

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**SOME DIAGNOSIS CODES THAT
ESSENCE HEALTHCARE, INC.,
SUBMITTED TO CMS
DID NOT COMPLY WITH
FEDERAL REQUIREMENTS**

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April 2019
A-07-17-01170

Office of Inspector General

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Report in Brief

Date: April 2019

Report No. A-07-17-01170

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



Why OIG Did This Review

Under the Medicare Advantage (MA) program, the Centers for Medicare & Medicaid Services (CMS) makes predetermined monthly payments to MA organizations according to a system of risk adjustment that depends on the health status of each enrollee. Accordingly, MA organizations are paid more for providing benefits to sicker enrollees than to healthier enrollees. To determine the health status of enrollees, CMS relies on MA organizations to collect diagnosis codes from their providers and submit these codes to CMS. Some diagnoses are at higher risk for being miscoded, which may result in overpayments from CMS.

For this audit, we reviewed one MA organization, Essence Healthcare, Inc. (Essence), and focused on two areas that included high-risk diagnosis codes. Our objective was to determine whether selected diagnosis codes that Essence submitted to CMS for use in CMS's risk adjustment program complied with Federal requirements.

How OIG Did This Review

We judgmentally selected 218 unique enrollee-years with high-risk diagnosis codes during calendar years 2012 through 2014. The 218 enrollee-years included 52 diagnoses of acute stroke and 166 diagnoses of major depressive disorder. We limited our review to the portions of the payments that were associated with these high-risk diagnosis codes, which totaled \$515,325.

Some Diagnosis Codes That Essence Healthcare, Inc., Submitted to CMS Did Not Comply With Federal Requirements

What OIG Found

Some of the diagnosis codes that Essence submitted to CMS for use in CMS's risk adjustment program did not comply with Federal requirements. For 75 of the 218 enrollee-years, the diagnosis codes (48 acute stroke and 27 major depressive disorder) that Essence submitted to CMS either were not supported in the medical records (70) or could not be supported because Essence could not locate the medical records (5).

These errors occurred because the policies and procedures that Essence had to detect and correct noncompliance with CMS's program requirements, as mandated by Federal regulations, were not always effective. As a result, Essence received \$158,904 of overpayments for the 75 enrollee-years.

What OIG Recommends and Auditee Comments

We recommend that Essence refund to the Federal Government the \$158,904 in overpayments; identify, for the diagnoses included in this report, similar instances of noncompliance that occurred during our audit period that we did not review and outside of our audit period and refund any resulting overpayments to the Federal Government; and enhance its policies and procedures to detect and correct noncompliance with Federal requirements for all diagnosis codes used to calculate risk-adjusted payments.

Essence concurred with our recommendations and described the actions that it had taken or planned to take to address them. Essence also stated that there is no requirement that a major depressive disorder diagnosis be submitted multiple times during the year to be supported.

We did not use the number of times that a diagnosis code was submitted as the basis to consider any enrollee-year to be in error. Rather, we classified enrollee-years with a major depressive disorder diagnosis on one or two claims as a means to identify high-risk diagnosis codes that *could* be miscoded. Ultimately, we relied on the results of Essence's internal coding review for our findings. Accordingly, Essence's comment did not cause us to make any revisions to our findings or recommendations.

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INTRODUCTION

WHY WE DID THIS REVIEW

Under the Medicare Advantage (MA) program, the Centers for Medicare & Medicaid Services (CMS) makes predetermined monthly payments to MA organizations based in part on the characteristics of the enrollees being covered. Using a system of risk adjustment, MA organizations are paid the anticipated cost of providing Medicare benefits to a given enrollee, depending on such risk factors as the age, gender, and health status of that individual. Accordingly, MA organizations are paid more for providing benefits to sicker enrollees relative to healthier enrollees. To determine the health status of enrollees, CMS relies on MA organizations to collect diagnosis codes¹ from their providers and submit these codes to CMS. We are auditing MA organizations because some diagnoses are at higher risk for being miscoded, which may result in overpayments from CMS.

