Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

BRAVO HEALTH PENNSYLVANIA, INC. (CONTRACT H3949), SUBMITTED MANY DIAGNOSES TO THE CENTERS FOR MEDICARE & MEDICAID SERVICES THAT DID NOT COMPLY WITH FEDERAL REQUIREMENTS FOR CALENDAR YEAR 2007

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Office of Inspector General

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EXECUTIVE SUMMARY

BACKGROUND

Under the Medicare Advantage (MA) program, the Centers for Medicare & Medicaid Services (CMS) makes monthly capitated payments to MA organizations for beneficiaries enrolled in the organizations' health care plans. Subsections 1853(a)(1)(C) and (a)(3) of the Social Security Act require that these payments be adjusted on the basis of the health status of each beneficiary. CMS uses the Hierarchical Condition Category (HCC) model (the CMS model) to calculate these risk-adjusted payments.

Under the CMS model, MA organizations collect risk adjustment data, including beneficiary diagnoses, from hospital inpatient facilities, hospital outpatient facilities, and physicians during a data collection period. MA organizations identify the diagnoses relevant to the CMS model and submit them to CMS. CMS categorizes the diagnoses into groups of clinically related diseases called HCCs and uses the HCCs and demographic characteristics to calculate a risk score for each beneficiary. CMS uses the risk scores to adjust the monthly capitated payments to MA organizations for the next payment period.

Bravo Health Pennsylvania, Inc. (Bravo), is an MA organization. (In November 2010, after our draft report, Bravo was acquired by HealthSpring, Inc. On January 31, 2012, HealthSpring, Inc. was acquired by the Cigna Corporation.) For calendar year (CY) 2007, Bravo had multiple contracts with CMS, including contract H3949, which we refer to as "the contract." Under the contract, CMS paid Bravo approximately $194 million to administer health care plans for approximately 13,755 beneficiaries.

OBJECTIVE

Our objective was to determine whether the diagnoses that Bravo submitted to CMS for use in CMS's risk score calculations complied with Federal requirements.

SUMMARY OF FINDINGS

The diagnoses that Bravo submitted to CMS for use in CMS's risk score calculations did not always comply with Federal requirements. The risk scores calculated using the diagnoses that Bravo submitted for 35 of the 100 beneficiaries in our sample were valid. The risk scores for the remaining 65 beneficiaries were invalid because the diagnoses were not supported for 1 or more of the following reasons:

- The documentation did not support the associated diagnosis.
- The documentation did not include the provider's signature or credentials.
- Bravo did not provide any documentation to support the associated diagnosis.

Bravo did not review the diagnosis codes received from providers before submitting the codes to CMS and therefore could not ensure that the diagnoses submitted to CMS complied with Federal requirements.

As a result of these unsupported diagnoses, Bravo received $422,409 in overpayments from CMS. On the basis of our sample results, we estimated that Bravo was overpaid approximately $22,108,905 in CY 2007.

RECOMMENDATIONS

We recommend the following:

- Bravo should refund to the Federal Government $422,409 in overpayments identified for the sampled beneficiaries.

- Bravo should work with CMS to determine the correct contract-level adjustment for the projected $22,108,905 of overpayments. (This amount represents our point estimate. The confidence interval for this estimate has a lower limit of $17.4 million and an upper limit of $26.9 million.)

- Bravo should modify its policies and procedures and improve its practices to ensure compliance with Federal requirements.

BRAVO COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

In written comments on our draft report, Bravo said that our sample approach and limited review were flawed; cited a disconnect between our audit and CMS's guidance and requirements; and suggested that we evaluate our audit process, existing and proposed CMS guidance, and Bravo's responses, including additional documentation. Bravo also stated that we did not account for error rates inherent in Medicare fee-for-service (FFS) data, specifically the disparity between FFS claim data and FFS medical records data and its potential impact on MA payments. In addition, Bravo described actions it has taken since the 2006 audit period and stated that it would continue to evaluate its policies and procedures for improvements consistent with CMS requirements.

Bravo disagreed with our assessment in the draft report that several HCCs were not supported by the medical record and supplied additional information. We reviewed all information that Bravo provided and submitted any new information to our medical review contractor. To the extent our medical review contractor found support in this additional information, we revised our findings using the results of this medical review.

Although an analysis to determine the potential impact of error rates inherent in FFS data on MA payments was beyond the scope of our audit, we acknowledge that CMS is studying this issue and its potential impact on audits of MA organizations. Therefore, because of the potential impact of these error rates on the CMS model that we used to recalculate MA payments for the beneficiaries in our sample, we (1) modified one recommendation to have Bravo refund only the

overpayments identified for the sampled beneficiaries rather than refund the estimated overpayments and (2) added a recommendation that Bravo work with CMS to determine the correct contract-level adjustments for the estimated overpayments.

We did not initially accept physician signature attestations. However, because Federal regulations regarding signature attestations changed in 2010, we accepted the signature attestations and revised our findings as applicable.

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INTRODUCTION

BACKGROUND

Medicare Advantage Program

The Balanced Budget Act of 1997, P.L. No. 105-33, established Medicare Part C to offer beneficiaries managed care options through the Medicare+Choice program. Section 201 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, P.L. No. 108-173, revised Medicare Part C and renamed it the Medicare Advantage (MA) program. Organizations that participate in the MA program include health maintenance organizations, preferred provider organizations, provider-sponsored organizations, and private fee-for-service (FFS) plans. The Centers for Medicare & Medicaid Services (CMS), which administers the Medicare program, makes monthly capitated payments to MA organizations for beneficiaries enrolled in the organizations' health care plans (beneficiaries).

Risk-Adjusted Payments

Subsections 1853(a)(1)(C) and (a)(3) of the Social Security Act require that payments to MA organizations be adjusted based on the health status of each beneficiary. In calendar year (CY) 2004, CMS implemented the Hierarchical Condition Category (HCC) model (the CMS model) to calculate these risk-adjusted payments.

Under the CMS model, MA organizations collect risk adjustment data, including beneficiary diagnoses, from hospital inpatient facilities, hospital outpatient facilities, and physicians during a data collection period. [1] MA organizations identify the diagnoses relevant to the CMS model and submit them to CMS. CMS categorizes the diagnoses into groups of clinically related diseases called HCCs and uses the HCCs, as well as demographic characteristics, to calculate a risk score for each beneficiary. CMS uses the risk scores to adjust the monthly capitated payments to MA organizations for the next payment period.[2]

Federal Requirements

Regulations (42 CFR § 422.310(b)) require MA organizations to submit risk adjustment data to CMS in accordance with CMS instructions. CMS issued instructions in its *2007 Risk Adjustment Data Training for Medicare Advantage Organizations Participant Guide* (the 2007 Participant Guide) that provided requirements for submitting risk adjustment data for the CY 2007 data collection period. CMS had issued similar instructions in its *2006 Risk Adjustment Data Basic Training for Medicare Advantage Organizations Participant Guide* (the 2006 Participant Guide).

[1] Risk adjustment data also include health insurance claim numbers, provider types, and the from and through dates for the service.

[2] For example, CMS used data that MA organizations submitted for the CY 2006 data collection period to adjust payments for the CY 2007 payment period.

Diagnoses included in risk adjustment data must be based on clinical medical record documentation from a face-to-face encounter; coded according to the *International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM)* (the Coding Guidelines); assigned based on dates of service within the data collection period; and submitted to the MA organization from an appropriate risk adjustment provider type and an appropriate risk adjustment physician data source. The 2006 and 2007 Participant Guides described requirements for hospital inpatient, hospital outpatient, and physician documentation.

Bravo Health Pennsylvania, Inc.

Bravo Health Pennsylvania, Inc. (Bravo), is an MA organization.[3] For CY 2007, Bravo had multiple contracts with CMS, including contract H3949, which we refer to as "the contract." Under the contract, CMS paid Bravo approximately $194 million to administer health care plans for approximately 13,755 beneficiaries.

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

Our objective was to determine whether the diagnoses that Bravo submitted to CMS for use in CMS's risk score calculations complied with Federal requirements.

Scope

Our review covered approximately $72 million of the CY 2007 MA organization payments that CMS made to Bravo on behalf of 5,234 beneficiaries. These payments were based on risk adjustment data that Bravo submitted to CMS for CY 2006 dates of service for beneficiaries who (1) were continuously enrolled under the contract during all of CY 2006 and January of CY 2007[4] and (2) had a CY 2007 risk score that was based on at least one HCC. We limited our review of Bravo's internal control structure to controls over the collection, processing, and submission of risk adjustment data.

We asked Bravo to provide us with one medical record that best supported the HCC(s) that CMS used to calculate each risk score. If our review found that a medical record did not support one or more assigned HCCs, we gave Bravo the opportunity to submit an additional medical record for a second medical review.

We performed our fieldwork at Bravo's offices and at CMS in Baltimore, Maryland, from December 2008 through December 2009.

[3] Bravo's offices are located primarily in Baltimore, Maryland. In November 2010, after our draft report, Bravo was acquired by HealthSpring, Inc. On January 31, 2012, HealthSpring, Inc., was acquired by the Cigna Corporation.

[4] We limited our sampling frame to continuously enrolled beneficiaries to ensure that Bravo was responsible for submitting the risk adjustment data that resulted in the risk scores covered by our review.

Methodology

To accomplish our objective, we did the following:

- We reviewed applicable Federal laws, regulations, and guidance regarding payments to MA organizations.

- We interviewed CMS officials to obtain an understanding of the CMS model.

- We obtained the services of a medical review contractor to determine whether the documentation that Bravo submitted supported the HCCs associated with the beneficiaries in our sample.

- We interviewed Bravo officials to gain an understanding of Bravo's internal controls for obtaining risk adjustment data from providers, processing the data, and submitting the data to CMS.

- We obtained enrollment data, CY 2007 beneficiary risk score data, and CY 2006 risk adjustment data from CMS and identified 5,234 beneficiaries who (1) were continuously enrolled under the contract during all of CY 2006 and January of CY 2007 and (2) had a CY 2007 risk score that was based on at least 1 HCC.

- We selected a simple random sample of 100 beneficiaries with 304 HCCs. (See Appendix A for our sample design and methodology.) For each sampled beneficiary, we:

    - analyzed the CY 2007 beneficiary risk score data to identify the HCC(s) that CMS assigned;

    - analyzed the CY 2006 risk adjustment data to identify the diagnosis or diagnoses associated with the beneficiary's HCC(s) that Bravo submitted to CMS;

    - requested that Bravo provide us one medical record that, in Bravo's judgment, best supported the HCC(s) that CMS used to calculate the beneficiary's risk score;

    - obtained Bravo's certification that the documentation provided represented "the one best medical record to support the HCC";[5] and

    - submitted Bravo's documentation and HCCs for each beneficiary to our medical review contractor for a first medical review and requested additional

[5] The 2007 Participant Guide, sections 7.2.3 and 7.2.3.1, and the 2006 Participant Guide, sections 8.2.3 and 8.2.3.1, require plans to select the "one best medical record" to support each HCC and indicate that the best medical record may include a range of consecutive dates (if the record is from a hospital inpatient provider) or one date (if the record is from a hospital outpatient or physician provider). Although we requested one best medical record, Bravo submitted full medical records, and the medical reviewer reviewed the records provided.

documentation from Bravo for a second medical review if the contractor found that documentation submitted during the first round did not support the HCCs.

- For some of the draft report findings with which it disagreed,[6] Bravo provided additional documentation and/or information, which we submitted to our medical review contractor for a third review.

- For the sampled beneficiaries that we determined to have unsupported HCCs, we (1) used the medical review results to adjust the beneficiaries' risk scores, (2) recalculated CY 2007 payments using the adjusted risk scores, and (3) subtracted the recalculated CY 2007 payments from the actual CY 2007 payments to determine the overpayments and underpayments CMS made on behalf of the beneficiaries.

- We estimated the total value of overpayments based on our sample results. (See Appendix B for our sample results and estimates.)

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.

FINDINGS AND RECOMMENDATIONS

The diagnoses that Bravo submitted to CMS for use in CMS's risk score calculations did not always comply with Federal requirements. The risk scores calculated using the diagnoses that Bravo submitted for 35 of the 100 beneficiaries in our sample were valid. The risk scores for the remaining 65 beneficiaries were invalid because the diagnoses were not supported for 1 or more of the following reasons:

- The documentation did not support the associated diagnosis.

- The documentation did not include the provider's signature or credentials.

- Bravo did not provide any documentation to support the associated diagnosis.

