

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**THE HOSPITAL OF CENTRAL
CONNECTICUT 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.*



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

**June 2015
A-03-15-00003**

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.

The Hospital of Central Connecticut incorrectly billed Medicare inpatient claims with Kwashiorkor, resulting in overpayments of \$114,000 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 the Hospital of Central Connecticut (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 Inpatient 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 diagnoses codes established by the *International Classification of Diseases, 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.

The Hospital of Central Connecticut

The Hospital, which is part of Hartford HealthCare Corporation, is a 414 bed acute-care not-for-profit hospital with facilities in Southington and New Britain, Connecticut. The Hospital

received \$1,798,254 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 \$334,061 of the \$1,798,254 in Medicare payments to the Hospital for 30 of the 106 inpatient hospital claims that contained diagnosis code 260 for Kwashiorkor. We did not review the remaining claims because removing the 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 30 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 3 of the inpatient claims, substituting a more appropriate diagnosis code produced no change in the DRG payment amount. However, for the remaining 27 inpatient claims, the errors resulted in overpayments of \$113,586. Hospital officials attributed these errors to a lack of clarity in the diagnosis coding guidelines.

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).

INCORRECT USE OF THE DIAGNOSIS CODE FOR KWASHIORKOR

The Hospital did not comply with Medicare billing requirements for Kwashiorkor for any of the 30 claims that we reviewed, resulting in overpayments of \$113,586. The coding guidelines establish diagnosis code 260 for Kwashiorkor. For 3 of the inpatient claims, substituting a more appropriate diagnosis code produced no change in the DRG payment amount. However, for the remaining 27 inpatient claims, the errors resulted in overpayments of \$113,586. Hospital officials attributed these errors to a lack of clarity in the diagnosis coding guidelines.

RECOMMENDATIONS

We recommend that the Hospital:

- refund to the Medicare program \$113,586 for the incorrectly coded claims and
- strengthen controls to ensure full compliance with Medicare billing requirements.

THE HOSPITAL OF CENTRAL CONNECTICUT COMMENTS

In written comments, the Hospital concurred with our finding that all 30 claims that we reviewed were incorrectly billed with a diagnosis code for Kwashiorkor and provided documentation to show that correcting the diagnosis code for 3 claims did not change the payment, which we reflected in our report. The Hospital said it would refund \$113,586 in overpayments and described the action it had taken to strengthen internal controls over the billing of Kwashiorkor.

The Hospital's comments are included as Appendix B. We excluded supporting documentation because it included personally identifiable information.

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

Our audit covered \$334,061 in Medicare payments to the Hospital for 30 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 April 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 30 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: THE HOSPITAL OF CENTRAL CONNECTICUT COMMENTS



April 15, 2015

Report Number: A-03-15-00003

Stephen Virbitsky
Regional Inspector General for Audit Services
Office of Inspector General
Office of Audit Services, Region III
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Dear Mr. Virbitsky:

The Hospital of Central Connecticut (HOCC) is in receipt of your letter dated March 4, 2015, regarding the billing of Medicare inpatient hospital claims with diagnosis code 260, Kwashiorkor. The objective of this review was to determine whether HOCC complied with Medicare regulations during calendar years 2010 through 2013 with respect to the coding and submission of inpatient hospital claims that included a diagnosis of Kwashiorkor.

In response to your request, we have reviewed the medical records associated with the claims identified by the OIG as having been submitted with a diagnosis of Kwashiorkor, reported to have increased Medicare reimbursement.

Of the 30 claims, 11 had documentation of Kwashiorkor in the medical record, 14 had documentation of protein malnutrition/protein deficiency, three cases contained documentation of protein deficiency/severe protein calorie malnutrition and two cases had documentation of mild malnutrition/mild protein calorie malnutrition. Upon physician clinical review of the cases, we determined that there were no patients with a qualifying diagnosis of Kwashiorkor. As indicated on the attached spreadsheet, three cases have clinical evidence of severe protein calorie malnutrition, qualifying as major co-morbid conditions for which there are no resulting DRG changes.

We have attributed the use of ICD-9 code 260 to misunderstanding of the use of the diagnosis of Kwashiorkor and lack of clarity in national coding guidelines for protein malnutrition. Codes were assigned to the claims in question based on coding guidelines that are available to coding staff. Official coding guidelines in the national ICD-9-CM index directs coders to assign code

260 when protein malnutrition or protein deficiency is documented. There are no other options listed for either diagnosis. The diagnosis of Kwashiorkor also points to code 260.

Based on the OIG Work Plan identifying Kwashiorkor as a risk area, the following communication was provided to all HHC coding staff on March 25, 2015:

Code 260, Kwashiorkor malnutrition, continues to be a focus of review by the OIG for FY 2015.

ICD-9-CM code 260 has caused much confusion in the healthcare industry. If one looks purely at the tabular coding index in the ICD book, documentation of "protein malnutrition" points to code 260. However, when you read the detail for this code 260, it says Kwashiorkor which is then defined. (The alphabetic index leads to code 260 with documentation specified as 'protein deficiency' and 'protein malnutrition'). Although that code may not appear appropriate in all cases, the code book does not provide another clear option.

Coding Clinic has advised in the past that this is a condition that is extremely rare in the United States. (Coding Clinic, Third Quarter 2009 Page: 06 Effective with discharges: September 15, 2009)

When protein malnutrition and protein deficiency is documented it requires severity level confirmation by physician of:

- Mild
- Moderate
- Severe

Coder, please post Query.

When 'Kwashiorkor' is documented or any other type of documentation that leads you to code 260, do not assign code 260. The account should be pended and sent for review by Clinical Documentation Specialists for the level of malnutrition supported by the clinical data and clarification obtained from physician following process already in place.

In follow-up to this audit, HOCC and all of our HHC hospitals have implemented edits in the billing scrubber to identify for pre-bill coding review, any claim containing a diagnosis code of 260.

HOCC and Hartford HealthCare are committed to compliance with CMS rules and regulations. We appreciate the opportunity to correct these accounts to ensure appropriate payment. Medical records containing clinical documentation of Kwashiorkor, severe protein calorie malnutrition or protein deficiency have been included with our response as well as a summary of the billing detail for all 30 claims.

We have determined that HOCC received a total overpayment amount of \$113,585.59 for which a check will be issued to National Government Services, our Medicare Administrative

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Contractor. We will wait to hear back from you regarding the three claims for which we have determined that there is no DRG change.

Sincerely,

/David Haig/
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