Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

UNIVERSITY HOSPITALS CASE 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.

Stephen Virbitsky
Regional Inspector General

March 2014
A-03-13-00031

Office of Inspector General

https://oig.hhs.gov

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EXECUTIVE SUMMARY

University Hospitals Case Medical Center incorrectly billed Medicare inpatient claims with Kwashiorkor, resulting in overpayments of $118,000 over 3 years.

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.

Our objective was to determine whether University Hospitals Case Medical Center (the Hospital) complied with Medicare billing requirements for Kwashiorkor.

BACKGROUND

The Centers for Medicare & Medicaid Services (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 Hospital is a 647-bed acute-care not-for-profit teaching hospital located in Cleveland, Ohio. The Hospital is part of the University Hospitals Health System. The Hospital received $3,986,868 in Medicare payments for inpatient hospital claims that included a diagnosis code for Kwashiorkor for Medicare beneficiaries during our audit period (CYs 2010 through 2012). We reviewed $3,794,318 for 95 of these claims.

WHAT WE FOUND

The Hospital did not comply with Medicare requirements for billing Kwashiorkor on any of the 95 claims that we reviewed. The Hospital used diagnosis code 260 for kwashiorkor, but should have used codes for other forms of malnutrition. For 76 of the inpatient claims, correcting the diagnosis code resulted in no change in the DRG. However, for the remaining 19 inpatient claims the errors resulted in overpayments of $117,863. Hospital officials attributed these errors to the medical coding software program used to code the diagnosis.

WHAT WE RECOMMEND

We recommend that the Hospital:

- refund to the Medicare program $117,863 for the incorrectly coded claims and
- strengthen controls to ensure full compliance with Medicare billing requirements.

UNIVERSITY HOSPITALS CASE MEDICAL CENTER COMMENTS

In written comments, the Hospital agreed with our finding that the 95 claims that we reviewed were incorrectly billed with a diagnosis code for Kwashiorkor. The Hospital described the action it is taking to refund the overpayments and strengthen controls over the billing of Kwashiorkor.

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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 University Hospitals Case 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 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.

University Hospitals Case Medical Center

The Hospital, which is part of the University Hospitals Health System, is a 647-bed acute-care not-for-profit teaching hospital located in Cleveland, Ohio. The Hospital received $3,986,868 in Medicare payments for inpatient hospital claims that included diagnosis code 260 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 $3,974,318 of Medicare payments to the Hospital for 95 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 95 claims that we reviewed. The Hospital used diagnosis code 260 for Kwashiorkor but should have used codes for other forms of malnutrition. For 76 of the inpatient claims, correcting the diagnosis code resulted in no change in the DRG payment. However, for the remaining 19 inpatient claims, the errors resulted in overpayments of $117,863. Hospital officials attributed these errors to the medical coding software program used to code the diagnosis.

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 on any of the 95 claims that we reviewed, resulting in overpayments of $117,863. 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 76 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 19 inpatient claims, the errors resulted in overpayments of $117,863. Hospital officials attributed these errors to the medical coding software program used to code the diagnosis.

RECOMMENDATIONS

We recommend that the Hospital:

- refund to the Medicare program $117,863 for the incorrectly coded claims and
- strengthen controls to ensure full compliance with Medicare billing requirements.

UNIVERSITY HOSPITALS CASE MEDICAL CENTER COMMENTS

In written comments, the Hospital agreed with our finding that the 95 claims that we reviewed were incorrectly billed with a diagnosis code for Kwashiorkor. The Hospital described the action it is taking to refund the overpayments and strengthen controls over the billing of Kwashiorkor.

The Hospital's comments are included in their entirety as Appendix B.

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

Our audit period (January 1, 2010 through December 31, 2012) covered $3,974,318 in Medicare payments to the Hospital for 95 inpatient claims that contained diagnosis code 260 for Kwashiorkor. We did not review managed care claims or claims that were under a 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 fieldwork from September through December 2013.

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 95 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;

- 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: UNIVERSITY HOSPTALS CASE MEDICAL CENTER COMMENTS

University Hospitals

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December 12, 2013

VIA HHS/OIG DELIVERY SERVER

Mr. Stephen Virbitsky
Regional Inspector General for Audit Services
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Office of Inspector General, Office of Audit Services, Region III
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Re: Report Number A-03-13-00031

Dear Mr. Virbitsky:

On behalf of University Hospitals Case Medical Center ("UHCMC"), I am writing to respond to the Office of Inspector General's ("OIG") review of UHCMC's billing of Medicare claims with diagnosis code 260 (Kwashiorkor). UHCMC appreciates the opportunity to respond to the OIG's findings in this matter.

OIG identified 95 Medicare inpatient hospital claims submitted by UHCMC during calendar years 2010 through 2012 with Kwashiorkor (diagnosis code 260) as a primary or secondary diagnosis. After reviewing the medical records for each of these claims, UHCMC agreed with OIG that the 260 diagnosis code was incorrect on all of the claims. Further, UHCMC agrees with OIG's final determination that correcting the diagnosis code resulted in no change in payment for 76 of the claims and that replacing diagnosis code 260 with the correct malnutrition code resulted in overpayments of $117,863 for the remaining 19 claims. UHCMC is processing the necessary adjustments through our Medicare Administrative Contractor.

In analyzing the cause of these overpayments, UHCMC determined that claims billed with the diagnosis code 260 (Kwashiorkor) were coded erroneously, facilitated by a decision path within our coding software, 3M Encoder. Currently, the Encoder software generates a warning message when a coder reaches a 260 diagnosis code in some, but not all, circumstances. These decision paths and warning messages are programmed into the software by 3M; UHCMC has no ability to change them. On October 2, 2013, we requested that 3M revise the Encoder product to include consistent warnings with diagnosis code 260, regardless of what path a coder follows to reach that diagnosis. Until the National Center for Health Care Statistics revises the ICD-9-CM Coding Manual index entries under mild and moderate protein malnutrition to provide clearer direction to coders or until 3M updates the Encoder software to include

warning messages in every pathway a coder could take to reach a 260 diagnosis code, we anticipate that UHCMC will generate additional claims in which malnutrition diagnoses are assigned a 260 diagnosis code. As described in the following paragraph, however, UHCMC has implemented internal controls to stop all claims with a 260 diagnosis code from processing until a member of our health information management ("HIM") staff manually reviews and makes any necessary corrections before the claims are submitted for payment.

After receiving the OIG's letter on September 5, 2013, UHCMC took immediate action to ensure those malnutrition-related claims are billed correctly and in accordance with Medicare requirements. On September 9, 2013, we requested a custom edit to our electronic claims software that automatically identifies inpatient and outpatient claims containing a 260 diagnosis code and appends an error message that stops the claims from processing, pending manual review and validation by each facility's HIM staff. The edit was fully implemented on September 9, 2013 for all claims created that day and thereafter, and training for hospital billing staff was completed by September 9, 2013 as well.

UHCMC has reviewed all inpatient hospital claims submitted to Medicare with discharge dates between September 15, 2009 and September 9, 2013, which identified 44 additional claims with an incorrect diagnosis code of 260. For 9 of these claims, the Kwashiorkor diagnosis increased the payment received. UHCMC has submitted documentation to OIG to identify these additional 44 claims and will process the necessary adjustments through our Medicare Administrative Contractor.

University Hospitals Case Medical Center is committed to compliance with Federal and State laws and regulations. We appreciate 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.

Respectfully submitted,

/Jennifer L. Edlind/

Director of Compliance