Department of Health and Human Services

**OFFICE OF INSPECTOR GENERAL**

# HOSPITALS OVERBILLED MEDICARE $1 BILLION BY INCORRECTLY ASSIGNING SEVERE MALNUTRITION DIAGNOSIS CODES TO INPATIENT HOSPITAL CLAIMS

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Principal
Deputy Inspector General

July 2020
A-03-17-00010

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https://oig.hhs.gov

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**Report in Brief**
Date: July 2020
Report No. A-03-17-00010

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

# Hospitals Overbilled Medicare $1 Billion by Incorrectly Assigning Severe Malnutrition Diagnosis Codes to Inpatient Hospital Claims

## Why OIG Did This Audit

Nutritional marasmus (diagnosis code E41) and unspecified severe protein-calorie malnutrition (diagnosis code E43) are two types of severe malnutrition. Previous OIG audits of severe malnutrition found that hospitals had incorrectly billed Medicare by using severe malnutrition diagnosis codes when they should have used codes for other forms of malnutrition or no malnutrition diagnosis code at all. Diagnosis codes E41 and E43 (severe malnutrition diagnosis codes) 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 hospitals complied with Medicare billing requirements when assigning severe malnutrition diagnosis codes to inpatient hospital claims.

## How OIG Did This Audit

Our audit covered $3.4 billion in Medicare payments for 224,175 claims with a discharge date in fiscal year (FY) 2016 or 2017 that contained a severe malnutrition diagnosis code and for which removing the diagnosis code changed the diagnosis-related group (DRG). We selected for review a random sample of 200 claims with payments totaling $2.9 million. We evaluated compliance with selected billing requirements and submitted the 200 claims to medical and coding review to determine whether the services were medically necessary and properly coded.

## What OIG Found

Hospitals correctly billed Medicare for severe malnutrition diagnosis codes for 27 of the 200 claims that we reviewed. However, hospitals did not correctly bill Medicare for the remaining 173 claims. For nine of these claims, the medical record documentation supported a secondary diagnosis code other than a severe malnutrition diagnosis code, but the error did not change the DRG or payment. For the remaining 164 claims, hospitals used severe malnutrition diagnosis codes when they should have used codes for other forms of malnutrition or no malnutrition diagnosis code at all, resulting in net overpayments of $914,128. On the basis of our sample results, we estimated that hospitals received overpayments of $1 billion for FYs 2016 and 2017.

## What OIG Recommends and CMS Comments

To address the 164 incorrectly billed hospital claims in our sample, we recommend that the Centers for Medicare & Medicaid Services (CMS) collect the portion of the $914,128 for the incorrectly billed hospital claims that are within the reopening period and, based on the results of this audit, notify appropriate providers so that the providers can exercise reasonable diligence to identify, report, and return any overpayments in accordance with the 60-day rule. To attempt recovery of the overpayment, which we estimate to be valued at $1 billion, resulting from incorrectly billed hospital claims paid during our audit period and to ensure claims made after our audit period are correct, we made additional recommendations. One of the recommendations includes reviewing all claims that were not part of our sample but were within the reopening period. The detailed recommendations are in the full report.

CMS concurred with our recommendations and stated that it will instruct its contractors to recover the overpayments consistent with relevant law and CMS's policies and procedures. However, CMS noted that the estimated overpayments we identified represent less than .5 percent of the overall payments made for inpatient services during the audit period. Despite this, CMS stated that it will instruct its contractors to review a sample of claims in the sampling frame to determine whether they were billed correctly. Of the claims that we reviewed, 82 percent were not correctly billed, which we maintain is significant and needs to be addressed. We continue to recommend that CMS review all claims in our sampling frame that were not part of our sample but were within the reopening period and work with the hospitals to ensure they correctly bill Medicare when using severe malnutrition diagnosis codes.

