

Department of Health and Human Services

**OFFICE OF  
INSPECTOR GENERAL**

**VIDANT 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

January 2017  
A-03-15-00011

# *Office of Inspector General*

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## EXECUTIVE SUMMARY

***Vidant Medical Center incorrectly billed inpatient claims with severe malnutrition, resulting in overpayments of approximately \$1.4 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 Vidant 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, which is affiliated with East Carolina University, is a 909-bed teaching hospital located in Greenville, North Carolina. The Hospital received \$16,693,564 in Medicare payments for 941 inpatient hospital claims that included a diagnosis code for a severe type of malnutrition from January 1, 2013, through June 30, 2015. For 401 of the 941 claims, removing diagnosis code 261 or 262 changed the DRG. Of these 401 claims, we reviewed a random sample of 100 claims totaling \$1,230,082.

## **WHAT WE FOUND**

The Hospital complied with Medicare billing requirements for diagnosis codes 261 and 262 for 11 of the 100 claims that we reviewed. However, the Hospital did not comply with Medicare billing requirements for the remaining 89 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 87 claims, the billing errors resulted in net overpayments of \$401,971. 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 \$1,403,132 for the audit period.

## **WHAT WE RECOMMEND**

We recommend that the Hospital:

- refund to the Medicare program \$1,403,132 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 agreed that 11 of the 89 claims we found to be in error, were errors. The Hospital did not agree that 78 of the 89 claims we found to be in error were in fact errors. Further, the Hospital did not concur with our second recommendation, but stated that it will investigate and refund as appropriate any overpayments outside of the OIG audit period as they relate to the 11 claims it agreed were errors. The Hospital also did not concur with the third recommendation because it maintains that its current coding and compliance programs provide adequate controls to ensure compliance with Medicare billing requirements.

After reviewing the Hospital's comments, we maintain that our finding and all of our recommendations are valid for all 89 claims found to be in error. We subjected the 89 claims to medical review and stand by those medical necessity and coding determinations. We also emphasize that even though the Hospital did not fully concur with our first and second

recommendations, it agreed that 11 claims were in error. As a result, the Hospital should implement our recommendation as it relates to the 11 claims and return the extrapolated overpayment associated with those claims and investigate any similar claims that may exist outside of the audit period. In addition, we maintain that the Hospital should repay the overpayments associated with all 89 claims and review similar payments outside the audit period to determine if additional overpayments exist.

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## 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 Vidant 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 overpayment amount over a 6-year lookback period, and (3) report and return any overpayments

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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 01, 2015.

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.

## **Vidant Medical Center**

The Hospital, which is affiliated with East Carolina University, is a 909-bed teaching hospital located in Greenville, North Carolina. The Hospital received \$16,693,564 in Medicare payments for 941 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 \$5,191,196 for the 401 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 \$1,230,802.

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 11 of the 100 inpatient claims that we reviewed. However, the Hospital did not comply with Medicare billing requirements for the remaining 89 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 87 claims, the billing errors resulted in net overpayments of \$401,971. 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 \$1,403,132 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 (the Act § 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 11 of the 100 inpatient claims that we reviewed. However, the Hospital did not comply with Medicare billing requirements for the remaining 89 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 87 claims, the billing errors resulted in net overpayments of \$401,971. 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 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 \$1,403,132 for the audit period.

## **RECOMMENDATIONS**

We recommend that the Hospital:

- refund to the Medicare program \$1,403,132 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 its 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 agreed that 11 of the 89 claims we found to be in error, were errors. The Hospital did not agree that 78 of the 89 claims we found to be in error were in fact errors. Further, the Hospital did not concur with our second recommendation, but stated that it will investigate and refund as appropriate any overpayments outside of the OIG audit period as it relates to the 11 claims it agreed were errors. The Hospital also did not concur with the third recommendation because it maintains that its current coding and compliance programs provide adequate controls to ensure compliance with Medicare billing requirements.

After reviewing the Hospital's comments, we maintain that our finding and all of our recommendations are valid for all 89 claims found to be in error. We subjected the 89 claims to medical review and stand by those medical necessity and coding determinations. We also emphasize that even though the Hospital did not fully concur with our first and second recommendations, it agreed that 11 claims were in error. As a result, the Hospital should implement our recommendation as it relates to the 11 claims and return the extrapolated overpayment associated with those claims and investigate any similar claims that may exist outside of the audit period. In addition, we maintain that the Hospital should repay the overpayments associated with all 89 claims and review similar payments outside the audit period to determine if additional overpayments exist.

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 \$5,191,196 in Medicare payments to the Hospital for 401 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 \$1,230,802. 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 fieldwork at the Hospital and at our offices from October 2015 through July 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;
- selected a simple random sample of 100 claims from our sampling frame for medical review;

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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.

- 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**

### **POPULATION**

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 401 inpatient claims totaling \$5,191,196 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 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 401. 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>
401	\$5,191,196	100	\$1,230,802	89	\$401,971

**ESTIMATES**

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

Point Estimate	\$1,611,905
Lower limit	\$1,403,132
Upper limit	\$1,820,678

## APPENDIX D: AUDITEE COMMENTS



**VIDANT HEALTH™**

### Office of Audit and Compliance

January 26, 2017

Mr. Jason C. Jelen  
Regional Inspector General for Audit Services  
US Dept. of Health and Human Services Office of the Inspector General  
Office of Audit Services, Region III  
Public Ledger Building, Suite 316 150  
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Philadelphia, PA 19106-3499

Re: Vidant Medical Center (Provider # 34-0040) Report # A-03-15-00011

Mr. Jelen,

The enclosed correspondence is being submitted on behalf of Vidant Medical Center, in response to the U.S. Department of Health and Human Services, Office of the Inspector General's (OIG) draft report entitled *Vidant Medical Center Incorrectly Billed Medicare Inpatient Claims with Severe Malnutrition*. Vidant Medical Center is a 909 bed acute care teaching hospital and is the primary teaching hospital for the Brody School of Medicine at East Carolina University. Vidant Medical Center is affiliated with East Carolina University, however, Vidant Medical Center is not a part of the Brody School of Medicine at East Carolina University.

