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ALJ Overturns All Malnutrition Denials in Hospital Appeal; CMS Has 'No Official Policy'

By Nina Youngstrom

Although the wheels of administrative justice moved slowly for a set of Medicare claims for severe malnutrition, Vaughn Matacale, M.D., physician advisor group director at ECU Health in Greenville, North Carolina, was convinced they were supported by medical records and coding guidance. Finally, an administrative law judge (ALJ) has agreed after reviewing all 77 claims one by one.

The ALJ's "fully favorable" decision reversed the lion's share of an HHS Office of Inspector General (OIG) finding that ECU (formerly Vidant Medical Center) was overpaid about $1.4 million over 2 1/2 years (an extrapolated amount).[1]

ALJ Sean McKee ruled that OIG's statistical sample and extrapolation were "valid" but so were the underlying claims. The thrust of the decision: Auditors rejected malnutrition diagnoses in the absence of formal CMS guidance after patients were diagnosed with malnutrition based on American Society for Parenteral and Enteral Nutrition (ASPEN) criteria for diagnosing malnutrition and their cases were coded using ICD-9-CM Official Guidelines for Coding and Reporting. There was the same dichotomy on appeal before the Medicare administrative contractor (MAC) and qualified independent contractor (QIC): no official guidance versus official guidance.

"It alters your view when it gets to such a large scale," Vaughn said. "It brings more gravity to the process of denials and appeals and a lot more tension when you put that many cases together. It was nice to see our approach affirmed in the legal document."

The hospital's experience may be of interest to others because malnutrition has been or is now a focus of audits by OIG, Medicare administrative contractors in Targeted Probe and Educate, the supplemental medical review contractor, Medicare Advantage plans and commercial payers, and is the subject of a national OIG Medicaid review. According to its work plan, OIG is doing "statewide reviews to determine whether hospitals complied with Medicaid billing requirements when assigning severe malnutrition diagnosis codes to inpatient hospital claims."[2] The review is due out this year.

Auditors are concerned that hospitals report severe malnutrition on the claim when moderate or milder forms of malnutrition should be reported—or no malnutrition. When auditors strip secondary diagnoses for severe malnutrition from the claim, it changes the DRG, often reducing reimbursement.

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