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# INTRODUCTION

## WHY WE DID THIS AUDIT

Nutritional marasmus (diagnosis code E41) and unspecified severe protein-calorie malnutrition (diagnosis code E43) are two types of severe malnutrition listed in the *International Classification of Diseases, Tenth Revision, Clinical Modification* (ICD-10-CM). 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. Previous Office of Inspector General (OIG) audits of severe malnutrition[1] found that hospitals had incorrectly billed Medicare by using severe malnutrition diagnosis codes when they should have used codes for other forms of malnutrition or no malnutrition diagnosis code at all. Diagnosis codes E41 and E43 (collectively referred to in this report as "severe malnutrition diagnosis codes") are classified as a type of major complication or comorbidity (MCC). Adding MCCs to a Medicare claim can result in a higher Medicare payment.

## OBJECTIVE

Our objective was to determine whether hospitals complied with Medicare billing requirements when assigning severe malnutrition diagnosis codes to inpatient hospital claims.

## BACKGROUND

### The Medicare Program

The Centers for Medicare & Medicaid Services (CMS) administers the Medicare program, which provides health insurance coverage primarily to people aged 65 or older. Medicare Part A provides inpatient hospital insurance benefits and extended care services coverage after hospital discharge. 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 diagnosis-related group (DRG) to which a patient'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 patient's stay. The DRG and severity level are determined according to diagnosis codes established by the ICD-10-CM.

OIG believes that this audit report constitutes credible information of potential overpayments. Upon receiving credible information of potential overpayments, providers must exercise reasonable diligence to identify overpayments (i.e., determine receipt of and quantify

[1] See Appendix B for related OIG reports.

any overpayments) during a 6-year lookback period. Providers must report and return any identified overpayments by the later of (1) 60 days after identifying those overpayments or (2) the date that any corresponding cost report is due (if applicable). This is known as the 60-day rule.[2]

The 6-year lookback period is not limited by OIG's audit period or restrictions on the Government's ability to reopen claims or cost reports. To report and return overpayments under the 60-day rule, providers can request the reopening of initial claims determinations, submit amended cost reports, or use any other appropriate reporting process.[3]

## HOW WE CONDUCTED THIS AUDIT

Our audit covered $3.4 billion in Medicare payments for 224,175 inpatient claims with a discharge date between October 1, 2015, and September 30, 2017,[4] (audit period) and that contained a severe malnutrition diagnosis code for which removing the severe malnutrition diagnosis code changed the DRG. We selected for review a random sample of 200 claims totaling $2.9 million.

We evaluated compliance with selected billing requirements and submitted the 200 claims for medical and coding review to determine whether the services were medically necessary and properly coded.

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, Appendix C for our statistical sampling methodology, and Appendix D for our sample results and estimates.

## FINDING

Hospitals correctly billed Medicare for severe malnutrition diagnosis codes for 27 of the 200 claims that we reviewed. However, hospitals did not correctly bill Medicare for the remaining 173 claims. For nine of these claims, the medical record documentation supported a secondary diagnosis code other than a severe malnutrition diagnosis code, but the error did not change the DRG or payment. For the remaining 164 claims, the billing errors resulted in net overpayments of $914,128. These errors occurred because hospitals used severe malnutrition

[2] The Social Security Act (The Act) § 1128J(d); 42 CFR §§ 401.301-401.305; and 81 Fed. Reg. 7654 (Feb. 12, 2016).

[3] 42 CFR §§ 401.305(d), 405.980(c)(4), and 413.24(f); CMS, *Provider Reimbursement Manual*—Part 1, Pub. No. 15-1 § 2931.2; 81 Fed. Reg. 7670.

[4] This was the most current data available at the time the audit began.

diagnosis codes when they should have used codes for other forms of malnutrition or no malnutrition diagnosis code at all. For these claims, hospitals provided medical record documentation that did not contain evidence that the malnutrition was severe or that it had an effect on patient care.

On the basis of our sample results, we estimated that hospitals received overpayments of $1 billion for our audit period.

