

The *Medicare Claims Processing Manual* (the Manual), Pub. No. 100-04, requires providers to complete claims accurately so that Medicare contractors may process them correctly and promptly (The Manual, chapter 1, § 80.3.2.2). The Manual also states that the principal diagnosis must be reported; applicable additional diagnosis codes must also be included on inpatient claims and are used in determining the appropriate DRG. The Manual specifies that the provider should report diagnoses for additional conditions “if they coexisted at the time of admission or developed subsequently, and ... had an effect upon the treatment or length of stay” (The Manual, chapter 23, § 10.2). Inpatient hospital claims may include up to 24 additional condition diagnosis codes.

ICD-9 coding guidelines provided general rules for reporting other diagnoses. The guidelines stated that diagnosis codes can be billed for additional conditions if those conditions affect patient care and require either clinical evaluation, therapeutic treatment, or diagnostic procedures, or if those conditions extend the length of the hospital stay or require increased nursing care and/or monitoring. Previous conditions that have no impact on the current stay should not be reported.

## **INCORRECT USE OF DIAGNOSIS CODES 261 AND 262**

The Hospital complied with Medicare billing requirements for diagnosis codes 261 and 262 for 2 of the 100 claims that we reviewed. However, the Hospital did not comply with Medicare billing requirements for the remaining 98 claims. For two of these claims, the medical record documentation supported a secondary diagnosis code other than 261 or 262, but the error resulted in no change to the DRG or payment. For the remaining 96 claims, the billing errors resulted in net overpayments of \$463,619. These errors occurred because the Hospital used diagnosis code 261 or 262 when it should have used codes for other forms of malnutrition or no

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<sup>2</sup> To be conservative, we recommend recovery of overpayments at the lower limit of a two-sided 90-percent confidence interval. Lower limits calculated in this manner will be less than the actual overpayment total at least 95 percent of the time.

malnutrition diagnosis code at all. For these claims, the Hospital-provided medical record documentation did not contain evidence that the malnutrition was severe or that that it had an effect on the treatment or the length of the hospital stay.

On the basis of our sample results, we estimated that the Hospital received overpayments of at least \$1,280,761 for the audit period.

### **RECOMMENDATIONS**

We recommend that the Hospital:

- refund to the Medicare program \$1,280,761 for the incorrectly coded claims;
- exercise reasonable diligence to identify and return any additional similar overpayments outside of our audit period, in accordance with the 60-day rule, and identify any returned overpayments as having been made in accordance with this recommendation; and
- strengthen controls to ensure full compliance with Medicare billing requirements.

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

In written comments on our draft report, the Hospital partially disagreed with our first recommendation and agreed with the remaining two recommendations. For 26 of the 98 claims, the Hospital agreed that using diagnosis code 261 or 262 resulted in billing errors. However, the Hospital did not agree with our determination that the other 72 claims incorrectly used diagnosis code 261 or 262. The Hospital stated that for each of these 72 claims, there was a diagnostic statement of malnutrition in addition to other clinical indicators. The Hospital also believes that diagnosis code 261 or 262 on each of these claims meets the definition of a secondary diagnosis and that there is adequate documentation to support the assignment of diagnosis code 261 or 262.

After reviewing the Hospital's comments, we maintain that our findings and recommendations are valid for all 98 claims in error. We subjected the 98 claims to medical review and stand by those medical necessity and coding determinations.

The Hospital's comments are included as Appendix D. We did not include the Hospital's attachments because they were too voluminous and contained personally identifiable information.

## APPENDIX A: AUDIT SCOPE AND METHODOLOGY

### SCOPE

Our audit covered \$3,611,647 in Medicare payments to the Hospital for 302 claims that contained diagnosis code 261 or 262 during the period from January 1, 2013, through June 30, 2015. We only reviewed claims for which removing diagnosis code 261 or 262 changed the DRG. We did not review managed care claims or claims that were under separate review. We selected for review a simple random sample of 100 claims totaling \$1,154,023. These 100 claims had dates of service in our audit period.

We evaluated compliance with selected billing requirements and subjected the 100 claims to medical and coding review to determine whether the services were medically necessary and properly coded. 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 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 fieldwork from December 2015 through September 2016.