Bravo did not review the diagnosis codes received from providers before submitting the codes to CMS and therefore could not ensure that the diagnoses submitted to CMS complied with the requirements of the 2007 and 2006 Participant Guides.

As a result of these unsupported diagnoses, Bravo received $422,409 in overpayments from CMS (Appendix B). On the basis of our sample results, we estimated that Bravo was overpaid approximately $22,108,905 in CY 2007.

[6] Of the 93 HCCs for which Bravo disagreed with our assessment, we accepted physician signature attestations on 32 HCCs and submitted 14 HCCs for a third medical review. However, some of the HCCs had more than one error. We were therefore able to validate only 22 additional HCCs.

FEDERAL REQUIREMENTS

Regulations (42 CFR § 422.310(b)) state: "Each MA organization must submit to CMS (in accordance with CMS instructions) the data necessary to characterize the context and purposes of each service provided to a Medicare enrollee by a provider, supplier, physician, or other practitioner. CMS may also collect data necessary to characterize the functional limitations of enrollees of each MA organization." The 2007 Participant Guide, section 8.7.3, and the 2006 Participant Guide, section 7.7.3, state that "MA organizations are responsible for the accuracy of the data submitted to CMS."

Section 2.2.1 of the 2007 and 2006 Participant Guides states that risk adjustment data submitted to CMS must include a diagnosis. The 2007 Participant Guide, section 7.1.4, and the 2006 Participant Guide, section 8.1.3, state that the diagnosis must be coded according to the Coding Guidelines. Section III of the Coding Guidelines states that for each hospital inpatient stay, the hospital's medical record reviewer should code the principal diagnosis and "… all conditions that coexist at the time of admission, that develop subsequently, or that affect the treatment received and/or length of stay. Diagnoses that relate to an earlier episode which have no bearing on the current hospital stay are to be excluded." Sections II and III of the Coding Guidelines state that "if the diagnosis documented at the time of discharge is qualified as 'probable,' 'suspected,' 'likely,' 'questionable,' 'possible,' or 'still to be ruled out,' code the condition as if it existed or was established."

Section IV of the Coding Guidelines states that for each outpatient and physician service, the provider should "[c]ode all documented conditions that coexist at the time of the encounter/visit, and require or affect patient care treatment or management." The Coding Guidelines also state that conditions should not be coded if they "… were previously treated and no longer exist. However, history codes … may be used as secondary codes if the historical condition or family history has an impact on current care or influences treatment." Additionally, in outpatient and physician settings, uncertain diagnoses, including those that are "probable," "suspected," "questionable," or "working," should not be coded.

The 2007 Participant Guide, section 7.1.4, and the 2006 Participant Guide, section 8.1.3, require that documentation support the diagnoses that MA organizations submit for use in CMS's risk score calculations. The documentation must include an acceptable physician signature and specialty credentials. The 2007 Participant Guide, section 7.2.4.5, and the 2006 Participant Guide, section 8.2.4.4, state: "[A]ll dates of service that are identified for review must be signed (with credentials) and dated by the physician or an appropriate physician extender (e.g., nurse practitioner.)" Examples of acceptable physician signatures include handwritten signatures or initials, signature stamps that comply with State regulations, and electronic signatures with authentications by the respective providers. Typed names; signatures of nonphysicians or nonphysician extenders (e.g., medical students); and signatures without credentials are unacceptable for risk adjustment purposes.

UNSUPPORTED HIERARCHICAL CONDITION CATEGORIES

To calculate beneficiary risk scores and risk-adjusted payments to MA organizations, CMS must first convert diagnoses to HCCs. During our audit period, Bravo submitted to CMS at least one diagnosis associated with each HCC that CMS used to calculate each sampled beneficiary's risk score for CY 2007. The risk scores for 65 sampled beneficiaries were invalid because the diagnoses that Bravo submitted to CMS (1) were not supported, (2) were missing signatures or credentials, or (3) had no documentation. Some diagnoses were invalid for more than one reason. These diagnoses had a total of 127 errors associated with 118 HCCs. Appendix C shows the errors associated with these HCCs.

Unsupported Diagnosis Coding

The documentation that Bravo submitted to us for medical review did not support the diagnoses associated with 112 HCCs. For 11 of the 112 HCCs, our medical reviewer determined other diagnoses to be more appropriate. In these instances, the documentation supported HCCs that were different from those that CMS used in determining the beneficiaries' risk scores. The following are examples of HCCs that were not supported by Bravo's documentation.

- For one beneficiary, Bravo submitted the diagnosis code for "other acute and subacute forms of ischemic heart disease, other." CMS used the HCC associated with this diagnosis in calculating the beneficiary's risk score. However, the documentation that Bravo provided noted only a consultation for blurry vision. The documentation did not mention an evaluation, clinical finding, or treatment related to the diagnosis code submitted.

- For another beneficiary, Bravo submitted the diagnosis code for "mucopurulent chronic bronchitis." CMS used the HCC associated with this diagnosis in calculating the beneficiary's risk score. However, the documentation that Bravo provided supported the diagnosis code for "acute bronchitis [viral]," which does not have an associated HCC.

Missing Signatures and Credentials

Fourteen HCCs were unsupported because the documentation that Bravo provided did not include the physicians' signatures and/or credentials, or attestations by the physicians.

For example, for one beneficiary, Bravo submitted the diagnosis code for "hypertensive heart disease, unspecified with heart failure." CMS used the HCC associated with this diagnosis in calculating the beneficiary's risk score. However, the documentation that Bravo submitted was not signed by the provider, and Bravo was unable to obtain a signature attestation from the provider after the fact.

No Documentation Provided

One HCC was unsupported because Bravo did not provide any documentation. Bravo submitted the diagnosis code for "chronic obstructive pulmonary disease." CMS used the HCC associated

with this diagnosis in calculating the beneficiary's risk score. However, Bravo officials advised us that they could not obtain any medical records to support the HCC.

CAUSE OF OVERPAYMENTS

During our audit period, Bravo officials stated that they had policies and procedures in place to validate risk adjustment data. However, Bravo officials also said that they did not review the diagnosis codes received from providers before submitting the codes to CMS. Bravo officials stated that, instead, Bravo conducted annual chart reviews to ensure that diagnoses codes were correct.

As demonstrated by the significant error rate found in our sample, Bravo's practices were not effective for ensuring that the diagnoses submitted to CMS complied with the requirements of the 2007 and 2006 Participant Guides. Bravo officials stated that after the audit period, Bravo increased its provider outreach efforts and initiated a Personal Health Profile to obtain provider information to supplement the diagnosis codes.

ESTIMATED OVERPAYMENTS

As a result of the unsupported diagnoses in our sample, Bravo received $422,409 in overpayments from CMS. On the basis of our sample results, we estimated that Bravo was overpaid approximately $22,108,905 in CY 2007. However, although an analysis to determine the potential impact of error rates inherent in FFS data on MA payments was beyond the scope of our audit, we acknowledge that CMS is studying this issue and its potential impact on audits of MA organizations.[7]

Therefore, because of the potential impact of these error rates on the CMS model that we used to recalculate MA payments for the beneficiaries in our sample, we (1) modified one recommendation, to refund only the overpayments identified for the sampled beneficiaries rather than refund the estimated overpayments, and (2) added a recommendation that Bravo work with CMS to determine the correct contract-level adjustments for the estimated overpayments.

RECOMMENDATIONS

We recommend the following:

- Bravo should refund to the Federal Government $422,409 in overpayments identified for the sampled beneficiaries.

- Bravo should work with CMS to determine the correct contract-level adjustment for the projected $22,108,905[8] of overpayments.

[7] 75 Fed. Reg. 19749 (April 15, 2010).

[8] This amount represents our point estimate. The confidence interval for this estimate has a lower limit of $17.4 million and an upper limit of $26.9 million. See Appendix B.

- Bravo should modify its policies and procedures and improve its current practices to ensure compliance with Federal requirements.

BRAVO COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

In written comments on our draft report, Bravo said that our sample approach and limited review were flawed; cited a disconnect between our audit and CMS's guidance and requirements; and suggested we evaluate our audit process, existing and proposed CMS guidance, and Bravo's responses, including additional documentation, prior to issuing a final report. Bravo also stated that we did not account for error rates inherent in Medicare FFS data, specifically the disparity between FFS claim data and FFS medical records data and its potential impact on MA payments. In addition, Bravo described actions it has taken since the 2006 audit period and stated that it would continue to evaluate its policies and procedures for improvements consistent with CMS requirements. Bravo's comments on our draft are included as Appendix D. We excluded the attachments to the comments because they contained personally identifiable information.

Although an analysis to determine the potential impact on MA payments of error rates inherent in FFS data was beyond the scope of our audit, we acknowledge that CMS is studying this issue and its potential impact on audits of MA organizations.[9] Therefore, because of the potential impact of these error rates on the CMS model that we used to recalculate MA payments for the beneficiaries in our sample, we (1) modified one recommendation to have Bravo refund only the overpayments identified for the sampled beneficiaries rather than refund the estimated overpayments and (2) added a recommendation that Bravo work with CMS to determine the correct contract-level adjustments for the estimated overpayments. We also accepted physician attestations in accordance with Federal regulations issued after our review.

We evaluated the additional information and documentation that Bravo provided after the second medical review and in response to the draft report. As applicable, we submitted the additional information and documentation for 14 HCCs to our medical review contractor for a third review. To the extent our medical review contractor found support in this additional documentation, we revised our findings accordingly.

Physician Signatures and Credentials

Bravo Comments

Bravo stated that we provided inconsistent guidance regarding physician signatures and did not follow CMS's audit methodology allowing physician signature attestations. Bravo noted that, as a result, we identified 46 HCCs that were invalid, in whole or in part, because they did not have physician signatures and credentials.

Office of Inspector General Response

The audit team advised Bravo on January 12, 2009, that it understood that the audit would not focus on technical issues such as missing signatures. However, while on site at Bravo on

[9] 75 Fed. Reg. 19749 (April 15, 2010).

January 15, 2009, the audit team updated Bravo and advised the Bravo representatives that it would be reviewing for signatures. Therefore, Bravo officials were aware of the signature guidance prior to providing the first medical records on February 2, 2009.

We did not initially accept physician attestations because the 2007 Participant Guide, section 7.2.4.5, and the 2006 Participant Guide, section 8.2.4.4, stated that documentation supporting the diagnosis must include an acceptable physician signature. However, after a 2010 change in Federal regulations (42 CFR § 422.311), we requested attestations. Bravo provided 32 physician signature attestations. We accepted them and revised our findings accordingly.

One Best Medical Record

Bravo Comments

Bravo stated that, although we ultimately did review the entire medical record, we inconsistently considered the one best medical record. Bravo stated that we validated some HCCs and, upon review, determined the HCC was not valid. (Bravo also stated that, in some cases, the opposite result occurred.) Bravo cited one example for which it believed the HCC was validated and the validation was subsequently reversed.

Office of Inspector General Response

The 2007 Participant Guide, sections 7.2.3 and 7.2.3.1, and the 2006 Participant Guide, sections 8.2.3 and 8.2.3.1, required the plan to select "one best medical record" to support each beneficiary HCC identified for risk adjustment validation. Although we requested one best medical record for review, Bravo submitted additional records for the beneficiaries. Our independent medical reviewer indicated that it reviewed entire records submitted for these beneficiaries.

The CMS model incorporates disease hierarchies. These hierarchies are used to provide payments only for the most severe manifestation of a disease, even when diagnoses for less severe manifestations of a disease are also present during the data collection year. Accordingly, for beneficiaries with multiple HCCs within a disease hierarchy, we submitted for first medical review a medical record to support the highest HCC. Initially, we did not submit the records to support lower HCCs in the hierarchy. If the medical reviewer validated the highest HCC, we accepted the HCC with no error. If the medical reviewer did not validate the HCC, we considered the HCC an error and submitted the next-highest HCC for that beneficiary. We submitted a further HCC for review only if the medical review did not validate the first or second HCC. We considered incorrect those HCCs that were specifically submitted to the medical reviewer and invalidated in that review.

For the beneficiary in Bravo's example, Bravo provided additional documentation after the second round of medical review had closed. We reflected that the HCC was not validated in the draft report. Subsequently, we contracted for a third round of medical review and submitted the new documentation. The new documentation validated the HCC, and it is no longer an error.