The OIG draft report states that Vidant Medical Center did not comply with Medicare billing requirements for diagnosis codes 261 and 262. The findings contained in the report appear to be based almost entirely on the claims review commissioned by the OIG from [REDACTED] Vidant Medical Center regards accurate coding very seriously and appreciates the opportunity to respond to the findings and requests your careful consideration of the enclosed response.

### **CONCURRENCE/NON-CONCURRENCE**

**1. *The OIG recommends that Vidant Medical Center refund to the Medicare program \$1,403,132 for the incorrectly coded claims.***

Vidant Medical Center does not concur with the finding that it received \$1,403,132 in overpayments related to incorrectly coded claims and the recommendation to refund this amount to the Medicare program. The OIG audit findings identified that 89 of 100 claims audited did not comply with Medicare billing requirements. There were no adverse findings for 11 of the 100 claims reviewed. Vidant Medical Center agrees with findings related to eleven (11) of the 89 Medicare claims in the audit sample that were questioned by the OIG. Vidant Medical Center disagrees with the findings related to the remaining seventy-eight (78) cases for which errors were identified.

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**2. The OIG recommends that Vidant Medical Center exercise reasonable diligence to identify and return any additional similar overpayments outside of the audit period, in accordance with the 60- day rule, and identify any returned overpayments as having been made in accordance with this recommendation.**

Vidant Medical Center recognizes that an OIG audit such as this one generally constitutes credible information of a potential overpayment which obligates a provider to proactively investigate whether it has in fact received money to which it is not entitled over a 6-year lookback period. If an overpayment is identified, we understand that the provider is obligated to return the overpayment in a timely fashion as set forth in 42 C.F.R. 401.301, et seq. (the “60-day overpayment rule”). As more fully described herein, Vidant Medical Center has undertaken a thorough investigation of its use of diagnosis codes 261 and 262 and has determined based on the 100 claims sample selected by the OIG the existence of at most an 11% coding/reportability error rate, and an associated 3% financial error rate.<sup>30</sup> To the extent this error rate constitutes credible information of potential overpayments that might exist outside of the OIG audit period, it will likewise investigate and refund as appropriate. However, in light of the context in which this OIG recommendation is made and given Vidant Medical Center disagrees with 78 of the 89 findings, it does not concur.

**3. The OIG recommends that Vidant Medical Center strengthen its controls to ensure full compliance with Medicare billing requirements.**

Vidant Medical Center is constantly reviewing its processes to strengthen its controls to ensure full compliance with Medicare billing requirements. However, in the context of this audit, Vidant Medical Center does not concur with this recommendation and maintains that the strength of its current coding and compliance programs provide adequate controls to ensure compliance with Medicare billing requirements.

### **NON-CONCURRENCE WITH OVERPAYMENT**

In review of the audit findings, [REDACTED] assertion that Vidant Medical Center incorrectly billed for diagnosis codes 261 and 262 appears to be based on one or more of the following rationale:

- Code 261 (Nutritional Marasmus) was submitted, but the patient did not have Nutritional Marasmus
- The patient did not have malnutrition in any form
- The patient had malnutrition, but it was not treated “enough” or did not impact the stay enough to be reported as a diagnosis
- The patient had malnutrition, but it was due to or an integral part of another condition and should not be separately reported as a diagnosis
- The patient had a form of malnutrition, but not the type of malnutrition that was coded

In the response set forth in this letter, we will address each point and provide supporting evidence that refutes the auditors’ rationale. In addition, we have included case studies (Appendix A) for each category that illustrate our position in more detail, as well as an index (Appendix B) grouping each case into the appropriate category should your team want to review additional examples.

The OIG auditors indicated that they are not clinicians or certified coders and therefore are not in a position to dispute [REDACTED] findings. However, as individuals with audit expertise they are able to evaluate the validity or appropriateness of the standards and procedures used by Vidant Medical Center

as opposed to [REDACTED] with respect to the malnutrition claims under review. As you know, no valid conclusions can result from any review unless generally accepted clinical and coding standards and audit principles are used. This was not the case with respect to the [REDACTED] review. For instance:

- [REDACTED] reviewers failed to use any identifiable guidelines for the assessment and diagnosis of malnutrition, such as the Academy of Nutrition and Dietetics (AND)/American Society for Parenteral and Enteral Nutrition (ASPEN) Guidelines described below.
- [REDACTED] in contrast to CMS and The Joint Commission guidance, failed to acknowledge the necessary and appropriate role of registered dietitians (RD) in the assessment, monitoring and/or treatment of malnutrition and as a result failed to consider all relevant documentation in the patient's medical record, undermining its findings.
- [REDACTED] failed to understand that diagnosis code 261 includes multiple conditions, including Severe Malnutrition Not Otherwise Specified (NOS), and in turn erroneously evaluated patient medical conditions and documentation against the presence of Nutritional Marasmus.
- [REDACTED] failed to apply basic standards of condition reportability according to nationally recognized coding guidelines and principles.
- [REDACTED] failed to understand the necessary and legitimate use of the query process to confirm diagnosis code assignment and to recognize such query documentation as a valid and appropriate part of the medical record.

Each of these issues, which seriously call into question the [REDACTED] findings, are discussed in more detail below.

#### **[REDACTED] Rationale: Code 261 (Nutritional Marasmus) Submitted, but the Patient Did Not Have Nutritional Marasmus**

In 22 of the 89 cases where code 261 was submitted and found to be incorrectly billed, the reviewers' rationale included the determination that the patient did not have Nutritional Marasmus. In four of those cases, this was the primary reason for the reviewers' determination that diagnosis code 261 was incorrectly billed. A table identifying all 22 cases is included in Appendix B.

