Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

UNIVERSITY OF WISCONSIN HOSPITALS AND CLINICS AUTHORITY INCORRECTLY BILLED MEDICARE INPATIENT CLAIMS WITH SEVERE MALNUTRITION

Inquiries about this report may be addressed to the Office of Public Affairs at Public.Affairs@oig.hhs.gov.

Gloria L. Jarmon
Deputy Inspector General
for Audit Services

June 2018
A-03-17-00005

Office of Inspector General

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Report in Brief
Date: June 2018
Report No. A-03-17-00005

U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES
OFFICE OF INSPECTOR GENERAL

University of Wisconsin Hospitals and Clinics Authority Incorrectly Billed Medicare Inpatient Claims With Severe Malnutrition

Why OIG Did This Review

Nutritional Marasmus and other/unspecified severe protein-calorie malnutrition are two types of severe malnutrition listed in the International Classification of Diseases, Clinical Modification. Previous OIG reviews have determined that hospitals incorrectly billed for Kwashiorkor, a third type of severe malnutrition. Nutritional Marasmus and other/unspecified severe protein-calorie malnutrition 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.

Our objective was to determine whether the University of Wisconsin Hospitals and Clinics Authority (the Hospital) complied with Medicare billing requirements when billing for Nutritional Marasmus and other/unspecified severe protein-calorie malnutrition.

How OIG Did This Review

Our audit covered $9,569,586 in Medicare payments for the 497 claims submitted by the Hospital from 2014 through 2016 that contained a severe malnutrition diagnosis code for which removing the code changed the diagnosis-related group (DRG). We selected for review a random sample of 100 claims totaling $1,796,325. 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 and billed.

What OIG Found

The Hospital complied with Medicare billing requirements for severe malnutrition diagnosis codes for 10 of the 100 claims that we reviewed. However, the Hospital did not comply with Medicare billing requirements for the remaining 90 claims. For two of these claims, the medical record documentation supported a secondary diagnosis code other than a severe malnutrition diagnosis code, but the error resulted in no change to the DRG or payment. For the remaining 88 claims, the billing errors resulted in net overpayments of $562,361. These errors occurred because the Hospital used severe malnutrition diagnosis codes 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 $2,412,137 from 2014 through 2016.

What OIG Recommends and Hospital Comments

We recommend that the Hospital (1) refund to the Medicare program $2,412,137 for the incorrectly coded claims; (2) 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 (3) strengthen controls to ensure full compliance with Medicare billing requirements.

In written comments on our draft report, the Hospital partially disagreed with our first recommendation and disagreed with the other two recommendations. For 3 of the 88 claims for which there was a change in the DRG, the Hospital agreed that including a diagnosis code for severe malnutrition resulted in a billing error. However, the Hospital did not agree that the remaining 85 claims incorrectly included a diagnosis code for severe malnutrition. The Hospital also provided comments about the guidance and sampling methodology we used in the review and about standards for diagnosing severe malnutrition. We maintain that our findings and recommendations are valid for all 88 claims. We subjected all 100 sampled claims to medical review and stand by those medical necessity and coding determinations. We also maintain that the guidance used in the report is current and that our sample is representative of the sample frame.

The final report can be found at https://oig.hhs.gov/oas/reports/region3/31700005.asp.

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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 classification): Kwashiorkor (diagnosis code 260), Nutritional Marasmus (diagnosis code 261), and other severe protein-calorie malnutrition (diagnosis code 262). Previous Office of Inspector General (OIG) reviews determined that hospitals incorrectly billed for Kwashiorkor, a disease that is rarely found in developed countries. On October 1, 2015, the *International Classification of Diseases, Tenth Revision, Clinical Modification* (ICD-10 coding classification) replaced the ICD-9 coding classification, and Nutritional Marasmus became diagnosis code E41. Other severe protein-calorie malnutrition became unspecified severe protein-calorie malnutrition, diagnosis code E43. 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, 262, E41, and E43 (severe malnutrition diagnosis codes) are each classified as a type of major complication or comorbidity (MCC). Adding an MCC to a Medicare claim can result in a different diagnosis-related group (DRG) that may command a higher Medicare payment.

OBJECTIVE

Our objective was to determine whether the University of Wisconsin Hospitals and Clinics Authority (the Hospital) complied with Medicare billing requirements when billing for Nutritional Marasmus and other/unspecified severe protein-calorie malnutrition.