### METHODOLOGY

To accomplish our objective, we:

- reviewed applicable 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 contained diagnosis code 261 or 262 as either the primary or a secondary diagnosis;
- removed any claims that were previously reviewed by a Recovery Audit Contractor (RAC)<sup>3</sup>;
- reviewed available data from CMS's Common Working File for the selected claims to determine whether the claims had been cancelled or adjusted;

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<sup>3</sup> The RAC program was created through the Medicare Modernization Act of 2003 to identify and recover improper Medicare payments paid to healthcare providers under fee-for-service Medicare plans. We removed claims previously reviewed by a RAC in order to avoid the possibility of penalizing the hospital twice for the same claim.

- selected a simple random sample of 100 claims from our sampling frame for medical review;
- used an independent contractor to determine whether the 100 selected claims met medical necessity and coding requirements;
- reviewed the medical record documentation that the Hospital provided to support the selected claims;
- repriced each selected claim in order to verify that the original payment made by the CMS contractor was done correctly;
- interviewed Hospital officials in order to obtain an understanding of their diagnosis coding and billing processes for inpatient hospital claims submitted to Medicare;
- reviewed Medicare medical review team results and shared results with the Hospital;
- discussed the incorrectly coded claims with Hospital personnel to determine the underlying causes of noncompliance with Medicare requirements;
- calculated the correct payments for those claims requiring adjustments;
- used the results of the sample to estimate the Medicare overpayment to the Hospital for our audit period (Appendix C); 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: SAMPLE DESIGN AND METHODOLOGY**

The population contained Medicare inpatient hospital claims with diagnosis codes 261 and 262 that had a discharge date between January 1, 2013, and June 30, 2015.

### **SAMPLING FRAME**

Our frame is a Microsoft Excel spreadsheet that contains 302 inpatient claims totaling \$3,611,647 with diagnosis code 261 or 262 that were billed by the Hospital during our audit period.

We removed diagnosis codes 261 and 262 from each claim and ran the claims through the MS-DRG grouper program in order to identify which claims experienced a change in the DRG when the codes were removed. Claims that did not experience a change were removed from our frame.

### **SAMPLE UNIT**

The sample unit was a Medicare paid claim.

### **SAMPLE DESIGN**

We used a simple random sample.

### **SAMPLE SIZE**

We selected 100 paid claims for review.

### **SOURCE OF RANDOM NUMBERS**

We generated the random numbers using the Office of Inspector General, Office of Audit Services (OIG/OAS) statistical software Random Number Generator.

### **METHOD FOR SELECTING SAMPLE UNITS**

The sampling frame was numbered sequentially from 1 to 302. After generating the 100 random numbers, we selected the corresponding frame items.

### **ESTIMATION METHODOLOGY**

We used the OIG/OAS statistical software to estimate the total amount of Medicare overpayments made by the Hospital during the audit period. We used the lower limit of the 90-percent confidence interval to estimate the amount of improper Medicare payments in our sampling frame during the audit period.

**APPENDIX C: SAMPLE RESULTS AND ESTIMATES**

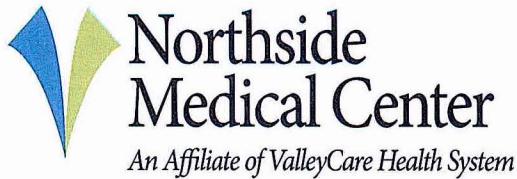
**Table 1: Sample Results**

<b>Frame Size</b>	<b>Value of Frame</b>	<b>Sample Size</b>	<b>Value of Sample</b>	<b>Number of Payment Errors</b>	<b>Net Value of Payment Errors</b>
302	\$3,611,647	100	\$1,154,023	96	\$463,619

**ESTIMATES**

**Table 2: Estimated Overpayments for the Audit Period**  
*Limits Calculated for a 90-Percent Confidence Interval*

Point Estimate	\$1,400,129
Lower limit	\$1,280,761
Upper limit	\$1,519,497



December 22, 2016

Mr. Leonard Piccari  
Audit Manager  
Department of Health and Human Services  
Office of Inspector General  
Office of Audit Services, Region III  
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Philadelphia, Pa. 19106

RE: Report Number: A-03-15-00012

Dear Mr. Piccari:

Northside Medical Center (Northside) received the Office of Inspector General Report Number: A-03-15-00012 ("the Draft Report") entitled *Northside Medical Center Incorrectly Billed Medicare Inpatient Claims With Severe Malnutrition* from your office on November 23, 2016. We welcome the opportunity to respond to the Draft Report, and appreciate your efforts and willingness to accept input from Northside in preparing your final report.