Disregard of Other Hierarchical Condition Categories

Bravo Comments

Bravo stated that, although we gave credit in the financial calculation for higher or lower HCCs in the same hierarchy, we did not reflect the higher or lower HCCs in the number of unsupported HCCs, thereby overstating the number of unsupported HCCs. Bravo also stated that we did not consider additional HCCs that were identified incidentally, by the medical reviewer or Bravo, during the audit.

Office of Inspector General Response

Our audit was designed to determine whether beneficiary medical records supported the diagnoses that Bravo had submitted to CMS. For each beneficiary, we submitted for review the single highest HCC. If the medical reviewer determined that the medical record did not support that HCC, we counted one error and submitted a second diagnosis code for review. We counted as errors only the HCCs determined to be incorrect by the medical reviewer. Diagnoses that were not reviewed were not considered errors, and each beneficiary was counted only once. Our review was limited to determining whether diagnoses that Bravo submitted to CMS complied with Federal requirements. Diagnoses that Bravo did not submit to CMS were outside the scope of our audit.

Communication Issues

Bravo Comments

Bravo questioned whether the audit team possessed adequate professional competence and expressed concern that because we would not identify or allow access to the medical review contractor, Bravo could not determine whether there was any conflict of interest. Bravo stated that it did not have access to the reviewers' specific comments and was denied the opportunity to resolve any differences in the reviewers' conclusions. Additionally, Bravo commented that much of the communication with the audit team was verbal and that the lack of written communication was inefficient and ineffective.

Bravo stated that it was disadvantaged by the timelag between the dates of service in 2006 for which we requested audit documentation and the notice of the audit (December 2008), which made it difficult to collect documentation from providers. For certain cases in which Bravo's own independent reviewer determined that the submitted documentation did not support the diagnosis, Bravo obtained diagnoses attestations from physicians when available. However, Bravo requested that we reconsider the finding for an HCC for which it was unable to obtain additional documentation because the physician had retired. Finally, Bravo noted that the audited contract covered a medically underserved area, and that physician resources may not allow for robust recordkeeping systems in those areas.

Office of Inspector General Response

The audit team collectively possessed the competence to perform the audit and understood the payment methodology. The Participant Guide states that diagnoses included in risk adjustment data must be based on clinical medical record documentation. Therefore, contacting the contractor would not be appropriate or necessary to support a medical record that properly documented the diagnosis. Audit methodologies often require the audit team to interview officials to elicit information.

The Participant Guide limits the types of acceptable documentation. Although changes in the Federal regulations allow signature attestations, diagnosis attestations are not acceptable forms of documentation. Regarding the HCC for which Bravo had no documentation, we followed the 2007 Participant Guide, which requires proper medical record documentation for accurate payment and successful data validation. In the absence of such documentation, we were unable to validate the HCC. Therefore, the HCC remains in error.

Although Bravo stated it was disadvantaged because of the timelag between the service dates and the audit start notice, CMS requires MA organizations to comply with certain terms. Specifically, Federal regulations require that MA organizations maintain ultimate responsibility for adhering to and otherwise fully complying with all terms and conditions of the contract with CMS, including the requirement to provide appropriate documentation upon request. Additionally, the regulations require that MA organizations agree to require that all contractors or subcontractors also agree to the Government's right to audit pertinent information for the contract period. The audit right exists through 10 years from the final date of the contract period (42 CFR § 422.504(h)(2)(i)).

Random Sample and Extrapolation

Bravo Comments

Bravo stated that our sample of 100 beneficiaries was insufficient to draw meaningful conclusions and did not fully represent the 5,234 members during the audit period. Bravo also stated that extrapolation was inappropriate given the sample, the FFS error rate, and the lack of precedent in the MA program.

Office of Inspector General Response

Our sample size of 100 beneficiaries provided a fair and unbiased representation of the 5,234 members in our sampling frame.

CMS, in its Final Rule "Medicare Program; Policy and Technical Changes to the Medicare Advantage and the Medicare Prescription Drug Benefit Programs," stated that there may be merit in further refining the calculation of payment errors that result from postpayment validation efforts.[10] Given the impact this error rate could have on the CMS model that we used to recalculate MA payments, we modified our first recommendation to seek a refund only for the

[10] 75 Fed. Reg. 19749 (April 15, 2010).

overpayments identified for the sampled beneficiaries. We made an additional recommendation that Bravo work with CMS to determine the correct contract-level adjustments for the estimated overpayments.

Limitations on the Risk Adjustment Payment and Validations

Bravo Comments

Bravo stated that OIG's audit findings unfairly hold Bravo responsible for inherent limitations in CMS's risk adjustment payment methodology because the payment methodology does not account for the errors in the underlying FFS claim data. Bravo also commented on the limitations of the risk adjustment data validation (RADV) process because the acceptable medical record sources are restrictive, and the one best medical record requirement limits the accuracy of HCCs. Bravo said that additional records from prior or subsequent years are often needed to verify accuracy.

Office of Inspector General Response

An analysis to determine the potential impact of error rates inherent in Medicare FFS data on MA payments was outside the scope of this audit. However, as noted, CMS stated in its April 15, 2010, Final Rule that there may be merit in further refining the calculation of payment errors, and given this potential impact, we modified our first recommendation and added a second.

Regarding the limits in CMS's audit methodology, the objective of our review was to determine whether diagnoses that Bravo submitted to CMS for use in CMS's risk score calculations complied with Federal requirements. Although we did not perform a RADV audit pursuant to the audit guidelines that CMS established in its 2007 and 2006 Participant Guides, we designed our review to be no more restrictive than CMS's methodology, which limits the documentation to the one best medical record, from only certain provider types, and for the relevant data collection period. As described in our methodology, if the HCC was in error after the first round of medical review, we requested that Bravo provide us with medical records in addition to the previous "one best medical record," which we provided to the contractor for a second review.

Responses to Individual Findings

Bravo Comments

In its response to our draft report, Bravo indicated that it disagreed with 24 of the invalidated HCCs. In subsequent communication, Bravo revised the number and stated that it disagreed with 93 of the errors we found that invalidated HCCs. Bravo provided additional documentation in its comments and in response to followup discussions with us.

Office of Inspector General Response

After we had completed our medical reviews, and in response to the draft report, Bravo provided additional information for 14 HCCs for which our contractor had not found adequate support. We accepted and evaluated the information and, where Bravo provided either (1) new documentation that it had not previously provided or (2) a new explanation as to why the documentation validated the selected HCC, we submitted the additional documentation to our contractor for a third review. For this medical review, our contractor followed the same protocol used in the earlier reviews. Our contractor found support in this additional documentation that validated four of the HCCs.

Because Federal regulations regarding signature attestations changed in 2010, we also requested signature attestations as needed. Bravo provided 32 signature attestations. We revised our findings as applicable.

OTHER MATTERS

In preparing our response to Bravo's comments on our draft report, we reviewed the information that Bravo provided to us during the audit. We discovered that some of the medical records that Bravo submitted to us during our fieldwork had been altered and resubmitted. For example, Bravo submitted a document on January 28, 2009, and subsequently resubmitted the document on September 17, 2009, with a medical annotation that did not appear on the original.

After we brought these discrepancies to Bravo's attention, Bravo conducted an internal review and identified another medical record that contained a "similar discrepancy." Bravo explained that the record, as originally provided to us, contained a medical annotation, but the annotation was not on the record that the provider furnished to Bravo. Bravo requested that the record be retracted and no longer used to support the HCC that had previously been validated. We did not use this or any of the altered documents that we had identified in determining whether HCCs were supported.

On July 26, 2013, OIG entered into a settlement agreement with Bravo and imposed a civil monetary penalty of $225,000 related to Bravo's submission of the falsified documents.

APPENDIXES

APPENDIX A: SAMPLE DESIGN AND METHODOLOGY

SAMPLING FRAME

The sampling frame consisted of 5,234 beneficiaries on whose behalf the Centers for Medicare & Medicaid Services paid Bravo Health Pennsylvania, Inc. (Bravo), approximately $72 million in calendar year (CY) 2007. These beneficiaries (1) were continuously enrolled under contract H3949 during all of CY 2006 and January of CY 2007 and (2) had a CY 2007 risk score that was based on at least one Hierarchical Condition Category.

SAMPLE UNIT

The sample unit was a beneficiary.

SAMPLE DESIGN

We used a simple random sample.

SAMPLE SIZE

We selected a sample of 100 beneficiaries.

SOURCE OF THE RANDOM NUMBERS

We used Office of Inspector General, Office of Audit Services, statistical software to generate the random numbers.

METHOD OF SELECTING SAMPLE ITEMS

We consecutively numbered the sample units in the sampling frame from 1 to 5,234. After generating 100 random numbers, we selected the corresponding frame items.

ESTIMATION METHODOLOGY

We used Office of Inspector General, Office of Audit Services, statistical software to estimate the total value of overpayments.

APPENDIX B: SAMPLE RESULTS AND ESTIMATES

Sample Results

Sampling Frame Size	Sample Size	Value of Sample	Number of Beneficiaries With Incorrect Payments	Value of Net Overpayments
5,234	100	$1,565,843	65	$422,409

Estimated Value of Overpayments

(Limits Calculated for a 90-Percent Confidence Interval)

Point estimate	$22,108,905
Lower limit	17,353,813
Upper limit	26,863,996

APPENDIX C: DOCUMENTATION ERRORS IN SAMPLE

A	Unsupported diagnosis coding
B	Missing signature and/or credentials
C	No documentation provided

	Hierarchical Condition Category	A	B	C	Total Errors
1	Vascular Disease	X			1
2	Chronic Obstructive Pulmonary Disease	X			1
3	Congestive Heart Failure	X			1
4	Chronic Obstructive Pulmonary Disease			X	1
5	Vascular Disease		X		1
6	Congestive Heart Failure	X			1
7	Specified Heart Arrhythmias	X			1
8	Diabetes Without Complication	X			1
9	Intestinal Obstruction/Perforation	X			1
10	Vascular Disease	X			1
11	Lymphatic, Head and Neck, Brain, and Other Major Cancers	X			1
12	Diabetes Without Complication	X			1
13	Diabetes With Renal or Peripheral Circulatory Manifestation	X			1
14	Diabetes With Ophthalmologic or Unspecified Manifestation	X			1
15	Rheumatoid Arthritis and Inflammatory Connective Disease Tissue	X			1
16	Specified Heart Arrhythmias	X			1
17	Diabetes Without Complication	X			1
18	Lung, Upper Digestive Tract, and Other Severe Cancers	X	X		2
19	Ischemic or Unspecified Stroke	X	X		2
20	Decubitus Ulcer of Skin	X	X		2
21	Vascular Disease	X			1
22	Breast, Prostate, Colorectal, and Other Cancers and Tumors	X			1
23	Spinal Cord Disorders/Injuries	X			1
24	Vascular Disease With Complications	X			1
25	Diabetes With Renal or Peripheral Circulatory Manifestation	X			1
26	Unstable Angina and Other Acute Ischemic Heart Disease	X			1
27	Renal Failure	X			1
28	Diabetes Without Complication	X			1
29	Vascular Disease	X			1
30	Congestive Heart Failure	X			1
31	Renal Failure	X			1
32	Polyneuropathy	X			1
33	Congestive Heart Failure	X			1
34	Unstable Angina and Other Acute Ischemic Heart Disease	X			1
35	Diabetes Without Complication	X			1
36	Ischemic or Unspecified Stroke	X			1