## 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)).

*ICD-10-CM Official Guidelines for Coding and Reporting* provides general rules for reporting other diagnosis codes. These guidelines state that diagnosis codes can be billed for additional conditions if those conditions affect patient care in terms of requiring clinical evaluation, therapeutic treatment, or diagnostic procedures or if those conditions extend the length of the hospital stay or require increased nursing care or monitoring. Previous conditions that have no impact on the current stay should not be reported.[5]

## HOSPITALS USED SEVERE MALNUTRITION DIAGNOSIS CODES INCORRECTLY

Hospitals correctly billed Medicare for severe malnutrition diagnosis codes for 27 of the 200 claims that we reviewed. However, hospitals did not correctly bill Medicare for the remaining 173 claims. For nine of these claims, the medical record documentation supported a secondary diagnosis code other than a severe malnutrition diagnosis code, but the error did not change the DRG or payment. For the remaining 164 claims, the billing errors resulted in net overpayments of $914,128. These errors occurred because hospitals used severe malnutrition diagnosis codes when they should have used codes for other forms of malnutrition or no malnutrition diagnosis code at all. The examples below show how incorrectly billing for severe malnutrition diagnosis codes resulted in overpayments.

[5] CMS includes similar guidance in the Medicare Claims Processing Manual, Chapter 23, § 10.2.

**Example 1: Patient Had Non-Severe Malnutrition**

One claim for a patient with moderate muscle wasting and edema[6] also included a secondary diagnosis of severe protein-calorie malnutrition. The nutritionist noted malnutrition secondary to obesity in the patient, and the physician documented non-severe protein-calorie malnutrition. The patient was placed on a heart-healthy diet and an oral protein supplement, and the patient's diagnosis did not affect patient care. Therefore, the medical record did not support the secondary diagnosis of severe protein-calorie malnutrition. This billing error resulted in a Medicare overpayment of $10,734.

**Example 2: Patient Had Moderate Malnutrition**

For another claim that included a secondary diagnosis of severe protein-calorie malnutrition, the medical record documented that the patient lost 7.5 percent total body weight in 1 month, with mild loss of fat and muscle mass. The physician diagnosed the patient with moderate malnutrition, which is supported by the medical record. The patient's moderate malnutrition diagnosis did affect the treatment plan, which involved an alternate method of feeding called total parenteral nutrition and laboratory monitoring. However, the medical record did not support the secondary diagnosis of severe protein-calorie malnutrition. This billing error resulted in a Medicare overpayment of $3,971.

## OVERALL ESTIMATE OF OVERPAYMENTS

On the basis of our sample results, we estimated that hospitals received overpayments of $1 billion for our audit period.

[6] Edema is defined as swelling caused by excess fluid trapped in the body's tissues, usually in the hands, feet, or abdomen.

## RECOMMENDATIONS

To address the 164 incorrectly billed hospital claims in our sample, we recommend that the Centers for Medicare & Medicaid Services:

- collect the portion of the $914,128 for the incorrectly billed hospital claims that are within the reopening period[7] and

- based upon the results of this audit, notify appropriate providers (i.e., those for whom CMS determines this audit constitutes credible information of potential overpayments) so that the providers can exercise reasonable diligence to identify, report, and return any overpayments in accordance with the 60-day rule, and identify any of those returned overpayments as having been made in accordance with this recommendation.

To attempt recovery of the overpayment, which we estimate to be valued at $1,024,623,449, resulting from incorrectly billed hospital claims paid during our audit period and to ensure claims made after our audit period are correct, we recommend that the Centers for Medicare & Medicaid Services:

- review the 224,175 inpatient claims in our sampling frame that were not part of our sample but were within the reopening period to identify which were incorrectly billed and recover identified overpayments and

- review how hospitals are using diagnosis code E41 for nutritional marasmus and diagnosis code E43 for unspecified severe protein-calorie malnutrition and work with hospitals to ensure that they correctly bill Medicare when using severe malnutrition diagnosis codes.

## CMS COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

In written comments on our draft report, CMS concurred with our recommendations and described the actions it has taken or plans to take to address them.