We note an inaccuracy in the Draft Report. While the Draft Report accurately identifies Northside Medical Center, some sections inaccurately refer to "Northside Memorial Hospital". In addition, the Draft Report describes Northside as "a 188-bed university-affiliated hospital...". Northside is in fact licensed as a 398-bed hospital by the Ohio Department of Health [March 28, 2016].

Attached, please find Northside's response to the findings described in the Draft Report, as well as our statement of concurrence or nonoccurrence with each recommendation.

Sincerely,

/Craig Hemminger/

Craig Hemminger  
Facility Compliance & Privacy Officer  
Northside Medical Center

OIG Report Number: A-03-15-00012

*Northside Medical Center Incorrectly Billed Medicare Inpatient Claims With Severe Malnutrition*

OIG Recommendations / Responses

1. *Refund to the Medicare program \$1,280,761 for the incorrectly coded claims.*

Northside response:

As indicated during the on-site review with OIG auditors from September 12-15, 2016, Northside disagrees with several of the findings of the third-party audit contractor, [REDACTED]. During the on-site review, we reviewed the preliminary audit findings (which were provided to us on August 17, 2016) with the auditors.

- We disagree with the determination of 72 claims. For these claims, a diagnostic statement of malnutrition was present, clinical indicator(s) were present, and the UHDDS definition of a secondary diagnosis was met. We contend the 72 claims have adequate documentation to support the coding assignment of diagnosis code 261 or 262. During the on-site review, we provided clinical-based evidence to support this contention.
- In the remaining 28 claims, we agree with the OIG's determination.
  - Two (2) of these were claims in which the assignment of diagnosis code 261 or 262 was affirmed by OIG as being appropriate.
  - The other 26 claims were adverse determinations, which we agree should be corrected.

In our response to these preliminary findings, we provided the attached Memo (*Review & Comparison with [REDACTED] Audit Findings*, dated September 30, 2016) and supporting information, including physician queries. A key observation that we noted was that the auditors appear to have not considered that the diagnosis and treatment of Malnutrition will also be based on clinical skill/judgment and the knowledge of the unique needs of the individual patient and populations. The judgment of the healthcare professional based on individual circumstances of the patient must always take precedence over the recommendations in these guidelines. Lastly, within our Memo, we cited several clinical studies which further support the criteria used to determine a diagnosis of malnutrition.

We respectfully request reconsideration of the determination of the 72 claims cited above. For the remaining 28 claims, we will revise the claims and refund the identified overpayment amount.



2. *Exercise reasonable diligence to identify and return any additional similar overpayments outside of our audit period, in accordance with the 60-day rule, and identify any returned overpayments as having been made in accordance with this recommendation.*

Northside response:

We will conduct an audit of claims for the six year look back period with assigned diagnosis codes of 261 or 262 to obtain overpayment amounts, which will then be refunded pursuant to the requirements of the 60-day overpayment rule. We will follow the steps described below:

- Select a statistically valid sample of claims and conduct a coding audit for:
  - December 1, 2010 – December 31, 2012
  - January 1, 2013 – June 30, 2015, 202 remaining claims in the universe. We will exclude claims already audited by OIG;
  - July 1, 2015 – September 30, 2016
- A probe audit will be conducted for the period October 1, 2016 – December 1, 2016 to determine whether errors under the ICD-10 coding system result in DRG change.
- The results from the coding audits will be extrapolated across the claims within the time period described.