	Hierarchical Condition Category	A	B	C	Total Errors
37	Chronic Obstructive Pulmonary Disease	X			1
38	Chronic Ulcer of Skin, Except Decubitus	X			1
39	Breast, Prostate, Colorectal, and Other Cancers and Tumors	X			1
40	Breast, Prostate, Colorectal, and Other Cancers and Tumors	X			1
41	Unstable Angina and Other Acute Ischemic Heart Disease	X	X		2
42	Chronic Obstructive Pulmonary Disease	X			1
43	Rheumatoid Arthritis and Inflammatory Connective Disease Tissue	X			1
44	Congestive Heart Failure	X			1
45	Unstable Angina and Other Acute Ischemic Heart Disease	X			1
46	Unstable Angina and Other Acute Ischemic Heart Disease	X	X		2
47	Ischemic or Unspecified Stroke	X			1
48	Vascular Disease With Complications	X			1
49	Vascular Disease	X	X		2
50	Lung, Upper Digestive Tract, and Other Severe Cancers	X			1
51	Pancreatic Disease	X			1
52	Major Depressive, Bipolar, and Paranoid Disorders	X			1
53	Intestinal Obstruction/Perforation	X			1
54	Congestive Heart Failure	X			1
55	Unstable Angina and Other Acute Ischemic Heart Disease	X			1
56	Vascular Disease With Complications	X			1
57	Breast, Prostate, Colorectal, and Other Cancers and Tumors	X			1
58	Diabetes Without Complication	X			1
59	Vascular Disease	X			1
60	Chronic Obstructive Pulmonary Disease	X			1
61	Diabetes Without Complication	X			1
62	Congestive Heart Failure		X		1
63	Vascular Disease		X		1
64	Congestive Heart Failure	X			1
65	Unstable Angina and Other Acute Ischemic Heart Disease	X			1
66	Bone/Joint/Muscle Infections/Necrosis	X			1
67	Angina Pectoris/Old Myocardial Infarction	X			1
68	Vascular Disease With Complications	X			1
69	Chronic Obstructive Pulmonary Disease	X			1
70	Coma, Brain Compression/Anoxic Damage	X			1
71	Renal Failure	X			1
72	Angina Pectoris/Old Myocardial Infarction	X			1
73	Diabetes With Neurologic or Other Specified Manifestation		X		1
74	Diabetes With Ophthalmologic or Unspecified Manifestation		X		1
75	Lung, Upper Digestive Tract, and Other Severe Cancers	X			1
76	Breast, Prostate, Colorectal, and Other Cancers and Tumors	X			1
77	Major Complications of Medical Care and Trauma	X			1
78	Hemiplegia/Hemiparesis	X			1

	Hierarchical Condition Category	A	B	C	Total Errors
79	Vascular Disease	X			1
80	Vascular Disease	X	X		2
81	Major Complications of Medical Care and Trauma	X			1
82	Major Depressive, Bipolar, and Paranoid Disorders	X			1
83	Seizure Disorders and Convulsions	X	X		2
84	Ischemic or Unspecified Stroke	X			1
85	Angina Pectoris/Old Myocardial Infarction	X			1
86	Chronic Obstructive Pulmonary Disease	X			1
87	Diabetes Without Complication	X			1
88	Ischemic or Unspecified Stroke	X			1
89	Vascular Disease With Complications	X			1
90	Congestive Heart Failure	X			1
91	Unstable Angina and Other Acute Ischemic Heart Disease	X			1
92	Specified Heart Arrhythmias	X			1
93	Ischemic or Unspecified Stroke	X			1
94	Chronic Obstructive Pulmonary Disease	X			1
95	Congestive Heart Failure	X			1
96	Cerebral Hemorrhage	X			1
97	Ischemic or Unspecified Stroke	X			1
98	Vascular Disease	X			1
99	Chronic Obstructive Pulmonary Disease	X			1
100	Diabetes With Neurologic or Other Specified Manifestation	X			1
101	Congestive Heart Failure	X			1
102	Angina Pectoris/Old Myocardial Infarction	X			1
103	Renal Failure	X			1
104	Diabetes With Ophthalmologic or Unspecified Manifestation	X			1
105	Diabetes With Neurologic or Other Specified Manifestation	X			1
106	Intestinal Obstruction/Perforation	X			1
107	Vascular Disease With Complications	X			1
108	Lymphatic, Head and Neck, Brain, and Other Major Cancers	X			1
109	Breast, Prostate, Colorectal, and Other Cancers and Tumors	X			1
110	Chronic Obstructive Pulmonary Disease	X			1
111	Cardiorespiratory Failure and Shock	X			1
112	Ischemic or Unspecified Stroke	X			1
113	Vascular Disease	X			1
114	Polyneuropathy	X			1
115	Specified Heart Arrhythmias	X			1
116	Vascular Disease	X			1
117	Lung, Upper Digestive Tract, and Other Severe Cancers	X			1
118	Schizophrenia	X	X		2
	Total	**112**	**14**	**1**	**127**

APPENDIX D: BRAVO COMMENTS

August 30, 2010

Stephen Virbitsky
Regional Inspector General
for Audit Services
Department of Health & Human Services
Office of Inspector General
Office of Audit Services, Region III
Public Ledger Building, Suite 316
150 S. Independence Mall West
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Re: Draft Report Number: A-03-09-00003
Risk Adjustment Data Validation of Payments Made to Bravo Health Pennsylvania, Inc., for Calendar Year 2007 (Contract Number H3949)

Dear Mr. Virbitsky:

Bravo Health, Inc. is in receipt of the above-referenced Office of Inspector General ("OIG") draft audit report (the "Draft Report") related to the risk adjustment data validation of calendar year 2007 payments to Bravo Health Pennsylvania, Inc. (Bravo Health, Inc. and Bravo Health Pennsylvania, Inc. are collectively referred to herein as "Bravo Health"). We appreciate the extension of time given to us by the OIG to respond to the Draft Report's preliminary findings and recommendations.

Per the Draft Report, the OIG Office of Audit Services provides auditing services for the Department of Health and Human Services ("HHS") and that "[t]hese assessments help reduce waste, abuse, and mismanagement and promote economy and efficiency throughout HHS." However, we do not believe that these goals are furthered by this audit. For example, the flaws in the approach used to identify a sample of Bravo Health members for audit as well as the limited review performed for the audit have resulted in a Draft Report that contains numerous findings with which Bravo Health disagrees and recommendations that are unwarranted and inequitable. Moreover, the apparent "disconnect" between the OIG audit and the Centers for Medicare and Medicaid Services ("CMS") program guidance and requirements related to risk adjustment data validation ("RADV") raises questions as to the purpose of this audit. Bravo Health believes that, before issuing a final audit report or recommendations to CMS, the OIG needs to fully evaluate (1) the process that was followed for this audit; (2) applicable CMS guidance and requirements as well as proposals under consideration by CMS

regarding RADV; and (3) Bravo Health's response including supporting documentation.

Set forth below is Bravo Health's detailed response with reference to supporting exhibits.

I. Observations on the Audit Process and Methodology

A. Inconsistency in Approach and Stated Objectives

1. Missing Signatures and/or Credentials

During the entrance conference between Bravo Health and OIG representatives, the OIG auditors stated that they were not conducting a CMS-type RADV audit. Rather, their objective was to review records to determine if there was clinical support within the medical records for the audited hierarchical condition categories ("HCCs"). OIG representatives indicated that the OIG was not concerned with technical issues such as signatures and credentials. Bravo Health confirmed its understanding regarding signatures and credentials on medical records with the OIG in an email dated January 12, 2009. See Exhibit 1. Thus, it was Bravo Health's understanding that a medical record that provided clinical support for the audited HCC would not be rejected solely because the physician's signature and/or credentials were missing or illegible. Despite Bravo Health's understanding, the OIG rejected medical records provided by Bravo Health that had missing or illegible physician signatures and/or credentials. In addition, the OIG would not accept physician signature attestations to support missing or illegible signatures and/or credentials. See OIG email dated July 10, 2009 attached hereto as Exhibit 2. See also Bravo Health's June 30, 2009 letter to the OIG attached hereto as Exhibit 3. Nevertheless, Bravo Health obtained physician signature attestations to support missing or illegible signatures or credentials subsequent to the conclusion of the audit.

As a result of the reversal of the OIG's initially stated position, the Draft Report includes findings that 46 HCCs were unsupported due to missing or illegible signatures and/or credentials. It is important to note that the Draft Report found that 23 of the 46 HCCs had appropriate clinical support in the medical record and that the sole reason for invalidating these 23 HCCs was that the physician's signature or credentials were missing or illegible.

Bravo Health objects to the OIG's refusal to accept physician signature attestations to support missing or illegible signatures or credentials on medical records. OIG's refusal is not only unfair given its prior representations to Bravo Health, but more importantly it is contrary to CMS RADV procedures. The OIG should not pick and choose which CMS RADV requirements it will follow. CMS has developed a physician signature attestation form, which it allows Medicare Advantage Organizations to use under such circumstances. In fact, CMS has

formalized through rulemaking the use of physician signature attestations to support missing or illegible signatures or credentials on medical records. *See* 42 C.F.R. § 422.311(c) (2010).

Included with this response as Exhibit 4 are 20 physician signature attestations that Bravo Health has obtained subsequent to the conclusion of the audit.[1] The text of these attestations is the same as the CMS-required form. There are nine other physician signature attestations that Bravo Health has been unable to obtain due to a physician retirement's or relocating out of the area, after the services were rendered in 2006. Therefore, Bravo Health has obtained attestations for all but nine of the 29 HCCs that Bravo Health believes are fully supported HCCs but are only missing signatures and/or credentials. Bravo Health requests that the OIG revise its findings, consistent with CMS requirements and the OIG's prior representations, to find that the HCCs for which Bravo Health has provided physician signature attestations are validated.

2. Inconsistent Consideration of the One Best Medical Record

The Draft Report provides at page i that the OIG's "objective was to determine whether the diagnoses that Bravo Health submitted to CMS for use in CMS's risk score calculations complied with the requirements of the [2007 Risk Adjustment Data Training for Medicare Advantage Organizations] Participant Guide." Per the Participant Guide at § 7.1.4, Medicare Advantage Organizations "must select 'one best medical record' to support each beneficiary HCC identified for validation." Similarly, the Draft Report provides at page 2,

> Consistent with CMS's risk adjustment data validation process, we did not request all medical records associated with a beneficiary. Instead, we limited our request to the portion of the sampled beneficiary's medical record associated with an encounter that, in Bravo's judgment, best supported the HCC(s) that CMS used to calculate the risk score. We refer to that portion of the medical record as "documentation."

Although the OIG ultimately did review the entire medical record submitted by Bravo Health,[2] the OIG's conclusions regarding the medical record documentation were inconsistent. In some cases, the OIG would determine that an HCC was validated but, upon subsequent review of the same documentation, determine that the HCC was not validated. See # 78 in Section IV.B below. In other cases, the opposite result occurred.

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[1] Exhibits 4 and 6 are being provided via an encrypted disc. (password will be provided separately)
[2] The OIG initially sought to limit its review to a specific item, line or paragraph that it required Bravo Health to identify within the medical record. See March 6, 2009 email attached hereto as Exhibit 5.

3. Disregard of Other HCCs

Although the OIG gave Bravo Health credit in the financial calculation for a higher or lower HCC if it was in the same hierarchy as the audited HCC, the OIG did not reflect the higher or lower HCC in the number of unsupported HCCs reported in the Draft Report thereby overstating the number of unsupported HCCs. In addition, the Draft Report ignores situations where the medical record did not support the audited HCC but did support another HCC. Bravo Health validated one alternate HCC in this manner. Finally, Bravo Health identified two medical records that were provided to the OIG that supported the audited HCC and contained three additional HCCs. The OIG did not identify nor give Bravo Health credit for these additional HCCs. See Section IV.B of this response.

B. Communication and Substantive Challenges

The OIG has performed numerous audits of various aspects of the program operations of Medicare Advantage Organizations. However, it is Bravo Health's understanding that the OIG has not previously audited risk adjustment payments under the CMS-HCC methodology until now. To assist in the audit, the OIG engaged a medical review contractor ("MRC") to perform the actual medical record reviews. Given that risk adjustment payments are a new and complex area of audit for the OIG, it was Bravo Health's expectation that the OIG audit process would include knowledgeable staff and open and frequent interaction between the audit participants. As discussed below, this was not case.

1. Lack of Knowledgeable OIG Staff and Denial of Access to the MRC Reviewers

While cordial and professional, the OIG audit staff did not appear to be familiar with the Medicare Advantage program including the basic fact that Medicare Advantage Organizations are paid on a capitated prospective payment basis rather than fee-for-service. Bravo Health staff was put in the awkward position of having to explain the basics of the program to the audit staff, which took time away from the substance of the audit. It is Bravo Health's understanding that generally accepted government auditing standards, which the Draft Report indicates were followed in performing the audit, require that the audit staff possess adequate professional competence for the tasks required. *See* Government Auditing Standards at § 3.40. The audit staff should also posses a general knowledge of the environment in which the audited entity operates and the subject matter under review. *Id.* at § 3.43.

As noted above, the OIG engaged an MRC to review the medical record documentation provided by Bravo Health. While engaging a contractor in connection with an audit may not be an unusual practice for a government agency, the "secrecy" surrounding the MRC was unusual based on Bravo Health's

experience with other government audits. Specifically, the OIG would not provide Bravo Health with the name of the MRC or the credentials of the MRC's reviewers and, most significantly, the OIG would not allow Bravo Health to have any discussions with the reviewers. Since Bravo Health did not know who the MRC was, Bravo Health could not evaluate whether the OIG's engagement of the MRC for the Bravo Health audit created any real or potential conflict of interest. Furthermore, interaction between Bravo Health and MRC staff would have facilitated the audit process particularly given the fact that medical record chart review is oftentimes a subjective process. Such interaction could have also compensated for the lack of experience of the OIG audit staff. Government Auditing Standards provide that "[i]n all matters relating to the audit work, the audit organization and the individual auditor, whether government or public, must be free from personal, external, and organizational impairments to independence, and must avoid the appearance of such impairments of independence." Government Auditing Standards at § 3.02.