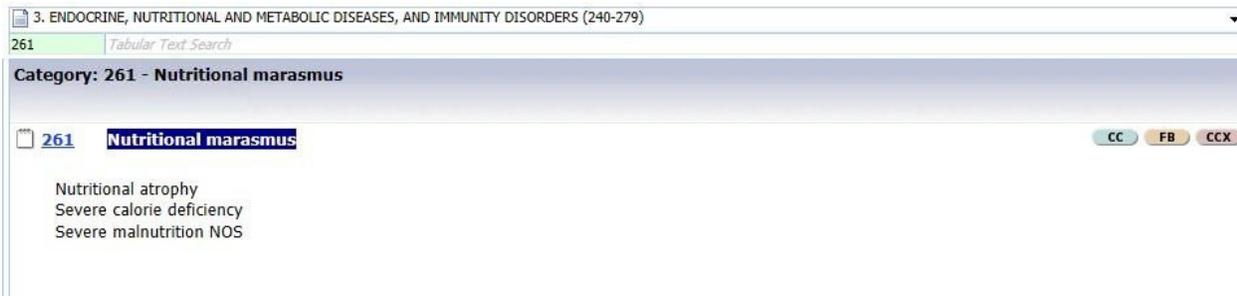
Vidant Medical Center understands the clinical symptomology of Nutritional Marasmus and agrees that the condition of Nutritional Marasmus was not present in the majority of this sample review. In fact, only one of the 53 cases for which 261 was coded had Nutritional Marasmus documented as a diagnosis (and was supported by [REDACTED] review). However, for the majority of the cases, Severe Malnutrition NOS was clinically present and supported by the documentation of the provider and interdisciplinary teams involved in the care of the patients and was the condition being coded when using diagnosis code 261.

Per the ICD-9-CM alphabetic index, "Malnutrition, Severe" is directed to ICD-9 code 261. The tabular index, which should always be used to confirm accurate code assignment, states that code 261, titled Nutritional Marasmus, includes the diagnoses of nutritional atrophy, severe calorie deficiency, and severe malnutrition NOS. Section I. A. 10 of the ICD-9-CM Official Coding Guidelines gives the following definition for Includes Notes and Inclusion Terms:

*Includes Notes: This note appears immediately under a three-digit code title to further define, or give examples of, the content of the category.*

*Inclusion Terms: List of terms included under certain four and five digit codes. These terms are the conditions for which that code number is to be used. The terms may be synonyms of the code title, or, in the case of "other specified" codes, the terms are a list of the various conditions assigned to that code. The inclusion terms are not necessarily exhaustive. Additional terms found only in the index may also be assigned to a code.*<sup>1</sup>

A screenshot of the ICD-9-CM tabular index is listed below:



ICD-9-CM Official Coding Guidelines, provided by CMS and the National Center for Health Statistics, are rules that have been developed for use in accordance with the ICD Coding Manual conventions and instructions for proper coding. Adherence to these published guidelines is required under the Health Insurance Portability and Accountability Act (HIPAA).

In addition to the ICD-9-CM Official Coding Guidelines, coding professionals rely upon the American Hospital Association's (AHA) Coding Clinic, a quarterly newsletter, to provide clarification and direction on certain coding scenarios. AHA Coding Clinic is the official publication for coding guidelines and advice as designated by the four Cooperating Parties (American Hospital Association, American Health Information Management Association, Centers for Medicare and Medicaid Services, and National Center for Health Statistics) and the Editorial Advisory Board.

An example of direction for coding Severe Malnutrition with code 261 can be found in AHA Coding Clinic, Third Quarter 2012, Page 10, effective with discharges September 15, 2012, which states:

"If provider documentation indicates that the malnutrition has progressed from moderate to severe, assign code 261, Nutritional Marasmus, for Severe Malnutrition."<sup>2</sup>

As has been widely published, the Office of Inspector General has performed nationwide audits on diagnosis code 260 (Kwashiorkor) and determined extensive inaccuracies in hospitals reporting this code. Hospitals that conceded incorrect coding of diagnosis code 260 were reportedly using this code when the patient had Protein Malnutrition, as directed by the ICD-9-CM alphabetic index. However, the tabular index, which must always be consulted to determine accurate code assignment, does not include Protein Malnutrition as an additional term for code 260. Hospitals cited the lack of clarity in coding guidelines for the incorrect assignment of 260. AHA Coding Clinic Third Quarter 2009 clarified this issue, giving guidance not to use code 260 unless the physician specifically documented the patient had Kwashiorkor.<sup>3</sup> Unfortunately, many hospitals continued to use this code even after the AHA Coding Clinic guidance was published.

In outlining why the OIG decided to perform a review of diagnosis codes 260 and 261, it was suggested that the rationale for previous determinations of hospitals incorrectly billing for Kwashiorkor could have also caused hospitals to incorrectly assign these codes, which are classified as a major complication or

comorbidity and can result in a higher Medicare payment. Based on the evidence presented above, we believe this to be an inaccurate assumption. In contrast to code 260 (Kwashiorkor) which does not list Protein Malnutrition as an inclusion note in the tabular index and is clarified through AHA Coding Clinic guidance as an incorrect code assignment, code 261 (Nutritional Marasmus) does list Severe Malnutrition, NOS as an inclusion note in the tabular index and is supported by AHA Coding Clinic guidance as the correct code assignment. In the 22 cases previously cited, it is clear that the [REDACTED] reviewers failed to acknowledge that diagnosis code 261 includes multiple conditions, such as Severe Malnutrition, NOS, and in turn erroneously evaluated patient medical conditions and documentation against the presence of Nutritional Marasmus.

Case Example 1 in Appendix A. illustrates a case in which the [REDACTED] reviewer inconsistently applied the coding guidelines. In this case, the reviewer disregarded the includes note for Severe Malnutrition, NOS for diagnosis code 261 (Nutritional Marasmus), but accepted the coding of another condition, Hypomagnesemia, to code 275.2 (Disorders of Magnesium Metabolism) based on the inclusion term of Hypomagnesemia listed under code 275.2 in the tabular index.