In concurring with our recommendations, CMS stated that it will instruct its contractors to recover the overpayments consistent with relevant law and CMS's policies and procedures, notify appropriate providers of this audit and the potential overpayment, and track any returned overpayments made in accordance with the 60-day rule.

[7] OIG audit recommendations do not represent final determinations by Medicare. CMS, acting through a Medicare Administrative Contractor or other contractor, will determine whether overpayments exist and will recoup any overpayments consistent with its policies and procedures. Providers have the right to appeal those determinations and should familiarize themselves with the rules pertaining to when overpayments must be returned or are subject to offset while an appeal is pending. The Medicare Part A and Part B appeals process has five levels (42 CFR § 405.904(a)(2)), and if a provider exercises its right to an appeal, the provider does not need to return overpayments until after the second level of appeal. Potential overpayments identified in OIG reports that are based on extrapolation may be re-estimated depending on CMS determinations and the outcome of appeals.

CMS also noted that the estimated overpayments identified by our audit represent less than .5 percent of the overall payments made for inpatient services during the audit period. Despite this, CMS stated that it will instruct its contractors to review a sample of those claims in the sampling frame that were not part of our sample but that were within the reopening period to determine whether they were billed correctly. Finally, CMS stated that Medicare contractors perform DRG validation reviews to ensure that diagnostic information on the claims matches the physician description and information in the medical record.

Since our audit period, CMS has implemented several Fraud Prevention System models that may identify inpatient hospital billing providers engaging in potential DRG upcoding, which is when a provider assigns an inaccurate billing code to a medical procedure or treatment to increase reimbursement. Additionally, CMS contractors have been performing reviews of code E41 for nutritional marasmus and code E43 for unspecified severe protein-calorie malnutrition to ensure they are being used appropriately. As part of this strategy, CMS recovers identified improper payments in accordance with relevant law and agency policies and procedures. In addition, CMS has taken action to prevent improper Medicare payments by educating health care providers on proper billing.

Even though the $1 billion we identified in estimated overpayments represent less than .5 percent of the overall payments made for inpatient services during the audit period, 82 percent of the claims that we reviewed were not correctly billed, which we maintain is significant. Therefore, these overpayments and their cause need to be addressed. We agree that CMS should instruct its contractors to review inpatient claims from our sample frame and to perform DRG validation reviews. However, we continue to recommend that CMS review all claims in our sampling frame that were not part of our sample but were within the reopening period, not just a sample of those claims, and also work with the hospitals to ensure they correctly bill Medicare when using severe malnutrition diagnosis codes.

CMS's comments are included in their entirety as Appendix E.

## APPENDIX A: AUDIT SCOPE AND METHODOLOGY

### SCOPE

Our audit covered $3,350,305,870 in Medicare payments to hospitals for 224,175 inpatient claims with a discharge date between October 1, 2015, and September 30, 2017,[8] and that contained diagnosis code E41 or E43. We only reviewed claims for which removing the severe malnutrition diagnosis code changed the DRG.

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.

We did not assess CMS's overall internal control structure. Rather, we limited our review of internal controls to those applicable to our audit objective.

We conducted our fieldwork from March 2018 through February 2020.

### METHODOLOGY

To accomplish our objective, we:

- reviewed applicable Federal laws, regulations, and guidance;
- extracted hospitals' inpatient paid claims data from CMS's National Claims History file for the audit period;
- initially selected all paid claims for which the severe malnutrition diagnosis code was the only MCC code on the claim[9];
- removed claims from three acute-care hospitals that had been part of previous OAS malnutrition reviews (Appendix B) and claims from the State of Maryland due to the waiver covering that State's All-Payer model;
- processed claims through the Medicare-Severity Diagnosis-Related Group (MS-DRG)[10] grouper program and removed any claims in which the program showed that removing the severe malnutrition diagnosis code did not affect the DRG;

[8] This was the most current data available at the time the audit began.

[9] All diagnosis codes supported in the medical record documentation were identified by the independent contractor when the medical records were reviewed. These diagnosis codes were then used to determine the correct DRG for payment.