Without direct interaction with the reviewers or even access to the reviewers' specific findings regarding the documentation provided by Bravo Health,[3] Bravo Health was denied the opportunity to try to resolve any differences in the conclusions drawn by the reviewers regarding the supporting documentation provided by Bravo Health. In fact, for 24 of the invalidated HCCs, Bravo Health believes that the medical record documentation it submitted complies with CMS requirements and supports the reported HCC. A final resolution with respect to these 24 HCCs could have been achieved before the Draft Report was issued had discussions between Bravo Health and the MRC reviewers been allowed.

2. Adverse Impact Due to Time Gap

Bravo Health was disadvantaged by the timing of the audit in relation to the audit period. Specifically, the significant time span between the audit period (dates of service in 2006) and the receipt of notice of the audit (December 2008), adversely affected Bravo Health's ability to locate some provider medical records for the sampled members. While Bravo Health does require participating providers to retain records for inspection in accordance with CMS requirements, Bravo Health ultimately does not have any control over whether a provider will have the needed medical records when they are requested. The record retention problem is further complicated by a physician's death, retirement or relocation. In this audit, no supporting medical record was available for one HCC due to the treating physician's retirement. See #5 in Section IV.B. The invalidated HCC associated with this retired physician should be removed from the Draft Report's findings.

For purposes of the OIG audit, Bravo Health engaged a third party vendor to assist Bravo Health in obtaining the needed records from physicians. For cases

[3] Please refer to Bravo Health's June 30, 2009 letter to the OIG at Exhibit 3 in which Bravo Health expressed concerns regarding the OIG's delay in providing the MRC reviewers' explanations.

where the medical record documentation provided by the physician did not support the diagnosis, Bravo Health obtained an attestation from the treating physician whereby the physician certified that he or she did see and treat the member on the date of service and treat the diagnosis submitted on the specific claim.

The physician diagnosis attestations were completed by the physicians who billed for the services that generated the HCC. In requesting the attestation, Bravo Health sent the physician the actual claim as well as any medical records that Bravo Health had for the relevant date of service. By signing the attestation, the physician acknowledged that the "medical record entries or diagnosis(es) submitted on the claim for the [enrollee] accurately, truthfully and completely reflect[ed] the medical condition(s), severity, complications and related medical treatments for this patient during the periods noted and fully support[ed] the diagnoses" included on the attestation. A physician's willingness to sign this knowing that it would be used in connection with the OIG audit of Bravo Health cannot be discounted. Bravo Health submitted 33 diagnosis attestations from the treating physicians before it received the Draft Report and has obtained 6 additional attestations since then. See Exhibit 6 for the six additional diagnosis attestations.[4]

3. Lack of Written Instruction by OIG

Other than the initial notice of audit, the OIG rarely communicated with Bravo Health in writing. Communication by the OIG was almost always verbal, which forced Bravo Health staff to send written follow-up communications to the OIG to confirm Bravo Health's understanding. The lack of written instruction and communication by the OIG was inefficient and ineffective.

4. Characteristics of H3949

Adding to the challenge posed by this audit was the fact that the contract selected by the OIG to audit, H3949, includes a Dual Eligible Special Needs Plan serving an economically disadvantaged inner city area. In fact, 31% of the audited members were dual eligible enrollees (i.e., individuals with both Medicare and Medicaid) and a total of 93% of the audited enrollees resided in Philadelphia County. Bravo Health's experience with physicians in medically underserved areas is that physician resources are limited to treating patients and may not allow for the time or other resources to devote to robust medical recordkeeping systems. Bravo Health's physician network for H3949 in 2006 was comprised of sole practitioners, small practices and practices acquired by hospitals. Very few of Bravo Health's primary care physicians in 2006 used electronic medical record maintenance systems.

[4] Exhibits 4 and 6 are being provided via an encrypted disc.

II. Sampling and Extrapolation Methodologies

A. Sampling

According to the Draft Report, the OIG selected a random sample of 100 members. This sample was taken from a universe of 5,234 members who (1) were continuously enrolled under contract H3949 during all of calendar year 2006 and January of calendar year 2007 and (2) had a calendar year 2007 risk score that was based on at least one HCC.

Bravo Health disagrees with both the size of the audited sample as well as the approach used by the OIG to select the 100 members as neither resulted in a random nor representative sample of Bravo Health's members during the audit period.[5] Furthermore, a sample of 100 records is insufficient statistically to draw meaningful conclusions, as the resulting confidence interval is too wide. The audit sample used by the OIG represents less than two percent of Bravo Health's total membership for the audit period.[6] The extrapolation of the audit findings to the total contract payments was based solely on the risk scores of the 100 continuously enrolled beneficiaries selected for the audit. This small sample's 1.0 bid is considerably greater (11%) than the population that is being extrapolated upon. Therefore, the extrapolation is overstating the change in revenue which would result from the error rate calculated in the sample.

The Medicare Program Integrity Manual ("MPIM") identifies other factors that should be considered in considering sample size. The factors include: (1) the underlying variation in the target population, (2) the particular sampling method that is employed (such as simple random, stratified, or cluster sampling), and the particular form of the estimator that is used. MPIM Ch. 3, § 3.10.2.[7] While there is precedent for extrapolation under other government programs, Bravo Health is not aware of any precedent for extrapolation under the Medicare Advantage program to arrive at contract-level payment adjustments.

B. Extrapolation

Historically, CMS and OIG audits of Medicare Advantage Organizations (and predecessor Medicare managed care contractors) have resulted in recommended repayments for the specific errors identified in the audit and have not been extrapolated to request repayment on a contract-level basis. The Draft Report, however, contains recommendations that Bravo Health repay not only the $481,834 based on the Draft Report's preliminary finding that 139 of the 304 audited HCCs

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[5] CMS RADV audits use a sample size of 200 members.

[6] *See Daytona Beach General Hospital v. Weinberger*, 435 F. Supp. 891 (M.D. Fla. 1977) (finding based on 10% of total cases upon which recoupment was made denied plaintiff due process.

[7] Audit methods should be valid and reliable in order to satisfy due process. *See Webb v. Shalala*, 49 F.Supp.2d 1114 (D.D.C. 1999).

were unsupported, but recommends repayment of $20,212,876 based on the extrapolation of that finding on a contract-level basis.

Bravo Health believes that the extrapolation methodology used by the OIG is both unfair and inappropriate for several reasons. One reason is, as noted in Section II.A. above, the audited sample upon which the extrapolation is based was neither random nor representative of Bravo Health's membership. Extrapolated findings based on a flawed sample are fundamentally unfair. Second, extrapolated payment adjustments should be used, if ever, for Medicare Advantage Organizations that have particularly high rates of unsupported diagnoses compared to unsupported Medicare fee-for-service ("FFS") diagnoses upon which CMS-HCC risk score data are based. In this regard, the diagnosis data used by CMS to develop the risk scores for the HCC payment methodology are from Medicare FFS claims. It is Bravo Health's understanding that Bravo Health's error rate is comparable to the error rate in Medicare FFS data. Medicare Advantage Organizations cannot be expected to have a lower error rate than Medicare FFS since the same physicians submit claims under both programs.[8] Third, precedent under the Medicare program for use of extrapolation is where there is a sustained or high level of payment error.[9] Neither a sustained nor high level of payment error is present here. Fourth, the extrapolation of the audit findings to the total contract was based solely on the risk scores of the 100 continuously enrolled beneficiaries selected for the audit. This small sample's 1.0 bid was considerably greater (11%) than the population which is being extrapolated upon. Therefore, the extrapolation is overstating the change in revenue that would result from the error rate calculated in the sample. Finally, it is unfair and inappropriate to seek contract-level extrapolated payment adjustments in the first year that payments to Medicare Advantage Organizations payments were 100% risk-adjusted. If extrapolation is to be used, it should be phased-in as were risk adjusted payments to Medicare Advantage Organizations.

III. Inherent Limitations of the Risk Adjustment Payment Methodology and RADV Process

In addition to the issues and concerns Bravo Health has regarding the audit as discussed above, Bravo Health believes that the OIG's findings unfairly hold Bravo Health responsible for inherent limitations in the risk adjustment payment methodology and RADV process. Specifically, the risk adjustment payment methodology and audit system must accurately capture the operational aspects and assumptions that make up CMS payments to Medicare Advantage Organizations including, but not limited to, FFS data errors and provider coding and documentation flaws. Otherwise, Medicare Advantage Organizations will be unfairly and inappropriately penalized for errors that are outside of their control.

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[8] Please see Section III.A for a discussion of the FFS adjustment factor.

[9] HCFA Ruling No. HCFAR-86-1 (Feb. 20, 1986). *See also* MPIM Ch. 3, 3.10.1.2.

A. Incorporation of FFS Adjustment Factor

For Medicare Advantage Organizations, the RADV process mandates a rule set regarding physician documentation that was not anticipated in the ICD–9-CM coding guidelines and differs from standard practice, as it is not enforced on Medicare FFS claims. The RADV process as well as the OIG's audit process assume that the underlying FFS claims data for the HCC risk scores are 100% accurate. As noted above, FFS claims data have a significant error rate. The result is *de facto* Medicare Advantage payment adjustments based on coding and documentation discrepancies without an adjustment to Medicare FFS risk scores for the same discrepancies. Thus, risk adjustment audits "double penalize" Medicare Advantage Organizations.

Bravo Health believes that before Medicare Advantage Organizations should be subjected to refund requests related to their risk-adjusted payments, the error rates inherent in the Medicare FFS data that affect Medicare Advantage error rates must be accounted for. It is Bravo Health's understanding that CMS is developing a FFS adjustment factor to account for the error in the FFS data that underlies the Medicare Advantage risk score data. *See* 72 Fed. Reg. 19678, 19749 (April 15, 2010). OIG should incorporate the results of CMS' analysis into its risk adjustment audit findings.

B. Overdependence on Physician Diagnosis Coding and Documentation

While incorporating an adjustment factor to account for the error rate in Medicare FFS claims data will help to facilitate more accurate risk adjustment audit findings, the FFS adjustment factor will not alone improve the accuracy of risk adjustment payments in reflecting members' health status or of RADV audits. Bravo Health respectfully suggests that CMS' limitations on the sources of acceptable medical records that a Medicare Advantage Organization may submit for risk adjustment purposes are restrictive and overlook other valid sources that would support a diagnosis and validate an HCC or are valid predictors of members' future health care costs. CMS' currently limited sources of acceptable documentation conflict with CMS' goals in selecting the CMS-HCC model, i.e., "to select a clinically sound risk adjustment model that improved payment accuracy while minimizing the administrative burden on MA organizations." Id. at § 1.3 (emphasis added).

In the common interest of CMS and OIG to ensure accurate HCCs are assigned to Medicare beneficiaries, acceptable documentation to verify diagnosis coding should not be unduly restricted. This is particularly true given that the CMS-HCC model is dependent upon the accurate and complete diagnosis coding and documentation practices of physicians. In this regard, CMS' own guidance provides that

> [The CMS-HCC] module emphasizes physician documentation and reporting of diagnosis codes. Historically, physician reimbursement in fee-for-service is primarily based on procedures or services rather than diagnoses, and physicians are very familiar with documentation guidelines for procedures and services. Physicians generally are not as familiar with diagnosis codes and their associated documentation guidelines as they are with procedure coding rules. The [CMS-HCC] models depend upon accurate diagnosis coding, which means that physicians must fully understand and comply with documentation and coding guidelines for reporting diagnoses. *Id.* at § 6.1 (emphasis added).

While Bravo Health trains and educates physicians on proper coding and documentation, the fact remains that it is the physicians who control the underlying medical documentation. While medical record reviews and audits by Bravo Health help to identify coding errors and deficiencies in documentation, it is unrealistic and impractical for CMS or the OIG to expect Medicare Advantage Organizations to review 100% of medical records. Bravo Health Pennsylvania alone currently processes approximately two million claims per year.