### **[REDACTED] Rationale: The Patient Did Not Have Malnutrition in Any Form**

In 31 of the 89 cases where code 261 or 262 was submitted and found to be incorrectly billed, the reviewers' rationale included the determination that the patient did not have any form of Malnutrition. In 29 of those cases, this was the primary reason for the reviewers' determination that the case was incorrectly billed. A table identifying all 31 cases is included in Appendix B.

The OIG draft report findings failed to identify what, if any nationally recognized guidelines, such as the AND/ASPEN, were used as a basis for decisions regarding the assessment and diagnosis of malnutrition. Furthermore, it is not apparent whether [REDACTED] reviewers' considered all relevant documentation supporting the diagnosis of malnutrition in the patient's medical record when determining its findings.

A substantial body of literature estimates that the incidence of malnutrition in patients who enter the hospital is 1 in 3<sup>4-6</sup>, some estimates are as high as 71%<sup>7</sup> and malnutrition has significant negative impacts on patient outcomes. Patients with malnutrition are (1) 2 times more likely to develop a pressure ulcer in the hospital<sup>8</sup>, (2) stay an average of 2 days longer than those screened and treated early<sup>9,10</sup>, (3) have 3 times the risk for surgical site infections<sup>11</sup>, and (4) 45% of patients that fall in the hospital are malnourished.<sup>12</sup> The diagnosis and treatment of malnutrition has substantial benefits on outcomes: (1) 25% reduction in pressure ulcer incidence<sup>13</sup>, (2) 28% reduction in avoidable readmissions<sup>14</sup>, (3) 14% reduction in overall complications<sup>15</sup>, and (4) an average length of stay reduction of 2 days<sup>9,10</sup>.

The deleterious effects of malnutrition on patient health and quality of life have long been recognized not only by medical professionals but also by hospital accreditation bodies. In 1983, the Board of Directors of ASPEN issued a special communication on malnutrition which stated that the state of malnutrition appears to effect patient morbidity and mortality rates.<sup>16</sup> Since 1995, The Joint Commission has partnered with ASPEN to develop accreditation survey criteria that emphasized interdisciplinary delivery of nutrition care and required that all patients have a nutrition screening within 24 hours of admission to the hospital.<sup>17,18</sup> The Joint Commission acknowledges that disease related malnutrition may be present on admission or develop during the hospitalization and affirms the prevalence of malnutrition in the hospitalized patient.<sup>18</sup>

Physicians and providers traditionally used the "classic" approach to identify malnutrition in hospitalized patients. This would involve the use of bedside clinical judgment based on the following, but

understanding that no one factor is diagnostic or preclusive; the key factor is the clinical judgment of the provider:<sup>19</sup>

- Physical findings such as fat and muscle wasting, or emaciation
- Risk factors increasing the patient's risk for developing malnutrition
- Biochemical markers (Albumin, Prealbumin, etc.) with interpretation in the context of other factors
- Body mass composition or weight loss

In 2012, new guidelines were released by the AND and ASPEN for the identification and documentation of malnutrition and is rapidly becoming the new gold standard for the diagnosis of malnutrition.<sup>20</sup>

*"multiple queries from members of both the Academy of Nutrition and Dietetics (AND), and the American Society for Parenteral and Enteral Nutrition (ASPEN) as well as from CMS regarding specific malnutrition criteria prompted the creation of an AND/ASPEN Malnutrition Workgroup. This workgroup was charged with developing a standardized approach to diagnosing malnutrition in the adult hospitalized patient."*<sup>21</sup>

In the AND/ASPEN guidelines, six characteristics are identified to assess for the presence of malnutrition:

- Weight loss
- Energy intake
- Subcutaneous fat loss
- Muscle loss
- Edema
- Reduced Grip strength<sup>20</sup>

If a patient demonstrates two or more characteristics, malnutrition can be diagnosed in the correct clinical setting.<sup>20</sup> Of these six parameters, four require the practitioner to complete a nutrition focused physical exam (NFPE) to evaluate the degree of malnutrition.<sup>20</sup>

Over the time period for the cases in this audit, Vidant Medical Center transitioned from the classic approach for diagnosing malnutrition taught in medical school, and in wide use at academic medical centers at that time, to the 2012 published evidence based guidelines of ASPEN.

Vidant Medical Center, along with the Centers for Medicare and Medicaid Services and The Joint Commission, recognize the necessary and appropriate role of registered dietitians in the assessment, monitoring and/or treatment of malnutrition. The Joint Commission cites data that suggests one of the barriers to diagnosing and treating malnutrition is inadequate resources and personnel to perform this evaluation on patients. They recommend educating professionals involved in the nutrition screening process and using a validated, standardized assessment tool to help drive consistency.<sup>18</sup>

This is precisely what Vidant Medical Center does, use credentialed dietitians and evidence based guidelines to evaluate and treat our patients with identified nutritional deficiencies. A final rule issued by CMS in May 2015 both concurs with the need for trained professionals to perform nutrition focused exams and to prescribe the appropriate diet to target the identified deficiencies. In this rule CMS states:

*"We believe that RDs (clarified as qualified nutrition professionals) are the professionals who are best qualified to assess a patient's nutritional status and to design and implement a nutritional treatment plan in consultation with the patient's interdisciplinary care team. In order for the patient to receive timely nutritional care the*

*RD must be viewed as an integral member of the hospital interdisciplinary care team, one who, as the team's clinical nutrition expert, is responsible for the patient's nutritional diagnosis and treatment in light of the patient's medical diagnosis."*<sup>22</sup>

CMS continued to say that:

*"All patient diets including therapeutic diets must be ordered by a practitioner responsible for the care of the patient, or by a qualified dietitian...hospitals that choose to grant these privileges to RDs may achieve a higher quality of care for their patients by allowing these professional to fully and efficiently function as important members of the hospital patient care team in the role for which they were trained."*<sup>22</sup>

The Joint Commission and CMS have supported and/or mandated the goals and methods that Vidant Medical Center has utilized to deliver evidence based dietary evaluation and care to our patients to improve morbidity, mortality and quality of life. As noted above, Registered Dietitians are credentialed practitioners specifically trained and qualified to provide nutrition and dietetics services. Performing a nutrition- focused physical assessment is within the dietitian's scope of practice.<sup>23</sup>

It is unclear why, in many cases, ██████ disregarded the supporting documentation by these highly trained professionals when making a determination that the record did not substantiate the physicians diagnosis of malnutrition. Several cases even stated documentation was missing when it was clearly documented in the dietitians' notes which were provided to the OIG as part of the medical records submission. Case Example 2 in Appendix A illustrates how key documentation supporting the physicians' diagnosis of malnutrition is contained in the dietitians' notes, but was not considered by the reviewer.