This review is part of a series of audits in which we are reviewing the accuracy of diagnosis codes that MA organizations submitted to CMS. Using data mining techniques and discussions with medical professionals, we identified diagnoses that were at higher risk for being miscoded and consolidated those diagnoses into specific groups (for example, we consolidated 14 major depressive disorder diagnoses into 1 group). We reviewed one MA organization, Essence Healthcare, Inc. (Essence), and focused on two groups of high-risk diagnosis codes.

OBJECTIVE

Our objective was to determine whether selected diagnosis codes that Essence submitted to CMS for use in CMS's risk adjustment program complied with Federal requirements.

BACKGROUND

Medicare Advantage Program

The MA program² offers beneficiaries managed care options by allowing them to enroll in private healthcare plans rather than having their care covered through Medicare's traditional fee-for-service program. These beneficiaries are known as enrollees. To provide benefits to enrollees, CMS contracts with MA organizations, which in turn contract with providers (including hospitals) and physicians.

¹ The providers code diagnoses using the International Classification of Diseases (ICD), Clinical Modification, *Official Guidelines for Coding and Reporting* (ICD Coding Guidelines). The ICD is a coding system that was created in 1948 by the World Health Organization and is used by physicians and other healthcare providers to classify and code all diagnoses, symptoms, and procedures.

² The Balanced Budget Act of 1997, P.L. No. 105-33, as modified by section 201 of the Medicare Prescription Drug, Improvement, and Modernization Act, P.L. No. 108-173, established the MA program.

CMS makes payments to MA organizations according to its risk adjustment program. Federal requirements mandate that these payments be based on the anticipated cost of providing Medicare benefits to a given enrollee and, in doing so, also account for variations in the demographic characteristics and health status of each enrollee.³ For calendar year 2016, CMS paid MA organizations \$188 billion, which represented 33 percent of all Medicare payments for that year.

Risk Adjustment Program

CMS uses two principal components to calculate the risk-adjusted payment that it will make to an MA organization for an enrollee: a base rate that CMS sets using bid amounts received from the MA organization and the risk score for that enrollee.

- *Base rate:* Before the start of each year, each MA organization submits bids to CMS that reflect the MA organization's estimate of the monthly revenue required to cover an enrollee with an average risk profile.⁴ CMS compares each bid to a specific benchmark amount for each geographic area to determine the base rate that an MA organization is paid for each of its enrollees.⁵
- *Risk score:* A risk score is a relative measure that reflects the additional or reduced costs that each enrollee is expected to incur compared to an average enrollee. CMS calculates risk scores based on an enrollee's health status (discussed below) and demographic characteristics (such as the enrollee's age and gender). This process results in an individualized risk score for each enrollee, which CMS calculates on an annual basis.

To determine an enrollee's health status for purposes of calculating the risk score, CMS collects diagnoses that the enrollee receives from face-to-face encounters with a physician (in an office, inpatient, or outpatient setting). MA organizations collect the diagnosis codes that physicians document on the medical records and submit these codes to CMS. CMS then maps certain diagnosis codes, on the basis of similar clinical characteristics and severity and cost implications, into Hierarchical Condition Categories (HCCs). CMS assigns a factor (which is a numerical value) to each HCC for use in the risk score.

The risk adjustment program is prospective; CMS uses the diagnosis codes that the enrollee received during one calendar year (known as the service year) to determine HCCs and calculate risk scores for the next calendar year (known as the payment year).

³ Sections 1853(a)(1)(C) and (a)(3) of the Social Security Act (the Act); 42 CFR § 422.308(c).

⁴ The Act § 1854(a)(6); 42 CFR § 422.254 *et seq.*

⁵ CMS's bid-benchmark comparison also determines whether the MA organization must offer supplemental benefits or must charge a basic beneficiary premium for the benefits.

The risk score calculation is an additive process: as the HCC factors accumulate for an enrollee, the enrollee's risk score increases, and the monthly risk-adjusted payment to the MA organization also increases. In this way, the risk adjustment program compensates MA organizations for the additional risk for providing coverage to sicker enrollees.