Allowing alternative sources of information to confirm that a member has a particular condition and to validate an HCC addresses the over-reliance on physician coding and documentation practices for RADV purposes. HCCs identify chronic health care conditions that generally are not curable, such as diabetes, congenital heart disease, chronic kidney disease and peripheral vascular disease. These chronic conditions are always present for affected patients, but will not necessarily be diagnosed or even noted on every medical record. Despite this, the RADV process precludes submission of anything but a single medical record, even when the balance of the member's medical record or other records would validate the HCC. CMS' own guidance recognizes the usefulness of "alternative data sources," such as diagnostic data and pharmacy records, in validating diagnoses. *See* Participant Guide at § 3.2.4. To this end, CMS could accept alternative data sources for risk adjustment purposes, as well.

CMS' requirements regarding acceptable records have changed over time. These changing requirements make it difficult for Medicare Advantage Organizations to develop and implement policies and procedures as well as provider training. One example of changing CMS requirements is diagnostic radiology. Diagnostic radiology was an acceptable physician specialty for dates of service occurring in 2003 through 2005. However, CMS eliminated diagnostic radiology as an appropriate risk adjustment physician specialty beginning with 2006 dates of services. Nine of the HCCs that the Draft Report found were not supported are supported by radiology reports prepared by physicians.

C. The Limitations of the One Best Medical Record Requirement

The one best medical record requirement for risk adjustment data validation limits the breadth and accuracy of the HCCs for Medicare beneficiaries. Multiple records are often needed to verify the accuracy of the HCCs. Furthermore, there may not be a single medical record that verifies every HCC. For example, the records of several specialists may be needed to validate the HCC, such as a diagnosis of diabetes with heart complications. Moreover, as CMS has acknowledged, pharmacy records and prescription drug data can verify many conditions such as congestive heart failure and other chronic conditions. *See* Participant Guide at § 3.2.4. Hospital records may also shed light on a member's condition whenever the medical record itself is not sufficiently clear.

The one best medical record approach is flawed because it leads to false negatives. Medicare members who have valid HCCs may not need to see a physician during the data collection period, while others may only see a physician during the data collection period for something that is not specifically related to the HCC diagnosis. Under the one best medical record requirement, there would be no acceptable medical record support for these members' HCCs.

The purpose of medical documentation is to document the patient's condition and treatment as necessary for clinical purposes. Under standard documentation practices, there is no requirement that a patient's underlying diagnosis be "re-documented" in every record every year. In fact, in the case of chronic conditions, the diagnosis will often not be noted each and every year following the initial diagnosis. Whether such chronic conditions are recorded depends on the care sought and the treatment rendered during the relevant encounter. The failure to re-document an underlying medical condition does not mean that the condition has "gone away." However, under CMS requirements, Medicare Advantage Organizations are precluded from submitting a record from a prior or subsequent year containing the relevant diagnosis to substantiate the HCC, or a sworn statement from the physician that the member had the relevant condition during the data collection period. This is an unreasonable and unwarranted limitation. Furthermore, this limitation is contrary to the goal of determining whether the individual actually had the condition identified by the HCC and ensuring that payments to Medicare Advantage Organizations accurately reflect their members' health status.

IV. Responses to Draft Report's Specific Findings and Recommendations

The Draft Report contains preliminary findings that the risk scores for 72 of the 100 sampled beneficiaries were invalid because the diagnoses were not supported by medical records. These unsupported diagnoses were associated with 139 unsupported HCCs. According to the Draft Report, the documentation errors associated with these 139 HCCs were unsupported diagnosis coding, missing or

illegible signatures and/or credentials, and, for one HCC, no documentation was provided. The alleged overpayments for the 139 unsupported HCCs were $481,834. According to the Draft Report, "[b]ased on the unsupported diagnoses identified in our sample, we estimated that Bravo was overpaid at least $20,212,876 in [calendar year] 2007." Draft Report at p. 7.

Based on the foregoing, the Draft Report recommends that Bravo Health:

- refund to the Federal Government $20,212,876 in overpayments, and
- modify its policies and procedures and improve its current practices to ensure compliance with the requirements of the Participant Guide.

Bravo Health disputes the Draft Report's finding of 139 unsupported HCCs and that it was overpaid by $481,834. Bravo Health also disagrees with the recommendation that it refund $20,212,876 in alleged overpayments. Furthermore, Bravo Health has improved its policies and procedures and implemented new policies and procedures in an effort to improve physicians' coding and documentation practices and to help ensure that diagnoses reported to CMS have appropriate clinical support.

A. Bravo Health's Policies, Procedures and Programs

During the calendar year 2007 payment period, Bravo Health employed systematic and automated proprietary claim edits to verify that each claim included an ICD-9-CM code. Claims that did not have an ICD-9-CM code were rejected and returned to the provider for proper coding. Bravo Health did not aggressively pursue revenue optimization initiatives that focused on increasing the risk scores of its members. During the calendar year 2007 payment period, Bravo Health's internal compliance procedure relating to the quality of diagnoses submitted by providers was an annual audit of a sample of medical records. This audit was performed through Bravo Health's Quality Improvement Department. To the extent the internal audit found errors, providers received education on how to improve their documentation. This procedure is still performed today.

Since the period covered by the audit, Bravo Health has implemented the following:

- Provider Relations Staff: Since 2006, Bravo Health has added individuals to its Provider Relations staff who have been trained to educate providers regarding required documentation in the medical record to support the diagnoses the providers submit on the claim form.
- Bravo Health Personal Health Profile: In the summer of 2009, Bravo Health launched a program to increase HCC coding compliance. Bravo

Health developed a Personal Health Profile form that primary care physicians are asked to complete annually to document Bravo Health members' conditions and treatment plans. See Exhibit 7.

- Clinical Coding Audits: Bravo Health has hired internal certified medical record coders who audit medical records in support of submitted diagnoses via claims and encounters.

The above initiatives will improve coding accuracy and documentation support for HCCs. Moreover, Bravo Health will continue to evaluate its policies and procedures for improvements consistent with CMS requirements and expectations. However, we wish to reassert that it is unrealistic and impractical for CMS or the OIG to expect Bravo Health to review 100% of medical records or to guarantee 100% HCC accuracy. Bravo Health providers are not coding Bravo Health member records differently than they are coding records for their FFS patients and therefore, an error rate consistent with FFS should be expected.

B. Bravo Health's Response to Alleged Unsupported HCCs

Set forth below is Bravo Health's response to each of the Draft Report's findings of an unsupported HCC. In a number of cases, Bravo Health's response includes information already provided to the OIG, but which was apparently either not considered or determined to be inadequate by the OIG's MRC. However, Bravo Health continues to believe that the documentation it provided supported the diagnosis and validated the HCC. In other cases, Bravo Health has provided a physician signature attestation in the CMS-required format to address unsupported HCCs due to missing or illegible signatures and/or credentials. As noted above, the OIG previously informed Bravo Health that it would not invalidate an HCC for a missing or illegible signature and/or credential. Finally, Bravo Health has included other physician or medical record documentation that supports the alleged unsupported HCCs.

		Draft Report Finding[10]			
	HCC	**A**	**B**	**C**	**Bravo Health Response**
1	Renal Failure		X		Documentation submitted for encounter dated 11/7/06 (progress note dated 11/15/06) supports HCC 131. However, there is no provider signature on the dictated progress note so Bravo Health obtained a signature attestation.
2	Vascular Disease	X			Documentation submitted was for a pathology report but there was no indication of HCC 105. Therefore Bravo Health submitted a diagnosis attestation to support HCC 105.
3	Chronic Obstructive Pulmonary Disease			X[11]	Documentation submitted did not support HCC 108, therefore Bravo Health obtained a diagnosis attestation.
4	Congestive Heart Failure	X			Documentation submitted did not support HCC 80. Bravo Health was unable to obtain a diagnosis attestation.
5	Chronic Obstructive Pulmonary Disease	X[12]			No documentation submitted to support HCC 108. Bravo Health was unable to obtain a chart/diagnosis attestation.
6	Vascular Disease		X		Documentation submitted for encounter dated 11/20/06 supports HCC 105. However, there is no provider signature on the dictated progress note. Bravo Health was unable to obtain signature attestation. Doctor is retired and is no longer practicing.

[10] Key: A = Unsupported diagnosis coding; B = Missing signature and/or credentials; C = No documentation provided.

[11] Per the spreadsheet provided to Bravo Health by the OIG, it is Bravo Health's understanding that the finding should be categorized as "A" and not "C".

[12] Per the spreadsheet provided to Bravo Health by the OIG, it is Bravo Health's understanding that the finding should be categorized as "C" and not "A".

		Draft Report Finding[10]			
	HCC	**A**	**B**	**C**	**Bravo Health Response**
7	Diabetes With Ophthalmologic or Unspecified Manifestation		X		Documentation submitted for encounter dated 4/17/06 supports HCC 18. However, there is no provider signature so Bravo Health obtained a signature attestation.
8	Congestive Heart Failure	X			Documentation submitted did not support HCC 80, therefore Bravo Health submitted a diagnosis attestation.
9	Specified Heart Arrhythmias	X			Documentation submitted for encounter dated 9/18/06 supports HCC 92. The documentation notes "SVT". The documentation has a signature but no credentials. Bravo Health was unable to obtain a signature attestation. The documentation is from an ER visit so Bravo Health was not able to locate a physician to sign the attestation.
10	Diabetes Without Complication	X			Documentation submitted for encounter dated 12/06/06 supports HCC 19. The documentation notes that the patient's past medical history is "significant for Diabetes Mellitus".
11	Intestinal Obstruction/Perforation	X			Documentation submitted for the encounter dated 11/22/06 supports HCC 31. The documentation notes "Bowel Obstruction".
12	Vascular Disease	X			Documentation submitted for the encounter dated 3/26/06-3/31/06 supports HCC 105. The documentation notes "Peripheral Vascular Disease" in the discharge summary.
13	Lymphatic, Head and Neck, Brain, and Other Major Cancers	X	X		Documentation submitted did not support HCC 9.

		Draft Report Finding[10]			
	HCC	**A**	**B**	**C**	**Bravo Health Response**
14	Diabetes Without Complication	X			Documentation submitted for the encounter dated 3/02/06 supports HCC 19. The documentation notes "DM" on the medical chart. This documentation contains a signature but no credentials so Bravo Health obtained a signature attestation.
15	Diabetes With Renal or Peripheral Circulatory Manifestation	X			Documentation submitted did not support HCC 15, therefore Bravo Health submitted a diagnosis attestation.
16	Diabetes With Ophthalmologic or Unspecified Manifestation	X			Documentation submitted for the encounter dated 3/21/06 supports HCC 18. The documentation notes "DM" and "glaucoma". This documentation does not contain a signature or credentials. Bravo Health was unable to obtain a signature attestation. OIG gave credit for HCC 19 in the payment calculation.
17	Rheumatoid Arthritis and Inflammatory Connective Disease Tissue	X			Documentation submitted did not support HCC 38, therefore Bravo Health submitted a diagnosis attestation.
18	Specified Heart Arrhythmias	X			Documentation submitted did not support HCC 92. Bravo Health was unable to obtain a diagnosis attestation.
19	Diabetes Without Complication	X			Documentation submitted did not support HCC 19. Bravo Health was unable to obtain a diagnosis attestation.
20	Lung, Upper Digestive Tract, and Other Severe Cancers	X	X		Documentation submitted did not support HCC 8. Bravo Health was unable to obtain a diagnosis attestation.

		Draft Report Finding[10]			
	HCC	**A**	**B**	**C**	**Bravo Health Response**
21	Ischemic or Unspecified Stroke	X	X		Documentation submitted for the encounter dated 4/2/06 is a radiology report that supports HCC 96. Bravo Health was unable to obtain a diagnosis attestation.
22	Decubitus Ulcer of Skin	X	X		Documentation submitted for the encounter dated 11/22/06 supports HCC 148. The documentation notes "Decubitus ulcer". This documentation contains a signature but no credentials. Bravo Health was unable to obtain a signature attestation. Bravo Health was unable to locate the doctor.
23	Vascular Disease	X			Documentation submitted for the encounter dated 1/30/06 is a radiology report that supports HCC 105.
24	Breast, Prostate, Colorectal, and Other Cancers and Tumors	X			Documentation submitted did not support HCC 10, therefore Bravo Health submitted a diagnosis attestation.
25	Spinal Cord Disorders/Injuries	X			Documentation submitted did not support HCC 69. Bravo Health was unable to obtain a diagnosis attestation.
26	Vascular Disease With Complications	X			Documentation submitted did not support HCC 104, but did support a lower HCC 105.
27	Diabetes With Renal or Peripheral Circulatory Manifestation	X			Documentation submitted did not support HCC 15. Bravo Health was able to obtain a diagnosis attestation.
28	Unstable Angina and Other Acute Ischemic Heart Disease	X			Documentation submitted did not support HCC 82 but did support a lower HCC 83.

