

Department of Health and Human Services

**OFFICE OF  
INSPECTOR GENERAL**

**PROVIDENCE PORTLAND MEDICAL  
CENTER 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).*



**Stephen Virbitsky  
Regional Inspector General  
for Audit Services**

**September 2014  
A-03-13-00034**

# ***Office of Inspector General***

<http://oig.hhs.gov>

---

The mission of the Office of Inspector General (OIG), as mandated by Public Law 95-452, as amended, is to protect the integrity of the Department of Health and Human Services (HHS) programs, as well as the health and welfare of beneficiaries served by those programs. This statutory mission is carried out through a nationwide network of audits, investigations, and inspections conducted by the following operating components:

## ***Office of Audit Services***

The Office of Audit Services (OAS) provides auditing services for HHS, either by conducting audits with its own audit resources or by overseeing audit work done by others. Audits examine the performance of HHS programs and/or its grantees and contractors in carrying out their respective responsibilities and are intended to provide independent assessments of HHS programs and operations. These assessments help reduce waste, abuse, and mismanagement and promote economy and efficiency throughout HHS.

## ***Office of Evaluation and Inspections***

The Office of Evaluation and Inspections (OEI) conducts national evaluations to provide HHS, Congress, and the public with timely, useful, and reliable information on significant issues. These evaluations focus on preventing fraud, waste, or abuse and promoting economy, efficiency, and effectiveness of departmental programs. To promote impact, OEI reports also present practical recommendations for improving program operations.

## ***Office of Investigations***

The Office of Investigations (OI) conducts criminal, civil, and administrative investigations of fraud and misconduct related to HHS programs, operations, and beneficiaries. With investigators working in all 50 States and the District of Columbia, OI utilizes its resources by actively coordinating with the Department of Justice and other Federal, State, and local law enforcement authorities. The investigative efforts of OI often lead to criminal convictions, administrative sanctions, and/or civil monetary penalties.

## ***Office of Counsel to the Inspector General***

The Office of Counsel to the Inspector General (OCIG) provides general legal services to OIG, rendering advice and opinions on HHS programs and operations and providing all legal support for OIG's internal operations. OCIG represents OIG in all civil and administrative fraud and abuse cases involving HHS programs, including False Claims Act, program exclusion, and civil monetary penalty cases. In connection with these cases, OCIG also negotiates and monitors corporate integrity agreements. OCIG renders advisory opinions, issues compliance program guidance, publishes fraud alerts, and provides other guidance to the health care industry concerning the anti-kickback statute and other OIG enforcement authorities.

# *Notices*

---

## **THIS REPORT IS AVAILABLE TO THE PUBLIC**

at <http://oig.hhs.gov>

Section 8M of the Inspector General Act, 5 U.S.C. App., requires that OIG post its publicly available reports on the OIG Web site.

## **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.

***Providence Portland Medical Center incorrectly billed Medicare inpatient claims with Kwashiorkor, resulting in overpayments of approximately \$13,000 over 3 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 through 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 Providence Portland Medical Center (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.

#### **Hospital Insurance Prospective Payment System**

CMS pays inpatient hospital costs at predetermined rates for patient discharges under the inpatient prospective payment system. 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 *International Classification of Disease, Ninth Revision, Clinical Modification* (coding guidelines). The 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.

#### **Providence Portland Medical Center**

The Hospital, which is part of Providence Health & Services, is a 483-bed acute-care not-for-profit hospital located in Portland, Oregon. The Hospital received \$3,625,216 in Medicare

payments for inpatient hospital claims that included a diagnosis code for Kwashiorkor during our audit period (CYs 2010 through 2012) based on CMS's National Claims History data.

## **HOW WE CONDUCTED THIS REVIEW**

Our audit covered \$2,868,197 of Medicare payments to the Hospital for 90 claims that contained diagnosis code 260 for Kwashiorkor. We 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 90 claims that we reviewed. The Hospital used diagnosis code 260 for Kwashiorkor but should have used codes for other forms of malnutrition. For 87 of the inpatient claims, correcting the diagnosis code resulted in no change in the DRG payment. However, for the remaining three inpatient claims, the errors resulted in overpayments of \$12,516. Hospital officials attributed these errors to a lack of clarity in the coding guidelines for malnutrition.