CMS multiplies the risk scores by the base rates to calculate the predetermined, total monthly payment that an MA organization receives for each enrollee. Miscoded diagnoses may result in HCCs that are not validated and may lead to overpayments from CMS to MA organizations.

High-Risk Diagnoses

Using data mining techniques and discussions with medical professionals, we identified diagnoses that were at higher risk for being miscoded and consolidated those diagnoses into specific groups. For this report, we focused on two high-risk areas:

- *Acute stroke*: An enrollee received an acute stroke diagnosis (which maps to the HCC entitled Ischemic or Unspecified Stroke) on one or two physician claims during the service year but did not have that diagnosis on a corresponding inpatient hospital claim. A diagnosis of history of stroke (which indicates that the provider is evaluating or treating residual conditions left behind by a prior stroke and which does not map to an HCC) typically should have been used.
- *Major depressive disorder*: An enrollee received a major depressive disorder diagnosis (which maps to the HCC entitled Major Depressive, Bipolar, and Paranoid Disorders) on one or two claims during the service year, rather than on several claims, which would have reflected long-term treatment. It is possible that a diagnosis of a less severe form of depression (which does not map to an HCC) should have been used.

In this report, we refer to the diagnosis codes associated with these groups as "high-risk diagnosis codes."

Essence Healthcare, Inc.

Essence, an MA organization based in St. Louis, Missouri, had an enrollment of approximately 53,000 as of December 31, 2015. For the 2013 through 2015 payment years (audit period), CMS paid Essence (contract number H2610) \$1,330,526,860 to provide coverage to its enrollees.

HOW WE CONDUCTED THIS REVIEW

Our audit included enrollees on whose behalf providers documented high-risk diagnosis codes during the 2012 through 2014 service years. Because enrollees could have high-risk diagnosis codes documented in more than 1 year, we classified the enrollees according to the condition and the year, which we refer to as "enrollee-years." We identified 7,639 unique enrollee-years

from which we judgmentally selected 218 unique enrollee-years with payments totaling \$3,466,198.

The 218 enrollee-years included 52 diagnoses of acute stroke and 166 diagnoses of major depressive disorder. We limited our review to the portions of the payments that were associated with these high-risk diagnosis codes, which totaled \$515,325.

At our request, Essence reviewed each of the 218 enrollee-years to determine whether the medical records supported the diagnosis code that it submitted to CMS. In each case, Essence reviewed the medical record for the claim that contained the diagnosis code that it had originally submitted to CMS. In some instances, Essence also reviewed other medical records of face-to-face encounters for the applicable enrollee-year that it believed supported that diagnosis code. We refer to this as the Essence internal coding review.

We evaluated each of the steps that Essence took to perform its internal coding reviews and then relied on the results of those reviews for 211 of the 218 enrollee-years for this report. However, for Essence's internal coding reviews for seven of the enrollee-years, Essence interpreted the ICD Coding Guidelines differently than we did. For that reason, we used an independent medical review contractor to perform a coding review for these seven enrollee-years to determine whether the medical records supported the diagnosis codes.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Appendix A contains the details of our audit scope and methodology.

FINDINGS

Some of the diagnosis codes that Essence submitted to CMS for use in CMS's risk adjustment program did not comply with Federal requirements. For 143 of the 218 enrollee-years, the medical records supported the diagnosis codes that Essence submitted to CMS. For the 75 remaining enrollee-years, however, the diagnosis codes (48 acute stroke and 27 major depressive disorder) either were not supported in the medical records or could not be supported because Essence could not locate the medical records.

These errors occurred because the policies and procedures that Essence had to detect and correct noncompliance with CMS's program requirements, as mandated by Federal regulations, were not always effective. As a result, the HCCs for these high-risk diagnosis codes were not validated, and Essence received \$158,904 of overpayments for the 75 enrollee-years.

FEDERAL REQUIREMENTS

Payments to MA organizations are adjusted for risk factors, including the health status of each enrollee (the Act § 1853(a)). CMS applies a risk factor based on data obtained from the MA organizations (42 CFR § 422.308).

