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OIG Worksheets From Malnutrition Audit Raise Questions About Reasons for Denials, Experts Say

By Nina Youngstrom

When the HHS Office of Inspector General (OIG) declared in July that hospitals had overbilled Medicare $1 billion in two years for severe malnutrition,[1] physician James Kennedy and compliance professional Paul Belton decided to look behind the curtain at OIG's conclusions. Kennedy submitted a Freedom of Information Act (FOIA) request to OIG for the audit worksheets and got 200 summaries of the malnutrition reviews, which shed more light on what the audits potentially mean for hospitals.

What they learned: In some cases, the reviewers hired by OIG were satisfied that patients met the American Society for Parenteral and Enteral Nutrition (ASPEN) criteria for severe malnutrition and that it was documented by the physician, which would seem to bode well for the inpatient claims. But some of the diagnosis codes were rejected anyway.

"OIG often stated the complexity of the treatment didn't support their interpretation of the coding guidelines as an additional diagnosis," Belton said. That doesn't square with the definition of an additional (secondary) diagnosis in coding guidelines and the *Coding Clinic*, said Kennedy, president of CDIMD in Nashville, Tennessee. According to the Uniform Hospital Discharge Data Set (UHDDS), secondary diagnoses are defined as "other diagnoses." For reporting purposes, "the definition of 'other diagnoses' is 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." Any one of them would allow the coding of malnutrition on the claim, which affects MS-DRG assignment because it's a major complication and comorbidity (MCC).

"The fact that the physician documented and addressed it is enough, given that the patient was clinically evaluated as to determine the presence of the documented diagnosis and treated in the safest manner possible," Kennedy said Nov. 4 on a podcast hosted by the Association of Clinical Documentation Integrity Specialists.[2] "It's codable." OIG's conclusions could be "putting uncertainty in the minds of coders," added Belton, former vice president of corporate compliance at Sharp HealthCare in San Diego who is now affiliated with CDIMD.[3]