[10] MS-DRG is a classification system to calculate pricing for inpatient hospital claims. The grouper program is a computer software system that classifies a patient's hospital stay as an established DRG based on the diagnosis and procedures provided to the patient.

- 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 200 claims with payments totaling $2,938,978 from our sampling frame for review;

- used an independent contractor to determine whether the 200 selected claims met medical necessity and coding requirements;

- repriced each selected claim and compared it with the original payment to verify that the original payment was correct;

- reviewed the independent contractor's results;

- calculated the correct payments for those claims requiring adjustments;

- used the results of the sample to estimate the Medicare overpayment to hospitals for our audit period (Appendix C); and

- discussed the results of our audit with CMS 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: RELATED OFFICE OF INSPECTOR GENERAL REPORTS

| Report Title | Report Number | Date Issued |
|---|---|---|
| *University of Wisconsin Hospitals and Clinics Authority Incorrectly Billed Medicare Inpatient Claims With Severe Malnutrition* | A-03-17-00005 | 6/1/2018 |
| *Vidant Medical Center Incorrectly Billed Medicare Inpatient Claims With Severe Malnutrition* | A-03-15-00011 | 1/31/2017 |
| *Northside Medical Center Incorrectly Billed Medicare Inpatient Claims With Severe Malnutrition* | A-03-15-00012 | 12/30/2016 |

## APPENDIX C: STATISTICAL SAMPLING METHODOLOGY

### SAMPLING FRAME

The sampling frame consisted of a Microsoft Excel spreadsheet that contained 224,175 inpatient claims with a discharge date between October 1, 2015, and September 30, 2017, that contained diagnosis code E41 or E43 totaling $3,350,305,870. Hospitals billed for these claims during our audit period. The sampling frame did not include claims that contained another MCC diagnosis code other than E41 or E43.

We removed diagnosis codes E41 and E43 from each claim and ran the claims through the MS-DRG grouper program to identify which claims experienced a change in the DRG when the codes were removed.

### SAMPLE UNIT

The sample unit was a Medicare paid claim.

### SAMPLE DESIGN

We used a simple random sample.

### SAMPLE SIZE

We selected 200 paid claims for review.

### SOURCE OF RANDOM NUMBERS

We generated the random numbers using the OIG, Office of Audit Services (OIG/OAS), statistical software.

### METHOD FOR SELECTING SAMPLE UNITS

The sampling frame was numbered sequentially from 1 to 224,175. After generating the 200 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 hospitals 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 D: 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 |
|---|---|---|---|---|---|
| 224,175 | $3,350,305,870 | 200 | $2,938,978 | 164 | $914,128 |

### ESTIMATES

### Table 2: Estimated Overpayments for the Audit Period

*(Limits Calculated for a 90-Percent Confidence Interval)*

| | |
|---|---|
| Point Estimate | $1,024,623,449 |
| Lower limit | $894,434,664 |
| Upper limit | $1,154,812,233 |

## APPENDIX E: CMS COMMENTS

DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

*Administrator*
Washington, DC 20201

**DATE:** May 15, 2020

**TO:** Christi Grimm
Principal Deputy Inspector General
Office of Inspector General

**FROM:** Seema Verma
Administrator
Centers for Medicare & Medicaid Services

**SUBJECT:** Office of Inspector General (OIG) Draft Report: Hospitals Overbilled Medicare $1 Billion by Incorrectly Assigning Severe Malnutrition Diagnosis Codes to Inpatient Hospital Claims (A-03-17-00010)

The Centers for Medicare & Medicaid Services (CMS) appreciates the opportunity to review and comment on the Office of Inspector General's (OIG) draft report.

CMS recognizes the importance of providing Medicare beneficiaries with access to medically necessary services and, at the same time, protecting the Medicare Trust Funds from improper payments. CMS uses a robust program integrity strategy to reduce and prevent Medicare improper payments, including automated system edits within the claims processing system and prepayment and postpayment medical reviews.