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, which provides health insurance coverage primarily to people aged 65 or older. 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, CMS pays inpatient hospital costs at predetermined rates for patient discharges. The rates vary according to the 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 current ICD coding classification.

OIG believes that this audit report constitutes credible information of potential overpayments. Providers who receive notification of these potential overpayments must (1) exercise reasonable diligence to investigate the potential overpayment, (2) quantify any overpayment amount over a 6-year lookback period, and (3) report and return any overpayments within 60 days of identifying those overpayments (60-day rule).[1]

University of Wisconsin Hospitals and Clinics Authority

The Hospital is a 648-bed university-affiliated hospital located in Madison, Wisconsin, that offers a wide range of inpatient, outpatient, emergency, diagnostic, and therapeutic services. The Hospital received $34,615,286 in Medicare payments for 1,159 inpatient hospital claims that included a malnutrition diagnosis code from January 1, 2014, through December 31, 2016, based on CMS's National Claims History data.

HOW WE CONDUCTED THIS REVIEW

Our audit covered $9,569,586 in Medicare payments for the 497 claims containing a severe malnutrition diagnosis code for which removing the malnutrition diagnosis code changed the DRG. We did not review managed care claims or claims that were previously reviewed by a Recovery Audit Contractor (RAC).[2] We selected for review a random sample of 100 claims totaling $1,796,325.

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.

[1] The Act § 1128J(d); 42 CFR part 401 subpart D; 42 CFR §§ 401.305(a)(2) and (f); and 81 Fed. Reg. 7654, 7663 (Feb. 12, 2016).

[2] The Medicare Fee-for-Service RAC Program was created as a demonstration program through the Medicare Modernization Act of 2003 and established under section 1893(h) of the Social Security Act to identify and recover overpayments. We removed claims previously reviewed by a RAC to avoid the possibility of penalizing the hospital twice for the same claim.

FINDING

The Hospital complied with Medicare billing requirements for severe malnutrition diagnosis codes for 10 of the 100 claims that we reviewed. However, the Hospital did not comply with Medicare billing requirements for the remaining 90 claims. For two of these claims, the medical record documentation supported a secondary diagnosis code other than a severe malnutrition diagnosis code, but the error resulted in no change to the DRG or payment. For the remaining 88 claims, the billing errors resulted in net overpayments of $562,361. These errors occurred because the Hospital used severe malnutrition diagnosis codes 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 (1) that the patient had severe malnutrition or (2) 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 $2,412,137 for the audit period.[3]

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, states that in order to be processed correctly and promptly, a claim must be completed accurately (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.

[3] 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.

The *ICD-9-CM Official Guidelines for Coding and Reporting* (ICD-9-CM coding guidelines), which provided general rules for reporting other diagnoses, was replaced by the *ICD-10-CM Official Guidelines for Coding and Reporting* (ICD-10-CM coding guidelines) on October 1, 2015. Both the ICD-9-CM and ICD-10-CM coding guidelines state that diagnosis codes can be billed for additional conditions if those conditions affect patient care, which is defined as requiring either: clinical evaluation; therapeutic treatment; diagnostic procedures; an extended length of the hospital stay; or increased nursing care and/or monitoring. Previous conditions that have no impact on the current stay should not be reported.

INCORRECT USE OF MALNUTRITION DIAGNOSIS CODES

The Hospital complied with Medicare billing requirements for severe malnutrition diagnosis codes for 10 of the 100 claims that we reviewed. However, the Hospital did not comply with Medicare billing requirements for the remaining 90 claims. For two of these claims, the medical record documentation supported a secondary diagnosis code other than a severe malnutrition diagnosis code, but the error resulted in no change to the DRG or payment. For the remaining 88 claims, the billing errors resulted in net overpayments of $562,361. These errors occurred because the Hospital used severe malnutrition diagnosis codes 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 $2,412,137 for the audit period.