Again, it is also uncertain if ██████ used any evidence-based criteria, and, if it did, what criteria they utilized when making their determinations. Unfortunately, the OIG was unable, as we understand it to clarify this with ██████ Based on the rationale given for the determinations, it is evident that any criteria used by ██████ were not the AND/ASPEN Guidelines, which is the most current and well recognized guideline for the assessment and diagnosis of malnutrition. Further, Vidant Medical Center was not afforded an opportunity to share with ██████ the evidence-based approach that was utilized within our institution.<sup>31</sup>

**██████ Rationale: The Patient Had Malnutrition, But It Was Not Treated "Enough" or Did Not Impact the Stay Enough To Be Reported as a Diagnosis:**

In 40 of 89 cases where code 261 or 262 was submitted and found to be incorrectly billed, the reviewers' affirmed that the patient had malnutrition, even stating in 32 cases that the patient medically had nutritional marasmus or suffered from severe malnutrition of some type, but claimed that the malnutrition was not treated "enough" or impactful enough on the patients' stays to be reported as a secondary diagnosis. In 30 of the cases, this was the primary reason for the reviewers' determination that the case was incorrectly billed. A table identifying all 40 cases is included in Appendix B.

Section III of the ICD-9-CM Official Guidelines for Coding and Reporting outlines the rules for reporting additional diagnoses stating:

*For reporting purposes the definition for “other diagnoses” is interpreted as additional conditions that affect patient care in terms of requiring:*

- *Clinical evaluation; or*
- *Therapeutic treatment; or*
- *Diagnostic procedures; or*
- *Extended length of hospital stay; or*
- *Increased nursing care and/or monitoring.<sup>1</sup>*

In many cases, ██████ referenced the level of treatment for the patient’s malnutrition, implying that there was not “enough” treatment to substantiate coding the condition. Nowhere in the guidelines for reporting diagnoses is there an outlined minimum threshold for treatment in order for a diagnosis to be coded. Treatment of malnutrition may involve counseling, dietary modifications, providing adequate nutrition via food or commercial formulas, and possibly supplements, vitamins and micronutrients. Enteral nutrition is superior to parenteral nutrition for many reasons including its safety, reduced incidence of complications, lower cost and its ability to maintain the mucosal barrier. Current standards would begin with the least invasive (oral or enteral nutrition) intervention with stepwise escalation ending in the most invasive (central parenteral nutrition) treatment if less invasive/risky interventions failed or were contra-indicated.<sup>24</sup> In many cases where ██████ affirmed the presence of malnutrition and the above outlined clinical best practice for treating malnutrition was followed, ██████ deemed the treatment “not enough” for it to be reported. Case Example 3 in Appendix A illustrates a case in which treatment was clearly given to the patient for malnutrition, meeting guidelines for a reportable diagnosis, yet ██████ findings stated the diagnosis should not be reported.

██████ also took issue with several cases where they affirmed the presence of malnutrition, but did not feel the malnutrition impacted the stay to a level that warranted coding. Similar to not having a minimum threshold for treatment, guidelines for coding and reporting a diagnosis do not outline a level of impact for a diagnosis to be coded. Guidelines do require that a condition be clinically evaluated, or treated, or require diagnostic procedures, or extend length of stay or require additional nursing care and/or monitoring. All 40 of these cases met the criteria for coding and reporting as evidenced by the clinical evaluation of the condition by the interdisciplinary care team, or the treatment of the malnutrition via the approach previously described, or the ongoing monitoring of the condition by the care team. Though only one of the criteria must be met in order for a diagnosis to be reported, many of these cases met multiple criteria. It is unclear why the ██████ reviewers did not consider the Official Guidelines for Coding and Reporting when making their determinations in these cases.

**██████ Rationale: The Patient Had Malnutrition, But It Was Due To or an Integral Part of Another Condition and Should Not Be Separately Reported as a Diagnosis**

In 18 of 89 cases where code 261 or 262 was submitted and found to be incorrectly billed, the reviewers affirmed that the patient had malnutrition, even stating in 14 cases that the patient medically had nutritional marasmus or suffered from severe malnutrition of some type, but claimed that the malnutrition was due to or an integral part of another condition and should not be separately reported as a diagnosis. In 11 of the cases, this was the primary reason for the reviewers’ determination that the case was incorrectly billed. A table identifying all 18 cases is included in Appendix B.

Section I. A. 6. of the ICD-9 CM Official Guidelines for Coding and Reporting states:

*Certain conditions have both an underlying etiology and multiple body system manifestations due to the underlying etiology. For such conditions, the ICD-9-CM has a coding convention that requires the underlying condition be sequenced first followed by the manifestation. Wherever such a combination exists, there is a “use additional code” note at the etiology code, and a “code first” note at the manifestation code. These instructional notes indicate the proper sequencing order of the codes, etiology followed by manifestation.<sup>1</sup>*

Malnutrition can be a manifestation of some conditions, and according to the above guidelines, manifestations are to be coded separately, and after the underlying condition. There is no support from the Uniform Hospital Discharge Data Set (UHDDS) Reporting Guidelines or guidance from the AHA Coding Clinic that provides direction for the coding of malnutrition to be included in another condition and not to be reported separately. While there are several conditions with direction to not report separately due to the intrinsic nature of the two conditions (symptoms related to a specific condition), malnutrition has never been one of them. As is true of all complications and comorbidities, the incidence of malnutrition is higher in certain populations such as cancer patients, patients with Acquired Immune Deficiency Syndrome, Inflammatory Bowel Disease patients, etc.; but malnutrition has not been defined as being integral to or an inherent symptom of another condition. In other words, not all patients who have cancer, Acquired Immune Deficiency Syndrome, or Inflammatory Bowel Disease also have malnutrition. Reporting guidelines do not require additional diagnoses be an “independent contributor to illness” and as there is no published guidance directing otherwise, it is appropriate for malnutrition, when documented by the physician and meeting guidelines for a reportable diagnosis, to be coded separately from other conditions with which it coexists.