## **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 (the Act), § 1862(a)(1)(A)). In addition, the Act precludes payment to any provider of services or other person without information necessary to determine the amount due the provider (§ 1833(e)).

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).

## **INCORRECT USE OF THE DIAGNOSIS CODE FOR KWASHIORKOR**

The Hospital did not comply with Medicare billing requirements for Kwashiorkor for all 90 claims we reviewed, resulting in overpayments of \$12,516. The coding guidelines establish diagnosis code 260 for Kwashiorkor. However, our review of the documentation provided did

not support the billing of this diagnosis code. For 87 of the inpatient claims, the Hospital included multiple diagnosis codes, at least one of which had a similar or greater severity level. Therefore, removing diagnosis code 260 or replacing it with a more appropriate diagnosis code resulted in no change in the DRG payment. However, for the remaining three inpatient claims, the error resulted in overpayments of \$12,516. Hospital officials attributed these errors to a lack of clarity in the coding guidelines for malnutrition.

### **RECOMMENDATIONS**

We recommend that the Hospital:

- refund to the Medicare program \$12,516 for the incorrectly coded claims and
- strengthen controls to ensure full compliance with Medicare billing requirements.

### **PROVIDENCE PORTLAND MEDICAL CENTER COMMENTS**

In written comments, the Hospital agreed with our findings. The Hospital said that it miscoded the claims because of a lack of clarity in the guidance before 2012 and recommended that CMS further clarify the various options for coding adult malnutrition.

The Hospital's comments are included as Appendix B.

## **APPENDIX A: AUDIT SCOPE AND METHODOLOGY**

### **SCOPE**

Our audit covered \$2,868,197 in Medicare payments to the Hospital for 90 inpatient claims that contained diagnosis code 260 for Kwashiorkor during the period January 1, 2010, through December 31, 2012. 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 October 2013 through August 2014.

### **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;
- 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 90 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;
- 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: PROVIDENCE PORTLAND MEDICAL CENTER COMMENTS



August 15, 2014

Mr. Leonard Piccari, Audit Manager  
Dept. of Health & Human Services  
OIG – Office of Audit Services Region III  
Public Ledger Building, Suite 316  
150 S. Independence Mall West  
Philadelphia, PA 19106

RE: Medicare Billing With Diagnosis Code 260, Kwashiorkor – Providence Portland Medical Center, Provider No. 380061

Dear Mr. Piccari,

Thank you for the time your professional staff spent in conference with us on July 1, 2014. We have received Lynne Pohler's recent communication regarding the status of our audit.

We would like to also thank you for allowing us to share with you our thorough and significant interdisciplinary infrastructure used to identify, document and report adult disease-related malnutrition in our hospital. The data we receive is used to prevent patient nutritional declines, improve our services, educate our team members and work to improve patient care in our clinics and hospital. As we discussed, we take attention to malnutrition, both in treating patients and coding and billing appropriately, very seriously and view doing so as part of our organizational mission of service to the poor and vulnerable.

We have reviewed the three accounts that were denied and agree with your findings. These case admissions were from 2010 and 2011 and occurred before the 2012 joint publications *Consensus Statement of the Academy of Nutrition and Dietetics/American Society for Parenteral and Enteral Nutrition: Characteristics recommended for the identification and documentation of adult malnutrition (under-nutrition)*, *J Acad Nutr Diet.* 2012 May; 112(5): 730-8 and *JPEN J Parenter Enteral Nutr.* 2012 May; 36(3):275-83). In late 2011, the National Center for Health Statistics ICD-9-CM Coding and Coverage Committee clarified with these organizations that ICD-9 code 260 was a strictly pediatric diagnosis. With publication, this message was broadly communicated to clinicians. At that time in 2012, Providence Portland Medical Center stopped using code 260 to describe adult disease-related malnutrition.