RECOMMENDATIONS

We recommend that the Hospital:

- refund to the Medicare program $2,412,137 for the incorrectly coded claims[4];
- 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

[4] OIG audit recommendations do not represent final determinations by the Medicare program but are recommendations to Department of Health and Human Services action officials. Action officials at CMS, acting through a Medicare Administrative Contractor or other contractor, will determine whether a potential overpayment exists and will recoup any overpayments consistent with its policies and procedures. While the statute allows overpayments to be collected within 5 years of the date the claim is paid, CMS policies specify that a claim must be re-opened within 4 years. If CMS does not re-open one or more sampled claim within this 4 year period, then the estimated overpayment would be adjusted accordingly. If a disallowance is taken, providers have the right to appeal the determination that a payment for a claim was improper (42 CFR § 405.904(a)(2)). The Medicare Part A/B appeals process has five levels, including a contractor redetermination, a reconsideration by a Qualified Independent Contractor, and a decision by the Office of Medicare Hearings and Appeals. If a provider exercises its right to an appeal, it does not need to return funds paid by Medicare until after the second level of appeal. An overpayment based on extrapolation is re-estimated depending on the result of the appeal.

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 OFFICE OF INSPECTOR GENERAL RESPONSE

In written comments on our draft report, the Hospital partially disagreed with our first recommendation and disagreed with the remaining two recommendations. For 3 of the 88 claims for which there was a change in the DRG, the Hospital agreed that including a diagnosis code for severe malnutrition resulted in a billing error. However, the Hospital did not agree with our determination that the remaining 85 claims incorrectly included a diagnosis code for severe malnutrition. The Hospital stated that for each of these 85 claims, there was a diagnostic statement of malnutrition in addition to other clinical indicators. The Hospital also believes that the use of a diagnosis code for severe malnutrition on each of these claims meets the definition of a secondary diagnosis and that there is adequate documentation to support the assignment of these diagnosis codes.

In addition, the Hospital stated that the guidance used for the review was vague and that the OIG did not specify any standard for the Hospital to use in diagnosing severe malnutrition. Finally, the Hospital stated that there were claims in the sampling frame for which removing the diagnosis code did not affect the DRG and that these types of claims were under-represented in the sample.

After reviewing the Hospital's comments, we maintain that our findings and recommendations are valid for all 88 claims where the DRG changed and we determined that they were billed in error. We subjected all 100 sampled claims to medical review and stand by those medical necessity and coding determinations. We instructed the medical review contractor to use all identifiable guidelines for the assessment and diagnosis of malnutrition. As part of its review, the contractor used the applicable American Hospital Association coding clinic responses and the Academy of Nutrition and Dietetics (Academy)/American Society for Parenteral and Enteral Nutrition (ASPEN) guidelines. We therefore maintain that the guidance presented in the report and used by the medical review contractor is the current guidance that should be followed to determine when a provider can bill Medicare for treating severe malnutrition.

In addition, we maintain that our statistical methods resulted in a valid, conservative estimate of the total overpayment made to the provider. We properly executed our statistical sampling methodology by defining our sampling frame and sampling unit, randomly selecting our sample, applying relevant criteria in evaluating the sample, and using statistical sampling software (i.e., RAT-STATS) to apply the correct formulas for the extrapolation. A valid statistical sample will differ from the sampling frame due to the randomness of the sampling process. We accounted for such differences in a manner favorable to the provider through our use of the lower limit of a two-sided 90 percent confidence interval. Lower limits calculated in this manner are conservative and will be less than the actual overpayment in the sampling frame 95

percent of the time. The conservative nature of the lower limit is not impacted by the potential difference described by the provider.

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

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

Our audit covered $9,569,586 in Medicare payments to the Hospital for 497 claims that contained severe malnutrition diagnosis codes during the period from January 1, 2014, through December 31, 2016. We only reviewed claims for which removing the severe malnutrition diagnosis code 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 $1,796,325. 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 our fieldwork from March 2017 through September 2017.

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 a severe malnutrition diagnosis code as either the primary or a secondary diagnosis;
- removed any claims that were previously reviewed by a RAC;
- processed claims through the MS-DRG grouper program and remove any claims where the program showed the severe malnutrition diagnosis code did not affect the DRG;
- reviewed available data from CMS's Common Working File for the selected claims to determine whether the claims had been canceled or adjusted;
- selected a simple random sample of 100 claims from our sampling frame for medical review;

- 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 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; 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

The population contained Medicare inpatient hospital claims with diagnosis codes 261, 262, E41, and E43 that had a discharge date between January 1, 2014, and December 31, 2016.

