Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

VIBRA HOSPITAL OF AMARILLO 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

September 2015
A-03-15-00001

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.

Vibra Hospital of Amarillo incorrectly billed Medicare inpatient claims with Kwashiorkor, resulting in overpayments of $584,000 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 Vibra Hospital of Amarillo (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* (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.

Vibra Hospital of Amarillo

The Hospital, which is part of Vibra Healthcare,[1] is a 72-bed long-term acute-care hospital located in Amarillo, Texas. The Hospital received $7,731,337 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 $2,889,381 of $7,731,337 in Medicare payments to the Hospital for 92 of the 228 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 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 92 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 5 of the inpatient claims, substituting a more appropriate diagnosis code produced no change in the DRG or payment amount. However, for the remaining 87 inpatient claims, the errors resulted in overpayments of $583,624. Hospital officials attributed these errors to a former owner of the Hospital and to a lack of clarity in the 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

[1] On June 1, 2011, during our audit period, Kindred Healthcare purchased Triumph Hospital –Amarillo from RehabCare Group and renamed it Kindred Hospital–Amarillo. On August 31, 2013, also during our audit period, Vibra Healthcare purchased Kindred Hospital–Amarillo and renamed it Vibra Hospital of Amarillo.

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 92 claims that we reviewed, resulting in overpayments of $583,624. The coding guidelines establish diagnosis code 260 for Kwashiorkor. For 5 of the inpatient claims, substituting a more appropriate diagnosis code produced no change in the DRG or payment amount. However, for the remaining 87 inpatient claims, the errors resulted in overpayments of $583,624. Hospital officials attributed these errors to a former owner of the Hospital and to a lack of clarity in the coding guidelines.

RECOMMENDATIONS

We recommend that the Hospital:

- refund to the Medicare program $583,624 for the incorrectly coded claims and
- strengthen controls to ensure full compliance with Medicare billing requirements.

VIBRA HEALTHCARE COMMENTS

In written comments, Vibra Healthcare concurred with our finding that 87 claims were incorrectly coded with diagnosis code 260. Vibra Healthcare said it would resubmit the 87 claims to adjust the payments the Hospital received. Vibra Healthcare said that the errors occurred during the period before it owned the Hospital and that when it acquired the Hospital it implemented its policy for coding malnutrition in accordance with CMS guidelines.

Vibra Healthcare's comments are included as Appendix B.

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

Our audit covered $2,889,381 in Medicare payments to the Hospital for 92 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 November 2014 through June 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 92 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: VIBRA HEALTHCARE COMMENTS

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July 17, 2015

Via Email
Stephen Virbitsky
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Re: Report Number A-03-15-00001; Diagnosis Code 260 (Kwashiorkor) Review

Dear Mr. Virbitsky:

I am writing to respond to your letter of January 20, 2015 regarding Vibra Hospital of Amarillo's (Medicare Provider #452060) (the "Hospital") billing of Medicare inpatient hospital claims with diagnosis code 260 (Kwashiorkor) during the period of time from 2010 through 2013. Importantly, as we have discussed during the subsequent audit process, Vibra Healthcare acquired the Hospital, including the Hospital's provider number, from Kindred Healthcare on August 31, 2013. The Office of Audit Services ("OAS") did not identify a single questionable claim with diagnosis code 260 subsequent to Vibra Healthcare's acquisition of the Hospital. Moreover, Kindred Healthcare's acquisition of the Hospital from RehabCare Group on June 1, 2011 post dates the admission date of all 92 patients identified in OAS's claims review, although one patient was discharged from the Hospital subsequent to Kindred's acquisition.

Health care systems are guided by the coding conventions set forth in the International Classification of Diseases, 9th revision. Historically, the coding process for "malnutrition (calorie) protein" would lead providers to code 260. Subsequent clarifications by the American Hospital Association Coding Clinic ("AHA") evidence the confusion of utilizing code 260. Specifically, the AHA stated that "[t]he National Center for Health Statistics (NCHS) is considering a proposal to revise the index entries under mild and moderate protein malnutrition in order to provide clearer direction to the coder."[1]

We undertook a thorough review of the 92 claims that OAS identified as incorrectly coded. As we have discussed, we are in agreement with OAS that 87 of the claims should be adjusted by

[1] AHA: 3Q '09, 6

removing code 260. These 87 claims will be resubmitted, with a reference to "OIG Audit Report Number A-03-15-00001" set forth in the remarks section.

Upon the Hospital's acquisition by Vibra, we have implemented Vibra's coding policy for the Hospital's internal coding process. Pursuant to this policy, Vibra codes malnutrition based on the provider's documentation pursuant to CMS coding guidelines and the AHA coding clinics

Please let me know if you have any additional questions or concerns related to this completed audit process. We appreciate the assistance OAS has provided throughout the process.

Sincerely,

/Douglas C. Yohe/

Senior Vice President & General Counsel

cc: Clint Fegan
Joseph Girardi (via email)
Ronald C. Lazas, Jr. (vial email)