		Draft Report Finding[10]			
	HCC	**A**	**B**	**C**	**Bravo Health Response**
29	Renal Failure	X			Documentation submitted did not support HCC 131, therefore Bravo Health submitted a diagnosis attestation.
30	Diabetes Without Complication	X			Documentation submitted for the encounters dated 9/26/06 and 10/11/06 support HCC 19 and higher payment HCC 18.
31	Vascular Disease	X			Documentation submitted did not support HCC 105, therefore Bravo Health submitted a diagnosis attestation.
32	Congestive Heart Failure	X			Documentation submitted did not support HCC 80.
33	Renal Failure	X			Documentation submitted for the encounter dated 10/16/06 supports HCC 131. The documentation notes "acute renal failure" and the diagnostic study has been interpreted by the attending physician as noted at the end of the report.
34	Rheumatoid Arthritis and Inflammatory Connective Disease Tissue		X		Documentation submitted for the encounter dated 8/31/06 supports HCC 38. Documentation contains a signature but no credentials. Bravo Health obtained a signature attestation.
35	Polyneuropathy	X			Documentation submitted did not support HCC 71. Bravo Health obtained a diagnosis attestation.

		Draft Report Finding[10]			
	HCC	**A**	**B**	**C**	**Bravo Health Response**
36	Congestive Heart Failure	X	X		Documentation submitted did not support HCC 80, therefore Bravo Health submitted a diagnosis attestation. Letter from the provider attached with the attestation form that justifies the diagnosis code assigned to HCC 80.
37	Unstable Angina and Other Acute Ischemic Heart Disease	X			Documentation submitted did not support HCC 82, therefore Bravo Health submitted a diagnosis attestation. Letter from the provider attached with the attestation form that justifies the diagnosis code assigned to HCC 82. However, there was documentation to support lower payment HCC 83. This documentation was an electronic medical record. OIG did not include HCC 83 in the payment calculation.
38	Chronic Obstructive Pulmonary Disease		X		Documentation submitted for the encounter dated 8/31/06 supports HCC 108. Documentation contains a signature but no credentials so Bravo Health obtained a signature attestation.
39	Diabetes Without Complication	X			Documentation submitted did not support HCC 19.
40	Ischemic or Unspecified Stroke	X			Documentation submitted did not support HCC 96.
41	Chronic Obstructive Pulmonary Disease	X			Documentation submitted did not support HCC 108.
42	Chronic Ulcer of Skin, Except Decubitus	X			Documentation submitted did not support HCC 149.

		Draft Report Finding[10]			
	HCC	**A**	**B**	**C**	**Bravo Health Response**
43	Breast, Prostate, Colorectal, and Other Cancers and Tumors	X			Documentation submitted did not support HCC 10. Bravo Health was unable to obtain a diagnosis attestation.
44	Breast, Prostate, Colorectal, and Other Cancers and Tumors	X			Documentation submitted did not support HCC 10, therefore Bravo Health submitted a diagnosis attestation.
45	Unstable Angina and Other Acute Ischemic Heart Disease	X	X		Documentation submitted did not support HCC 82. Bravo Health was unable to obtain a diagnosis attestation.
46	Chronic Obstructive Pulmonary Disease	X			Documentation submitted for the encounter dated 8/29/06 supports HCC 108. The documentation notes "COPD" on the medical record.
47	Rheumatoid Arthritis and Inflammatory Connective Disease Tissue	X	X		Documentation submitted did not support HCC 38, therefore Bravo Health submitted a diagnosis attestation.
48	Vascular Disease		X		Documentation submitted for the encounter dated 1/25/06 supports HCC 105. Documentation contains a signature but no credentials, so Bravo Health obtained a signature attestation.
49	Congestive Heart Failure	X			Documentation submitted did not support HCC 80, therefore Bravo Health submitted a diagnosis attestation. Physician letter submitted with diagnosis attestation on 6/11/09 also supports HCC 80.

		Draft Report Finding[10]			
	HCC	**A**	**B**	**C**	**Bravo Health Response**
50	Unstable Angina and Other Acute Ischemic Heart Disease	X			Documentation submitted did not support HCC 82, therefore Bravo Health submitted a diagnosis attestation. Physician letter submitted with diagnosis attestation on 6/11/09 also supports HCC 82.
51	Unstable Angina and Other Acute Ischemic Heart Disease	X	X		Documentation submitted for the encounter dated 1/15/06 supports HCC 82. The EKG report notes "inferior infarct, age undetermined" and the report has been confirmed by a MD as noted on the report.
52	Ischemic or Unspecified Stroke	X			Documentation submitted did not support HCC 96. Bravo Health was unable to obtain a diagnosis attestation.
53	Vascular Disease With Complications	X			Documentation submitted did not support HCC 104, therefore Bravo Health submitted a diagnosis attestation.
54	Vascular Disease	X	X		Documentation submitted for the encounter dated 3/15/06 is a radiology report that supports HCC 105.
55	Lung, Upper Digestive Tract, and Other Severe Cancers	X			Documentation submitted did not support HCC 8, therefore Bravo Health submitted a diagnosis attestation.
56	Pancreatic Disease	X			Documentation submitted did not support HCC 32, therefore Bravo Health submitted a diagnosis attestation.

		Draft Report Finding[10]			
	HCC	**A**	**B**	**C**	**Bravo Health Response**
57	Major Depressive, Bipolar, and Paranoid Disorders	X	X		Documentation submitted for encounter dated 2/17/06 supports HCC 55. The documentation notes "major depression" under the assessment section of the electronic medical record. Dr. Mercado's office considers his typed name on the electronic record as his signature for records with dates of service in 2006. Nevertheless, Bravo Health has a signature attestation on file.
58	Congestive Heart Failure		X		Documentation submitted for encounter dated 2/17/06 supports HCC 80. Dr. Mercado's office considers his typed name on the electronic record as his signature for records with dates of service in 2006. Nevertheless, Bravo Health has a signature attestation on file.
59	Intestinal Obstruction/Perforation	X	X		Documentation submitted did not support HCC 31. Bravo Health was unable to obtain a diagnosis attestation.
60	Congestive Heart Failure	X			Documentation submitted did not support HCC 80, therefore Bravo Health submitted a diagnosis attestation.
61	Unstable Angina and Other Acute Ischemic Heart Disease	X			Documentation submitted did not support HCC 82, therefore Bravo Health obtained a diagnosis attestation.
62	Vascular Disease With Complications	X			Documentation submitted did not support HCC 104. Bravo Health was unable to obtain a diagnosis attestation.

		Draft Report Finding[10]			
	HCC	**A**	**B**	**C**	**Bravo Health Response**
63	Breast, Prostate, Colorectal, and Other Cancers and Tumors	X			Documentation submitted for encounter dated 4/10/06 supports HCC 10. The documentation notes "breast cancer" under the diagnosis section of a preanesthesia evaluation form. Bravo Health also obtained an attestation for signature.
64	Angina Pectoris/Old Myocardial Infarction	X	X		Documentation submitted for the encounter dated 9/20/06 supports HCC 83. The documentation notes past medical history of "MI" two times within the chart.
65	Diabetes Without Complication	X			Documentation submitted did not support HCC 19, therefore Bravo Health submitted a diagnosis attestation.
66	Ischemic or Unspecified Stroke		X		Documentation submitted for encounter dated 5/31/06 supports HCC 96. Documentation contained a signature but no name or credentials so Bravo Health obtained a signature attestation.
67	Vascular Disease	X	X		Documentation submitted did not support HCC 105. Bravo Health was unable to obtain a diagnosis attestation.
68	Chronic Obstructive Pulmonary Disease	X			Documentation submitted for the encounter dated 4/30/06 is a radiology report that supports HCC 108. The documentation notes "COPD".
69	Diabetes Without Complication	X			Documentation submitted for the encounter dated 3/6/06 supports HCC 19. The documentation notes past medical history of "Diabetes with neuropathy".

		Draft Report Finding[10]			
	HCC	**A**	**B**	**C**	**Bravo Health Response**
70	Congestive Heart Failure		X		Documentation submitted for encounter dated 11/16/06 supports HCC 80. However, there is no provider signature on the progress note. Bravo Health was unable to obtain a signature attestation. Doctor has retired.
71	Vascular Disease		X		Documentation submitted for encounter dated 6/5/06 supports HCC 105. However, there is no provider signature on the progress note. Bravo Health was unable to obtain a signature attestation. Doctor has retired.
72	Congestive Heart Failure	X			Documentation submitted did not support HCC 80, therefore Bravo Health submitted a diagnosis attestation. Physician letter submitted with the diagnosis attestation on 6/11/09 also supports HCC 80.
73	Unstable Angina and Other Acute Ischemic Heart Disease	X			Documentation submitted did not support HCC 82, therefore Bravo Health obtained a diagnosis attestation.
74	Bone/Joint/Muscle Infections/Necrosis	X			Documentation submitted did not support HCC 37, therefore Bravo Health submitted a diagnosis attestation.
75	Angina Pectoris/Old Myocardial Infarction	X	X		Documentation submitted did not support HCC 83, therefore Bravo Health submitted a diagnosis attestation.
76	Vascular Disease With Complications	X			Documentation submitted did not support HCC 104, therefore Bravo Health submitted a diagnosis attestation.
77	Chronic Obstructive Pulmonary Disease	X			Documentation submitted did not support HCC 108.

		Draft Report Finding[10]			
	HCC	**A**	**B**	**C**	**Bravo Health Response**
78	Chronic Ulcer of Skin, Except Decubitus	X			Documentation submitted for the encounter dated 11/2/06 supports HCC 149. The documentation notes that the patient has "peripheral vascular disease and ulcer on the right heel". OIG accepted this HCC initially but later dismissed it.
79	Vascular Disease		X		Documentation submitted for encounters dated 7/13/06 and 12/5/06 support HCC 105. However, there is no provider signature on the progress note. Bravo Health obtained an attestation.
80	Coma, Brain Compression/Anoxic Damage	X			Documentation submitted for the encounter dated 11/22/06 is a radiology report that supports HCC 75. The documentation (CT scan) notes "multiple hemorrhagic lesions in the brain with significant vasogenic edema".
81	Chronic Obstructive Pulmonary Disease		X		Documentation submitted for encounter dated 6/30/06 supports HCC 108. This documentation contains a signature but no name and credentials, so Bravo Health obtained a signature attestation.
82	Renal Failure	X			Documentation submitted for encounter dated 7/28/06 supports HCC 131. The documentation notes "CRI" in the progress note. This documentation contains a signature but no name and credentials so Bravo Health obtained a signature attestation.

		Draft Report Finding[10]			
	HCC	**A**	**B**	**C**	**Bravo Health Response**
83	Angina Pectoris/Old Myocardial Infarction	X			Documentation submitted did not support HCC 83. Bravo Health was unable to obtain a diagnosis attestation. Claim is from a hospital hence not able to locate a physician to sign the attestation.
84	Diabetes With Neurologic or Other Specified Manifestation		X		Documentation submitted for encounter dated 9/26/06 supports HCC 16. This documentation contains a signature but no name and credentials. Bravo Health tried to obtain a signature attestation but the doctor retired.
85	Diabetes With Ophthalmologic or Unspecified Manifestation		X		Documentation submitted for encounter dated 9/26/06 supports HCC 18. This documentation contains a signature but no name and credentials. Bravo Health tried to obtain a signature attestation but the doctor retired.
86	Lung, Upper Digestive Tract, and Other Severe Cancers	X			Documentation submitted did not support HCC 8. Bravo Health was unable to obtain a diagnosis attestation.
87	Breast, Prostate, Colorectal, and Other Cancers and Tumors	X			Documentation submitted did not support HCC 10. Bravo Health was unable to obtain a diagnosis attestation.
88	Major Complications of Medical Care and Trauma	X			Documentation submitted for the encounter dated 6/22/06 did not support HCC 164. Bravo Health was unable to obtain a diagnosis attestation.