Case Example 4 in Appendix A illustrates a case in which ██████ agreed that the patient had severe malnutrition; the malnutrition was evaluated, monitored and treated, meeting guidelines for a reportable diagnosis, but ██████ deemed the malnutrition part of another condition and should not be reported separately.

**██████ Rationale: The Patient Had a Form of Malnutrition, But Not the Type of Malnutrition That Was Coded**

In 18 of 89 cases where code 261 or 262 was submitted and found to be incorrectly billed, the reviewers affirmed that the patient had a form of malnutrition, but determined a different code should have been submitted. In 15 of the cases, this was the primary reason for the reviewers’ determination that the case was incorrectly billed. A table identifying all 18 cases is included in Appendix B.

ICD-9-CM Official Guidelines for Coding and Reporting dictate that diagnoses must be coded to the highest degree of specificity.<sup>1</sup> CMS also clarified this requirement stating:

*The physician should code the ICD-9-CM code that provides the highest degree of accuracy and completeness. In the context of ICD-9-CM coding, the “highest degree of specificity” refers to assigning the most precise ICD-9-CM code that most fully explains the narrative description of the symptom or diagnosis.<sup>25</sup>*

In many of the sample cases, [REDACTED] has agreed that malnutrition was clinically present and appropriate to code, but suggested using codes that are unspecified or not as specific as the medical record documentation supports, such as code 263.0 (Moderate Malnutrition) or 263.9 (Unspecified Protein Calorie Malnutrition). Following this instruction would be in direct conflict with the nationally accepted ICD-9-CM Guidelines for Coding and Reporting and the expectations of CMS as outlined above.<sup>1,25</sup> Case Example 5 in Appendix A will highlight a case where severe malnutrition was documented, evaluated, treated and monitored, but [REDACTED] recommended an unspecified code be used.

Additionally, it appeared that [REDACTED] reviewers were attempting to retrospectively re-diagnose the type of malnutrition present with their findings based on undisclosed criteria that does not align with the most current and recognized standards. This discredits the clinical judgment of physicians directly involved in the care of the patient. The ICD-10-CM Official Guidelines for Coding and Reporting, as well as AHA Coding Clinic, Fourth Quarter ICD-10 2016, though published after the timeframe of this audit, specifically discuss issues relative to the opinions offered by [REDACTED] audit findings. Briefly, the guidelines specifically state that code assignment is based solely on the provider’s diagnostic statement and is not based on clinical criteria.<sup>28</sup> The AHA Coding Clinic elaborates by acknowledging this is not a new concept though it had not previously been explicitly included in Official Coding Guidelines and further acknowledges “Coding Clinic and the official coding guidelines have always stated that code assignment should be based on provider documentation”.<sup>29</sup> The AHA Coding Clinic further states “Coders should not be disregarding physician documentation and deciding on their own, based on clinical criteria, abnormal test results, etc., whether or not a condition should be coded”.<sup>29</sup> In light of these long standing conventions, it would be inappropriate to assign a less specific code or one that is not supported by the physician documentation.

Also, in many of the [REDACTED] reviewed samples, the Post-Discharge and/or Concurrent Query process was utilized so that the physician of record can clarify the medical record documentation that already outlines clinical indicators, evaluation and/or treatment provided to that patient in regards to a condition that has not been specified in the medical record. These indicators are available either from the physician’s documentation, documentation from the clinical dietitians, labs or other ancillary documentation that is reviewed during the coding process.

Following the guidance of the American Health Information Management Association (AHIMA) Practice Brief for Coding Queries, clinical indicators from the medical record are presented to the provider in the form of a compliant query allowing the opportunity for the physician to provide a response that identifies the condition being treated, evaluated and/or monitored during the patient’s stay.<sup>26,27</sup> The query, as well as the provider’s response are maintained in the permanent medical record and properly referenced when coding reportable conditions. According to the Practice Brief, it is not considered leading to introduce a new condition, using a multiple choice format in the query, when clinical indicators are present in the medical record.<sup>27</sup> In several instances, the query process was utilized to confirm or clarify the diagnosis of malnutrition in the record, yet the [REDACTED] reviewer did not appear to consider the query during their

review. Case example 6 in Appendix A demonstrates a case in which the physician confirms the diagnosis in a query, and the query was included in the medical records submitted to the OIG; however, the query does not appear to have been considered as part of [REDACTED] review.