SAMPLING FRAME

Our frame is a Microsoft Excel spreadsheet that contains 497 inpatient claims totaling $9,569,586 with diagnosis code 261, 262, E41, or E43 that were billed by the Hospital during our audit period.

We removed diagnosis codes 261, 262, E41, and E43 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 paid 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 497. 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

Frame Size	Value of Frame	Sample Size	Value of Sample	Number of Payment Errors	Net Value of Payment Errors
497	$9,569,586	100	$1,796,325	88	$562,361

ESTIMATES

Table 2: Estimated Overpayments for the Audit Period

Limits Calculated for a 90-Percent Confidence Interval

Point Estimate	$2,794,933
Lower limit	$2,412,137
Upper limit	$3,177,728

APPENDIX D: HOSPITAL COMMENTS

UW Health

January 31, 2018

Mr. Jason C. Jelen
Regional Inspector General for Audit Services
Department of Health and Human Services
Office of Inspector General
Office of Audit Services, Region III
Public Ledger Building, Suite 316
150 S. Independence Mall West
Philadelphia, PA 19106

RE: Report Number A-03-17-00005

Dear Mr. Jelen:

On December 13, 2017, University of Wisconsin Hospitals and Clinics Authority (UWHCA) received the draft Office of Inspector General Report entitled *University of Wisconsin Hospitals and Clinics Authority Incorrectly Billed Medicare Inpatient Claims with Severe Malnutrition.* We appreciate the opportunity to respond to OIG's report.

It is well-established that patients with malnutrition are at an increased risk of adverse outcomes, complications, readmissions, and longer lengths of stay. UWHCA has devoted significant resources to ensuring our patients' nutrition needs are addressed and thus that they have improved outcomes. UWHCA also takes pride in the strength of its billing and coding compliance program.

UWHCA asserts that medical record documentation supports a severe malnutrition diagnosis code[5] in at least 85 of the 88 claims with which OIG's contractor disagreed, as discussed in more detail below. UWHCA intends to appeal all claim denials resulting from the findings of OIG's contractor.

Hospital Inpatients and Malnutrition

The increased risk of adverse outcomes for inpatients with malnutrition and the benefit of a timely nutrition intervention for inpatients was recognized by CMS in its 2017 Inpatient Prospective System Final Rule (2017 IPPS Final Rule), CMS noted:

> Malnutrition is associated with many adverse outcomes including depression of the immune system, impaired wound healing, muscle wasting, and increased mortality. Patients who are malnourished during a hospital stay have an increased risk of complications, readmissions, and length of stay. In addition, evidence demonstrates an association between malnutrition risk and

[5] ICD-9 diagnosis codes 261 (nutritional marasmus) and 262 (other severe, protein-calorie malnutrition); ICD-10 diagnosis codes E41 (nutritional marasmus) and E43 (unspecified severe protein-calorie malnutrition).

> increased inpatient costs. . . . Malnutrition risk screening, using a validated screening tool, can be useful in predicting certain patient outcomes including length of stay, mortality, and post-operative complications. Nutrition assessments for patients identified as at-risk for malnutrition have been associated with improved patient outcomes including less weight loss, reduced length of stay, improved muscle function, better nutritional intake, and fewer readmissions. Further, there is evidence of a performance gap with regard to nutritional screening and assessment. . . . Thus, there is an opportunity for hospitals to improve nutrition screening and assessment.[6]

Considering the negative impact of malnutrition, UWHCA has devoted significant resources to assessing, improving, and maintaining our patients' nutritional status. In addition to working with physicians to properly diagnose and treat malnutrition, UWHCA has built a Clinical Nutrition Services department with 50 registered dietitian nutritionists (RDNs). These RDNs provide comprehensive care to our often medically complex patients. RDNs perform nutrition-focused physical exams for patients at nutrition risk, using the Academy/ASPEN Guidelines and recommendations to identify malnutrition.

Standards for Billing Severe Malnutrition Diagnosis Codes

Although OIG's report references various general standards that were used in its audit, none specifically address severe malnutrition diagnoses. The most pertinent standards are from the Medicare Claims Processing Manual and ICD-9 and ICD-10 coding guidelines, which, in OIG's summary, allow use of diagnoses codes for conditions that "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." The contractor's findings are based entirely on this vague guidance. Neither OIG nor its contractor specified any discernable, objective standard for UWHCA to apply in diagnosing severe malnutrition or determining whether malnutrition affected the treatment or length of stay.