		Draft Report Finding[10]			
	HCC	**A**	**B**	**C**	**Bravo Health Response**
89	Seizure Disorders and Convulsions		X		Documentation submitted for the encounter dated 10/9/06 supports HCC 74. Documentation contains a signature but no name and credentials, so Bravo Health obtained a signature attestation.
90	Hemiplegia/Hemiparesis	X	X		Documentation submitted for the encounter dated 10/9/06 supports HCC 100. The documentation notes "right hemiparesis". This documentation contains a signature but no name and credentials and is also missing beneficiary name so Bravo Health obtained a signature attestation.
91	Vascular Disease	X	X		Documentation submitted for the encounter dated 6/4/06 supports HCC 105. The documentation notes "PVD". Documentation contains a signature but no name and credentials and is also missing beneficiary name so Bravo Health obtained signature and diagnosis attestations.
92	Vascular Disease	X	X		Documentation submitted did not support HCC 105. Bravo Health was unable to obtain a diagnosis attestation.
93	Major Complications of Medical Care and Trauma	X			Documentation submitted did not support HCC 164. Bravo Health was unable to obtain a diagnosis attestation.
94	Major Depressive, Bipolar, and Paranoid Disorders	X			Documentation submitted for the encounter dated 1/16/06 supports HCC 55. The documentation notes "major depression" within the medical update section of the record.

		Draft Report Finding[10]			
	HCC	**A**	**B**	**C**	**Bravo Health Response**
95	Seizure Disorders and Convulsions	X	X		Documentation submitted for the encounter dated 9/2/06 supports HCC 74. The documentation notes "seizures". However, there is no provider signature on the progress note. Bravo Health was unable to obtain an attestation. Doctor states that his partner is no longer working with him and the chart belongs to his partner.
96	Ischemic or Unspecified Stroke	X			Documentation submitted for the encounter dated 9/20/06 did not support HCC 96. Bravo Health was unable to obtain a diagnosis attestation. The physician is no longer working at the same office.
97	Angina Pectoris/Old Myocardial Infarction	X			Documentation submitted for the encounter dated 4/9/06 supports HCC 83. The documentation notes "unstable angina" in the admission note.
98	Chronic Obstructive Pulmonary Disease	X			Documentation submitted for the encounter dated 12/14/06 is a radiology report that supports HCC 108.
99	Renal Failure		X		Documentation submitted for the encounter dated 2/6/06 supports HCC 131. Documentation contains a signature but no name and credentials, so Bravo Health obtained a signature attestation.

		Draft Report Finding[10]			
	HCC	**A**	**B**	**C**	**Bravo Health Response**
100	Diabetes Without Complication	X			Documentation submitted for the encounter dated 10/9/06 supports HCC 19. The documentation notes 250.00 diagnosis code by a podiatrist who was performing diabetic foot care. This documentation contains a signature but no name and credentials so Bravo Health obtained a signature attestation.
101	Ischemic or Unspecified Stroke	X			Documentation submitted did not support HCC 96, therefore Bravo Health submitted a diagnosis attestation.
102	Vascular Disease With Complications	X			Documentation submitted for encounter dated 7/19/06 did not support HCC 104 but did support a lower HCC 105.
103	Congestive Heart Failure	X			Documentation submitted did not support HCC 80, therefore Bravo Health submitted a diagnosis attestation. Physician letter submitted with the diagnosis attestation on 6/11/09 also supports HCC 80.
104	Unstable Angina and Other Acute Ischemic Heart Disease	X			Documentation submitted did not support HCC 82, therefore Bravo Health obtained a diagnosis attestation.
105	Vascular Disease	X			Documentation submitted for the encounter dated 8/28/06 supports HCC 105. The documentation notes "Aortic Root and Valve are Sclerotic" that is assigned an ICD-9 code of 440.0 and HCC 105.

		Draft Report Finding[10]			
	HCC	**A**	**B**	**C**	**Bravo Health Response**
106	Specified Heart Arrhythmias	X	X		Documentation submitted did not support HCC 92. Bravo Health was unable to obtain a diagnosis attestation. Physician noted a billing error as the cause of incorrect diagnosis code on the claim.
107	Ischemic or Unspecified Stroke	X			Documentation submitted did not support HCC 96, therefore Bravo Health submitted a diagnosis attestation.
108	Chronic Obstructive Pulmonary Disease	X			Documentation submitted did not support HCC 108, therefore Bravo Health submitted a diagnosis attestation.
109	Diabetes With Renal or Peripheral Circulatory Manifestation	X	X		Documentation submitted for the encounter dated 9/27/06 supports HCC 15. The documentation notes "Diabetes Mellitus type 2 w/peripheral circulatory disease, uncontrolled-250.72 (primary)". Dr. Mercado's office considers his typed name on the electronic record as his signature for records with dates of service in 2006. Nevertheless, Bravo Health has a signature attestation on file.
110	Polyneuropathy		X		Documentation submitted for the encounter dated 6/12/06 supports HCC 71. Documentation contains a signature but no name and credentials, so Bravo Health obtained a signature attestation.

		Draft Report Finding[10]			
	HCC	**A**	**B**	**C**	**Bravo Health Response**
111	Vascular Disease	X	X		Documentation submitted for the encounter dated 10/27/06 supports HCC 105. The documentation notes "Diabetes Mellitus type 2 w/peripheral circulatory disease, uncontrolled-250.72 (primary)" and "peripheral vascular disease". Dr. Mercado's office considers his typed name on the electronic record as his signature for records with dates of service in 2006. Nevertheless, Bravo Health has a signature attestation on file.
112	Chronic Obstructive Pulmonary Disease		X		Documentation submitted for the encounter dated 12/18/06 supports HCC 108. The documentation notes "COPD (Chronic Obstructive Pulmonary Disease)-496 (Primary)". Dr. Mercado's office considers his typed name on the electronic record as his signature for records with dates of service in 2006. Nevertheless, Bravo Health has a signature attestation on file.
113	Diabetes Without Complication		X		Documentation submitted for the encounters dated 11/20/06 and 12/21/06 support HCC 19. However, there is no provider signature on the progress note, so Bravo Health obtained a signature attestation.
114	Congestive Heart Failure	X			Documentation submitted did not support HCC 80. Bravo Health was unable to obtain a diagnosis attestation.

		Draft Report Finding[10]			
	HCC	**A**	**B**	**C**	**Bravo Health Response**
115	Cerebral Hemorrhage	X			Documentation submitted for the encounter dated 9/27/06 supports HCC 95. The documentation notes "Stroke, hemorrhagic 431 (primary)". Dr. Mercado's office considers his typed name on the electronic record as his signature for records with dates of service in 2006. Nevertheless, Bravo Health has a signature attestation on file.
116	Ischemic or Unspecified Stroke	X			Documentation submitted for the encounter dated 11/29/06 supports HCC 96. The documentation notes "CVA (Cerebrovascular accident) Nos-436". Dr. Mercado's office considers his typed name on the electronic record as his signature for records with dates of service in 2006. Nevertheless, Bravo Health has a signature attestation on file.
117	Hemiplegia/Hemiparesis		X		Documentation submitted for the encounter dated 12/7/06 supports HCC 100. This documentation notes "Left hemiparesis" under the past medical history section and the note is signed by an MD.
118	Vascular Disease	X			Documentation submitted did not support HCC 105, therefore Bravo Health submitted a diagnosis attestation.
119	Chronic Obstructive Pulmonary Disease	X			Documentation submitted did not support HCC 108, therefore Bravo Health submitted a diagnosis attestation.

		Draft Report Finding[10]			
	HCC	**A**	**B**	**C**	**Bravo Health Response**
120	Diabetes With Neurologic or Other Specified Manifestation	X			Documentation submitted did not support HCC 16. Bravo Health was unable to obtain a diagnosis attestation.
121	Congestive Heart Failure	X			Documentation submitted did not support HCC 80. Bravo Health was unable to obtain a diagnosis attestation.
122	Angina Pectoris/Old Myocardial Infarction	X			Documentation submitted for the encounter dated 9/7/06 (signed 9/8/06) supports HCC 83. The documentation notes "atypical angina" under the diagnosis section of the medical chart. This documentation contains a signature but no name and credentials so Bravo Health obtained a signature attestation.
123	Diabetes With Ophthalmologic or Unspecified Manifestation		X		Documentation submitted did not support HCC 18, therefore Bravo Health submitted a diagnosis attestation.
124	Diabetes Without Complication		X		Documentation submitted for the encounter dated 9/1/06 supports HCC 19. This documentation contains a signature but no name and credentials, so Bravo Health obtained a signature attestation.
125	Diabetes With Neurologic or Other Specified Manifestation	X			Documentation submitted did not support HCC 16. Bravo Health was unable to obtain a diagnosis attestation.
126	Intestinal Obstruction/Perforation	X			Documentation submitted for the encounter dated 5/20/06 is a radiology report that supports HCC 31.
127	Vascular Disease With Complications	X			Documentation submitted did not support HCC 104 but did support a lower HCC 105.

		Draft Report Finding[10]			
	HCC	**A**	**B**	**C**	**Bravo Health Response**
128	Lymphatic, Head and Neck, Brain, and Other Major Cancers	X			Documentation submitted for the encounter dated 8/23/06 supports HCC 9. The documentation from 8/23/06 notes "large left sided cervical schwannoma". Additional documentation from 8/29/06 notes "triangle brachial plexus tumor" and from 11/8/06 notes "desmoid tumor in the neck that will require extensive radiation".
129	Breast, Prostate, Colorectal, and Other Cancers and Tumors	X			Documentation submitted for the encounter dated 8/23/06 supports HCC 10. Bravo Health also submitted a diagnosis attestation for this HCC. The same documentation that supports HCC 9 supports HCC 10 since they are in the same hierarchy.
130	Chronic Obstructive Pulmonary Disease	X	X		Documentation submitted did not support HCC 108, therefore Bravo Health submitted a diagnosis attestation.
131	Cardiorespiratory Failure and Shock	X			Documentation submitted for the encounter dated 1/20/06 is a radiology report that supports HCC 79.
132	Ischemic or Unspecified Stroke	X			Documentation submitted for the encounter dated 11/17/06 is a radiology report that supports HCC 96.
133	Vascular Disease		X		Documentation submitted for the encounter dated 10/25/06 supports HCC 105. This documentation contains a signature but no name and credentials so Bravo Health obtained a signature attestation.

		Draft Report Finding[10]			
	HCC	**A**	**B**	**C**	**Bravo Health Response**
134	Vascular Disease	X			Documentation submitted for the encounter dated 6/5/06 supports HCC 105. The documentation notes code "443.9" within the clinical patient profile. The diagnosis code has been noted by a MD.
135	Polyneuropathy	X			Documentation submitted did not support HCC 71, therefore Bravo Health submitted a diagnosis attestation.
136	Specified Heart Arrhythmias	X			Documentation submitted did not support HCC 92, therefore Bravo Health submitted a diagnosis attestation.
137	Vascular Disease	X			Documentation submitted did not support HCC 105, therefore Bravo Health submitted a diagnosis attestation.
138	Lung, Upper Digestive Tract, and Other Severe Cancers	X			Documentation submitted did not support the HCC.
139	Schizophrenia	X	X		Documentation submitted did not support HCC 54. Bravo Health was unable to obtain a diagnosis attestation as the doctor moved offices and unable to be located.

V. Conclusion

For the reasons set forth above, Bravo Health disagrees with the Draft Report's finding that 139 HCCs were unsupported and with the recommendation that Bravo Health should refund to the Federal Government $20,212,876 in alleged overpayments. With respect to the Draft Report's recommendation regarding Bravo Health's policies and procedures, Bravo Health has implemented several enhancements to the policies and procedures that were in effect during the calendar year 2007 payment period. In addition, Bravo Health will continue to evaluate its policies and procedures for appropriate improvements consistent with CMS requirements and expectations.

It is Bravo Health's expectation that, in accordance with government auditing standards, the OIG will thoroughly review this response so that any final report that is issued reflects due consideration of Bravo Health's response and is not simply an automatic finalization of the Draft Report.

Please contact Scott Tabakin at 410-864-4646 if you have any questions or require additional information.

Sincerely,

Scott M. Tabakin
EVP & Chief Financial Officer

Enclosures

List of Exhibits

Exhibit 1	Bravo Health email to OIG dated January 12, 2009
Exhibit 2	OIG email to Bravo Health dated July 10, 2009
Exhibit 3	Bravo Health letter to OIG dated June 30, 2009
Exhibit 4	Physician Signature Attestations*
Exhibit 5	Internal Bravo Health email dated March 6, 2009
Exhibit 6	Diagnosis Attestations*
Exhibit 7	Sample Bravo Health Personal Health Profile Form

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* Exhibits 4 and 6 are being provided via an encrypted disc.