### **NON-CONCURRENCE RELATED TO REASONABLE DILIGENCE**

As noted above, Vidant Medical Center of course recognizes that OIG audits such as this one generally constitute credible information of a potential overpayment, triggering further investigation and refunds as warranted under the 60-day overpayment rule. Upon receipt of the initial OIG letter dated October 16, 2015 advising of this audit, Vidant Medical Center immediately launched its own thorough investigation. A team of more than twenty people, including physicians, HIMS representatives, coders, dietitians and compliance experts, carefully reviewed all 100 claims included in the OIG sample. Moreover, when the OIG auditors came onsite the week of June 6, 2016, this entire team spent close to four full days with them reviewing on a chart-by-chart basis the medical record documentation, along with specific Medicare billing and coding requirements, supporting each disputed claim as submitted. As we have previously expressed, we were disappointed that any further meaningful investigation was prevented by the fact that neither Vidant Medical Center nor the OIG auditors were able to discuss the particular substantive points of disagreement with the [REDACTED] experts who were commissioned by the OIG for this audit or to have even a handful of claims re-reviewed. Vidant Medical Center was not even given the credentials of the [REDACTED] reviewers. As a consequence, based on Vidant Medical Center's exercise of reasonable diligence, there would appear to be a possible financial error rate of only 3% during the OIG audit period. To the extent this fact standing alone triggers further inquiry outside of the audit period under the 60-day overpayment rule, Vidant Medical Center will comply. Vidant Medical Center would note however that the OIG findings and report is merely a recommendation to CMS, which we believe should not be adopted, and that Federal Register commentary to the 60-day overpayment rule confirms that the rule is not intended to deny a provider its appeal rights even when the investigation and refund or recoupment is in connection with an OIG audit.<sup>32</sup>

However, in the context of the OIG's findings and other available information, Vidant Medical Center does not concur with the recommendation that further inquiry is required. As stated in the previous comments related to clinical evaluation and monitoring, medical record documentation, code assignment, and diagnosis reportability, Vidant Medical Center continues firm in its stance that the OIG identified overpayments did not occur in 78 of the 89 cases. This view is further evidenced by the fact that Vidant Medical Center was previously under the jurisdiction of Connolly Healthcare (Connolly) for Recovery Audit activities and had 21 claims with diagnosis code 261 and 262 as the primary diagnosis or a secondary diagnosis, with dates of service from the same timeframe as the OIG audit (1/1/2013 – 6/30/2015) reviewed. Of the 21 claims reviewed, 18 claims had favorable review findings by Connolly. The favorable review numbers represent Connolly's concurrence with Vidant Medical Center's coding and reporting of these diagnoses in 86% of the claims reviewed. Of the remaining three (3) claims, one (1) is in the appeal process and Vidant Medical Center accepted the findings of Connolly reviewers for two (2) cases. This represents a financial error rate of 8% for the Connolly cases when utilizing the OIG's method of dividing sample overpayments net underpayments by total sample payments.

The Connolly concurrence rate of 86% is in distinct contrast to the OIG findings and call into question the methods by which two different Medicare audit contractors can review similar documentation and coding and have such diverse audit results. As stated previously, Vidant Medical Center agreed with the OIG findings in 11 of 89 cases, representing an internally calculated 88% accuracy rate, which is very similar to Connolly's prior findings for the same issue. Given that the OIG audit contractors repeatedly suggested coding assignment that was in direct conflict with nationally accepted ICD-9-CM guidelines for coding and reporting diagnoses, and the extreme difference in Connolly and Vidant Medical Center's findings versus the OIG audit findings, evidence suggests that there is a distinct difference in the level of proficiency and expertise of the OIG audit contractors compared to the Vidant Medical Center coders and the Connolly auditors.

Appendix C provides RAC reviewed case examples that are similar to the general theme for patient encounters reviewed by [REDACTED]

### **NON-CONCURRENCE RELATED TO STRENGTHENING CONTROLS**

Vidant Medical Center firmly believes that existing controls over accurate diagnosis and procedure coding meet professionally recognized standards. Vidant Medical Center utilizes generally accepted clinical and coding standards as maintained by the AHIMA, and believes that complete documentation is the essential source for accurate coding. All data that is gathered for reporting is handled with strict adherence to national and facility approved coding guidelines/rules, including the Medicare Claims Processing Manual; the ICD-9-CM Official Guidelines for Coding and Reporting; the AHA Coding Clinic; and in conjunction with Federal Compliance Regulations.

Vidant Medical Center is committed to maintaining a competent and compliant coding team, as evidenced by our robust Audit and Education program. We employ both a Coding Educator and a team of Coding Auditors that are equipped with advanced-level coding knowledge. The Coding Auditors are responsible for evaluating coder performance and accuracy through monthly coding audits. Feedback from these audits are provided immediately to each individual coder and then used to generate education to our entire team. The Coding Educator develops and delivers education centered on identified trends within the facility, and at the state and national level, to ensure our staff stays proficient and up to date on coding requirements. This education is delivered through a variety of methods including publications, face to face educational sessions, and webinars. Content developed and shared by the Coding Educator has been evaluated and approved for continuing education credits by the AHIMA.

Vidant Medical Center also employs a team of seasoned nursing professionals and experienced physicians, trained in coding guidelines and conventions, in the CDI program and Physician Advisor program. This team is involved with providers and clinicians on a concurrent and post-discharge basis to ensure clinical documentation supports identified diagnoses and clinical conditions. CDI Specialists and Physician Advisors adhere to the same stringent guidelines and expectations as other HIM Professionals with the goal of securing accurate information within the medical record for valid reporting of data for each episode of care. These teams utilize their clinical background to communicate with providers on education related to certain topics as a means to clarify documentation discrepancies or offer support in

understanding how to document effectively. Assuring accuracy of coded data is a shared responsibility of the CDI, Physician Advisor and Coding teams at Vidant Medical Center.

As part of the coding process, a comprehensive review of all medical record documentation is performed to ensure the codes are accurate and meet the definitions of the Uniform Hospital Data Set (UHDDS). Coding professionals do not assign codes that the documentation provided by the physicians of record does not clearly support. When necessary to clarify unclear, conflicting, or incomplete information in the medical record, coding professionals and CDI specialists will present a query to the physicians of record, outlined in a compliant format, which is then kept as part of the permanent medical record.

Further, the professional organizations through which Coders and Clinical Documentation Specialists maintain certification, the American Health Information Management Association and the Association for Clinical Documentation Improvement Specialists, both put forth standards for ethical behavior. Failure to adhere to these standards could result in loss of professional credentials. Vidant Medical Center reiterates the expectation of adherence to these standards in our own internal policies and procedures to reinforce their importance with our Coding and Clinical Documentation Improvement staff.