3. *Strengthen controls to ensure full compliance with Medicare billing requirements.*

Northside response:

Prior to the OIG review Northside had the following internal controls in place:

- Dietary /Nutrition Services
  - Patients are screened for Nutrition Risk within 24 hours of admission.
  - Registered Dietitian Nutritionist (Dietitian) is consulted based on nutrition screen – automatic consult for high nutrition risk, open wounds, enteral or parenteral nutrition- as well as by physician referral.
  - Dietitians also work in collaboration with the Clinical Documentation Improvement (CDI) specialists when patients are identified with malnutrition, to communicate and document plans and intervention.
  - Nutrition Assessment completed by the Dietitian within 48 hours of receipt of consult.
  - Additional reasons for Nutrition Assessment: Patients who are NPO greater than three days; length of stay greater than seven days; and/or clear liquid diet greater than three days.
  - Assessments, plans, and interventions are based on the ASPEN guidelines.
  - The Nutrition Care Process (NCP) is utilized to assess patients once consulted, which is designed to improve the consistency and quality of

the individualized care for the patient and the predictability of patient outcomes.

- A systemic method is used to obtain, verify, and interpret data needed to identify nutrition related problems, their causes, and their significance.
  - A nutrition assessment includes, but is not limited to: food and nutrition related history, anthropometric measurements, biochemical data, medical tests and procedures, nutrition-focused physical assessments, and general medical history as well as current medical findings.
  - Ongoing evaluation and intervention throughout hospital stay, pending nutrition related progress and needs for adjustment in the care plan.
  - Nutrition intervention may include: adjustments of diet regimen, oral supplementation, and/or the need for nutrition support and/or nutrition education. All intervention is documented.
  - Dietitians participate in daily multidisciplinary medical and discharge rounds where nutritional status and progress is discussed.
  - Dietitians are an integral part of the medical education residency program, providing multiple presentations and in-services on such topics as enteral and parenteral nutrition, diet prescriptions, and malnutrition and intervention based on ASPEN guidelines.
  - For Malnutrition Week 2016, the Dietitians displayed posters and provided educational materials to the physicians, residents, and interns to improve and reinforce appropriate documentation of malnutrition and related factors affecting outcomes.
- PHIIP/CDI (Patient Health Information Improvement Program/Clinical Documentation Improvement)  
The query process for potential malnutrition in patients includes:
    - If clinical indicators of malnutrition, per ASPEN guidelines, are documented in the medical record, a request is made for Nutrition Services staff to assess the patient if they have not already been consulted.
    - If the Dietitian assesses the patient and identifies the presence of ASPEN clinical indicators and it is not already documented by the physician, CDI staff place a query to the physician for the potential diagnosis of malnutrition.
    - If physician documents malnutrition without a degree (severity), CDI staff requests the Dietitian to evaluate the patient, and CDI staff will place a query to the physician.



- If the physician documents malnutrition and the Dietitian does not agree (possibly lacks ASPEN criteria), it will still be coded based on the physician documentation.
- If physician documents malnutrition of any degree and it is identified the Dietitian has not been consulted, CDI staff notifies the Dietitian.
- CDI staff provides regular teaching on clinical documentation improvement and queries in general at every resident orientation. CDI staff also provides ongoing education during the course of the year and daily during interdisciplinary rounds.
- Health Information and Informatics Department /Coding
  - Coding Audit Program: Both pre-bill and retrospective inpatient coding/DRG audits are conducted on an ongoing basis to ensure codes and DRGs are assigned accurately and are supported by medical record documentation. Audit sample selection is based on volume and risk identification. Focused malnutrition diagnosis coding audits were conducted in 2014, 2015 and 2016 for Kwashiorkor.
  - Coding Education: Education regarding accurate code and DRG assignment is provided on a monthly basis to Coders and CDI staff. Education is provided through a variety of media, including monthly and quarterly webinars and newsletters. Education addresses a variety of topics related to both inpatient and outpatient coding.
  - Specific education regarding malnutrition coding was provided to Coders and CDI staff via webinar on September 2, 2014. Additional education regarding malnutrition diagnosis coding was provided in the November 2016 Coding Audit & Education newsletter and at the November 30, 2016 CDI Forum.

We will take this opportunity to evaluate and strengthen our internal controls.

Additional controls implemented are:

- Query forms were recently updated to ensure succinct documentation of a patient's nutritional status.
- A billing system edit has been implemented for malnutrition diagnoses, which flags the claim for an additional review by the Coding staff.