Curiously, the draft report makes no mention of the Academy/ASPEN Guidelines, although OIG stated at the beginning of the audit that it would apply the guidelines. CMS has not formally adopted the Academy/ASPEN Guidelines, but it recognized in the 2017 IPPS Final Rule that malnutrition assessments using validated screening tools can lead to better outcomes-and specifically cited the Academy/ASPEN Guidelines.[7]

OIG also recently added severe malnutrition diagnosis review to its work plan. It is unclear whether OIG or its contractors will apply more specific malnutrition criteria than were used in this audit. Without clear guidance, hospitals may reduce resources devoted to nutrition programs, resulting in poorer outcomes for at-risk Medicare patients.

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[6] Medicare Program: Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective System and Policy Changes and Fiscal Year 2018 Rates, Final Rule, 82 Fed. Reg. 37,990, 38,378-79 (August 14, 2017).

[7] 2017 IPPS Final Rule at 38,378-79.

Response to Audit Findings and Recommendations

As noted above, UWHCA disagrees with the contractor's findings in at least 85 of the 88 claims at issue. At this time, UWHCA does not dispute the contractor's findings for three of the sample claims where an overpayment was alleged. UWHCA will return these alleged overpayments, unless additional information comes to light that changes our position.

With regard to the remaining 85 claims, UWHCA asserts that its medical record documentation supports the inclusion of severe malnutrition diagnosis codes. In each case, the patients met criteria for severe malnutrition diagnoses based on, among other factors, application of the Academy/ASPEN Guidelines, physician documentation of severe malnutrition, and meeting other requisite standards for including the diagnoses on the claims (e.g., the patients were evaluated for and received therapeutic interventions to address the severe malnutrition).

Contrary to assertions in this report, OIG also included several claims in the sampling frame for which removing the severe malnutrition code either did not affect the DRG or resulted in an increased DRG. These claims were then underrepresented in the sample when compared to the sampling frame, so when OIG extrapolated to the full sampling frame, the error was compounded and improperly inflated the alleged overpayment.

We are also concerned that UWHCA was provided no opportunity to have a meaningful discussion with OIG or the contractor about the substance of the findings. In addition, we were provided no guidance on proper utilization of severe malnutrition diagnosis codes in the future. This response and the appeals resulting from this audit provide the only venue for UWHCA to meaningfully respond to what UWHCA believes are incorrect findings.

Because UWHCA disagrees with the vast majority of OIG's contractor's findings, we disagree with OIG's recommendations that are tied to those findings, namely (1) refund to the Medicare program $2,412,137, (2) exercise reasonable diligence to identify and return any additional similar overpayments outside the audit period, and (3) strengthen controls to ensure full compliance with Medicare billing requirements.

In addition, we disagree with OIG's recommendation to identify and return alleged similar overpayments outside of the audit period. UWHCA understands that an OIG audit can constitute a notice of potential overpayment for claims outside the audit period, per guidance issued with the Medicare 60-day rule.[8] However, we assert that this audit is not an indication of potential overpayments outside the audit period because the audit provided no discernable standard by which UWHCA could evaluate claims outside the audit period. We also question whether the potential 3% error rate warrants generalizing beyond the audit period, much less the sample claims themselves.

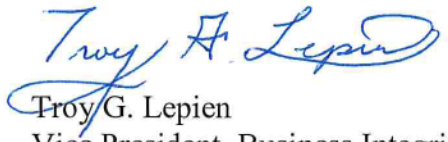
Finally, UWHCA disagrees with the recommendation that this audit indicates a need to strengthen controls to ensure full compliance with Medicare billing requirements. UWHCA has

[8] 42 C.F.R. § 401.305

appropriately provided and billed for the services at issue, and it is proud of its efforts to ensure Medicare billing compliance. When a potential billing error is identified, UWHCA promptly determines the scope of the error and repays the Medicare program for any identified overpayments.

UWHCA will, however, reconsider these recommendations during and after its appeals triggered by the audit. UWHCA would like to thank your audit team for their responsiveness and communication throughout this audit. Please feel free to contact me regarding the audit or this response.

Sincerely,



Troy G. Lepien
Vice President, Business Integrity
Chief Compliance Officer
University of Wisconsin Hospitals and Clinics Authority