Other technical controls include Vidant Medical Centers' utilization of software containing the most recent updates to governmental regulations set forth in the Federal Register, National Coverage Determination and Local Medical Review Policies. The coded encounter is analyzed by this technology and edits are applied based on these policies. Encounters containing edits are then flagged for additional review by a coding professional prior to being billed.

Given the rigorous internal processes, and in consideration of the RAC auditor findings, Vidant Medical Center believes the existing processes are more than sufficient to demonstrate internal controls over coding audit processes that assure compliance with Medicare billing requirements.

## **SUMMARY**

Vidant Medical Center is concerned that the stated rationale for embarking on this audit by the OIG is based upon a faulty premise. In the OIG Executive Summary of the Vidant Medical Center audit under the heading of "Why We Did This Review" the purpose for pursuing this audit is outlined by referring to past audits at other institutions that found evidence of erroneously reported Kwashiorkor (a disease that is rarely found in developed countries) and compared that condition to Nutritional Marasmus which, like Kwashiorkor, is a rare clinical condition in the United States. It is correctly noted that Nutritional Marasmus is a primary form of serious protein-energy malnutrition that is caused by a deficiency in calories and energy and is usually found in children with significant restrictions in access to food; and pointed out that the Medicare program provides health insurance coverage primarily to people aged 65 or older.

Vidant Medical Center would expect increased scrutiny to investigate the reporting of a rare condition as having an increasing incidence in the Medicare population. In fact, one of the main purposes of the ICD system is to allow for the epidemiological tracking of disease processes. But, in this case, the OIG has used an incorrect basis for their findings. Vidant Medical Center has not demonstrated or claimed an increase in

adult cases of Nutritional Marasmus seen and treated at our Medical Center as asserted for the justification for this scrutiny. Of the 100 cases reviewed there was only one where Nutritional Marasmus was diagnosed and that case was upheld by the audit. The rest of these cases involve patients who were diagnosed with either Severe Malnutrition NOS or Other Severe Protein Calorie Malnutrition.

We have, through evidence based methods and practices, identified a small increased fraction of adult patients with severe malnutrition, a condition that the literature estimates to occur in 30-70% of the inpatient adult population. This approach allows for appropriate treatment and monitoring that has been demonstrated to improve the overall health and quality of life of Medicare beneficiaries, at the same time reducing costs to the Medicare program. It is alarming to imagine that the OIG could extend these audits nationwide based upon an incorrect appreciation of what condition was diagnosed, treated and coded. Again, we cannot more clearly state that we diagnosed and treated Severe Malnutrition not Nutritional Marasmus. These two conditions just happen, by convention, to have the same ICD-9 code. Further, it is important to note that the ICD system was developed over one hundred years ago as a method to classify causes of death. It evolved over the ensuing years as a standardized tool for epidemiological, health management and clinical purposes. This includes the analysis of the general health situation of population groups. It is used to monitor the general incidence and prevalence of diseases and other health problems providing a picture of the general health situation of country and populations. The World Health Organization states that ICD is used by physicians, nurses, other providers, researchers, health information managers and coders, health information technology workers, policy-makers, insurers and patient organizations to classify diseases and other health problems recorded on many types of health and vital records. In addition to enabling the storage and retrieval of diagnostic information for clinical epidemiological and quality purposes these records also provide for the compilation of national mortality and morbidity statistics by WHO member states.

The United States is almost unique in its use of this classification system for billing purposes and when the OIG or CMS "disallows" for reimbursement purposes, a diagnosis made by a physician on a Medicare patient, the result has far-reaching, if unintended, consequences. These patients will be incorrectly evaluated for risk of and cause of mortality; allocation of goods and services; assignment to various health registries for assimilation of data for research and future treatments; assessment of the quality of care delivered and more. Most importantly, denying a diagnosis determined by a physician will adversely impact the communication between providers with regard to the patient's treatment and give an inaccurate picture of the patient's overall health and well-being with the potential for real harm. In the age of electronic medical records and HIPAA, with the stated purpose of a complete and accurate medical record, incorrect interpretation of assigned diagnosis codes can result in wide ranging harm to patients and is contrary to both CMS and Vidant Medical Center's shared goal of delivering informed, quality based, effective patient care.

In conclusion, Vidant Medical Center stands by its assessments, findings and coding of malnutrition and respectfully disagrees with the report's findings and recommendations. As discussed in your team's onsite visits, as well as outlined in our initial rebuttal letter, Vidant Medical Center has raised what we believe to be legitimate concerns regarding the criteria used by the [REDACTED] reviewers in validating the diagnosis of malnutrition, as well as the reviewers' seeming lack of proficiency in applying coding guidelines. In light

of these concerns, we requested an opportunity to meet and discuss the findings directly with the [REDACTED] reviewers, or have the claims reviewed by a different audit firm prior to the draft OIG report being prepared. Unfortunately, this request was denied. Obviously, this decision is very disappointing, as it leaves Vidant Medical Center without a reasonable opportunity to refute these findings. After careful consideration of the enclosed response, if the OIG audit results still remain unchanged, Vidant Medical Center will pursue further appeal rights afforded under the Medicare Program.

Vidant Medical Center appreciates the 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.

With Regards,

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## Works Cited

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30. Between the claims in the sample that both parties have determined were billed correctly (11) and those claims that Vidant Medical Center disputes were billed in error and believes were billed correctly (78), only eleven (11) claims of the 100 claims were billed in error. The financial error rate was determined utilizing the OIG's method of dividing sample overpayments net underpayments by total sample payments. The OIG has set an acceptable error rate as at or below 5%. This is detailed further in An Open Letter to Health Care Providers dated November 20, 2001 from the Inspector General.
31. One suggestion as a provider we might make for the future is that in the construct of these audits providers be given an opportunity through the OIG to at least pose questions to its outside consultant to better understand their findings or that at a minimum the OIG auditors be able to ask its own questions to their consultant following the conclusion of its initial review.
32. See 81 Federal Register 7654, 7667 (February 12, 2016).