Historically, beginning in the mid-1970's, ICD-9 Code 260 was embedded and broadcast in clinical professional literature, research and practice and was renamed in textbooks and professional literature for adult use, to "adult Kwashiorkor", "kwashiorkor-like malnutrition", "adult hypo-albuminemic malnutrition", "adult protein malnutrition." These terms and others were typically used to reflect ICD-9 code 260 in order to differentiate by name from the pediatric manifestation, "kwashiorkor". These adult-focused naming conventions were used

across the US and also at Providence Portland Medical Center. During these years, up until the publications mentioned above in 2011, ICD-9 code 260 was the clearest match to classify a specific type of metabolic and clinical scenario in malnutrition in both adults and children. Pediatric use of ICD-9 code 260 was well-known, and because there was no other code that best fit the unique metabolic presentation in adults, these other terms were used in an effort to differentiate adult use of the code from pediatric use. As we discussed on the conference call, we would like to highlight some areas within the area of the diagnosis of adult malnutrition which would support clinicians in obtaining valuable diagnosis data to better prevent, recognize, treat and track malnutrition in adults in all care settings:

1. Harmonization of current clinical presentation criteria with regulatory (RAC, OIG) and classification systems (ICD-9/10) would improve medical and clinical understanding, diagnosis and alignment of malnutrition diagnoses with regulatory requirements. (See diagram below).
2. Alignment of clinical presentation criteria with ICD classifications (ICD-9 260, 261, 262, 263 series) would assist health care providers in diagnosing malnutrition when present and reduce diagnostic inconsistencies. With the exception of ICD-9 Codes 262, 263.0, the current definitions are not substantive in nature causing clinicians and health care organizations to under diagnose malnutrition.
3. Altered metabolism expressed in adult malnutrition is not reconciled with ICD-9 malnutrition codes or with regulatory guidelines. An exception is recent guidance between the National Center for Health Statistics ICD-9-CM Coding and Coverage Committee and Academy of Nutrition and Dietetics/American Society of Parenteral and Enteral Nutrition, published in 2012. This recent guidance considers the severity of malnutrition in adults, ICD-9 code 262, 263.0, but does not differentiate the three different etiology-based types of adult malnutrition (adult starvation-related or acute or chronic-disease related), nor does it clarify the meaning of ICD-9 codes 260, 261, 263.1, 263.2, 263.8, 263.9. Clarification would support aligned interpretation for health systems working to establish appropriate clinical practices, protocols and documentation and to comply with regulatory requirements.
4. Failure to diagnose promptly and treat the less severe types of malnutrition causes increasing disease severity in the patient, which then increases utilization of health care services and costs of care. Harmonization will improve early identification of malnutrition and treatment of patients as well as management of health care costs.
5. Harmonization will increase identification and treatment in ambulatory settings reducing the number of patients requiring treatment for severe malnutrition who require higher levels of care.
6. Clarification and harmonization of malnutrition will further support much needed integration of accurate nutrition terms in SNOMED and HL-7, for electronic health record systems and to obtain population data and better manage health care resources.

**Relationships that need to harmonize for better patient care and accurate population data to improve healthcare:**

<p>Clinical experience and practice, textbooks, reference manuals, modern medical understanding of severity and types of disease-related malnutrition in adults</p>	<p>Recommendations by professional organizations to their members and practitioners</p>	<p>ICD-9 Classification</p>	<p>RAC criteria used to determine if documentation supports diagnosis of malnutrition</p>	<p>OIG criteria used to determine coding compliance</p>
---	---	-----------------------------	---	---

Thank you for allowing us to forward our specific and broader concerns as we work to better provide clinical and health care services to our community as part of our Mission.

Sincerely,  
*Judy K. Olson*

Judy K. Olson  
 Director Revenue Cycle Compliance  
 Providence Health & Services

cc: Mindy Taylor  
 Department of Legal Affairs  
 Providence Health & Services