CMS also uses the Fraud Prevention System to analyze Medicare fee-for-service claims using sophisticated algorithms to target investigative resources, generate alerts for suspect claims or providers and suppliers, provide information to facilitate and support investigations of the most egregious, suspect, or aberrant activity. CMS uses the Fraud Prevention System information to prevent and address improper payments using a variety of administrative tools and actions, including claims denials, payment suspensions, Medicare billing privilege revocations, and law enforcement referrals.

The estimated overpayments identified by the OIG represent less than .5 percent of the overall payments made for inpatient services during the audit timeframe. Since the OIG audit period, CMS implemented several Fraud Prevention System models that identify inpatient hospital billing providers engaging in potential Diagnosis Related Group upcoding, which is when a provider assigns an inaccurate billing code to a medical procedure or treatment to increase reimbursement. This could include providers who inappropriately code for severe malnutrition. Additionally, CMS contractors have been performing reviews of code E41 for nutritional marasmus, and code E43 for unspecified severe protein-calorie malnutrition to ensure they are being used appropriately. As part of this strategy, CMS recovers identified improper payments in accordance with relevant law and agency policies and procedures.

Additionally, CMS has taken action to prevent improper Medicare payments by educating health care providers on proper billing. CMS educates health care providers on appropriate Medicare billing through various channels including the Medicare Learning Network, weekly electronic newsletters, and quarterly compliance newsletters.

The OIG's recommendations and CMS' responses are below.

**OIG Recommendation**
The OIG recommends that the Centers for Medicare & Medicaid Services collect the portion of the $914,128 for the incorrectly billed hospital claims that are within the reopening period.

**CMS Response**
CMS concurs with this recommendation. CMS will instruct its Medicare Administrative Contractors to recover the identified overpayments consistent with relevant law and the agency's policies and procedures.

**OIG Recommendation**
The OIG recommends that the Centers for Medicare & Medicaid Services based upon the results of this audit, notify appropriate providers (i.e., those for whom CMS determines this audit constitutes credible information of potential overpayments) so that the providers can exercise reasonable diligence to identify, report, and return any overpayments in accordance with the 60-day rule, and identify any of those returned overpayments as having been made in accordance with this recommendation.

**CMS Response**
CMS concurs with this recommendation. CMS will instruct its Medicare Administrative Contactors to notify appropriate providers of the OIG's audit and the potential overpayment and track any returned overpayments made in accordance with this recommendation and the 60-day rule.

**OIG Recommendation**
The OIG recommends that the Centers for Medicare & Medicaid Services review the 224,175 inpatient claims in our sampling frame that were not part of our sample but were within the reopening period to identify which were incorrectly billed and recover identified overpayments.

**CMS Response**
CMS concurs with this recommendation and notes that the estimated overpayments identified by the OIG represent less than .5 percent of the overall payments made for inpatient services during the audit timeframe. CMS will instruct its Medicare contractors to review a sample of the inpatient claims in the sample frame that were not part of the sample but are within the reopening period to determine whether they were billed correctly. Based on the findings of the sample review, CMS will determine the appropriate course of action. CMS will recover, as appropriate, any identified overpayments associated with the reviews consistent with agency policy and procedures.

**OIG Recommendation**
The OIG recommends that the Centers for Medicare & Medicaid Services review how hospitals are using diagnosis code E41 for nutritional marasmus and diagnosis code E43 for unspecified severe protein-calorie malnutrition and work with hospitals to ensure that they correctly bill Medicare when using severe malnutrition diagnosis codes.

**CMS Response**
CMS concurs with this recommendation. As part of our medical reviews of inpatient hospital claims for Part A payments, Medicare contractors perform Diagnosis Related Group validation reviews according to the requirements of Pub. 100-08 (Program Integrity Manual) Chapter 6,

Section 6.5.3 to ensure that diagnostic and procedural information and the discharge status of the beneficiary, as coded and reported by the hospital on its claim, matches both the attending physician's description and the information contained in the beneficiary's medical records. As part of this process, reviewers validate principle diagnosis, secondary diagnoses, and procedures affecting or potentially affecting the Diagnosis Related Group.