Federal regulations state that MA organizations must follow CMS's instructions and submit to CMS 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 (42 CFR § 422.310(b)). MA organizations must obtain risk adjustment data required by CMS from the provider, supplier, physician, or other practitioner that furnished the item or service (42 CFR § 422.310(d)(3)).

Federal regulations also state that MA organizations are responsible for the accuracy, completeness, and truthfulness of the data submitted to CMS for payment purposes and add that if any related entity, subcontractor, or contractor generates such data, that entity is similarly responsible (42 CFR § 422.504(l)). CMS has provided instructions to MA organizations regarding the submission of data for risk scoring purposes (*Medicare Managed Care Manual* (the Manual) (last rev. Sept. 19, 2014), chapter 7).

CMS requires all submitted diagnosis codes to be documented on the medical record and to be documented as a result of a face-to-face encounter (the Manual, chapter 7, section 40). The diagnosis must be coded according to the ICD Coding Guidelines. Further, the MA organizations must implement procedures to ensure that diagnoses come only from acceptable data sources, which include hospital inpatient facilities, hospital outpatient facilities, and physicians (the Manual, chapter 7, section 40).

Federal regulations state that MA organizations must monitor the data that they receive from providers and submit to CMS. Federal regulations also state that MA organizations must have administrative and management arrangements to "adopt and implement an effective compliance program, which must include measures that prevent, detect, and correct non-compliance with CMS' program requirements . . ." Further, MA organizations must establish and implement an effective system for routine monitoring and identification of compliance risks (42 CFR § 422.503(b)(4)(vi)).

SOME OF THE DIAGNOSIS CODES THAT ESSENCE SUBMITTED TO CMS FOR USE IN CMS'S RISK ADJUSTMENT PROGRAM DID NOT COMPLY WITH FEDERAL REQUIREMENTS

Some of the diagnosis codes that Essence submitted to CMS for use in CMS's risk adjustment program did not comply with Federal requirements. Of the 218 enrollee-years sampled, 75 were not supported. These errors included 48 of 52 acute stroke diagnosis codes and 27 of 166 major depressive disorder diagnosis codes.

Incorrectly Submitted Diagnosis Codes for Acute Stroke

Essence incorrectly submitted diagnosis codes for acute stroke for 48 of the 52 sampled enrollee-years. The medical records did not support these diagnosis codes.⁶ Specifically:

- For 46 of the enrollee-years, the physicians should have documented a history of stroke diagnosis code instead of an acute stroke diagnosis code.

In one example, the Essence internal coding review noted that no treatment plan was documented in the patient’s medical history and added that the acute stroke diagnosis code in the medical record was incorrect. In another example, the Essence internal coding review noted that the claim that Essence had originally submitted to CMS used the diagnosis code for “current stroke” (that is, acute stroke) when it should have used “history of stroke.”

A diagnosis for history of stroke does not map to an HCC; therefore, Essence should not have received an increased payment for acute stroke for these enrollee-years.

- For 1 of the enrollee-years, a physician—a non-inpatient provider—incorrectly documented a diagnosis code that had been ruled out. For this enrollee-year, Essence provided two medical records: one for the physician and one for the inpatient facility. According to the ICD Coding Guidelines, non-inpatient providers may not document diagnoses that have been ruled out.⁷ The acute stroke diagnosis was ruled out (and not included) on the inpatient facility record; therefore, the acute stroke diagnosis documented on the physician’s medical record was not supported and should not have been submitted to CMS.
- For 1 of the enrollee-years, Essence could not locate the medical record in which the diagnosis code of acute stroke originated. A representative from the physician’s office stated that the office staff was unable to locate any medical record reflecting services provided to this enrollee on the date of service requested. Because the original medical record could not be located and the diagnosis code could not be supported, Essence should not have received an increased payment for acute stroke for this enrollee.

⁶ Of the 48 enrollee-years, the Essence internal coding review determined that 45 enrollee-years were not supported in the medical records, and the independent medical review contractor determined that 3 enrollee-years were not supported. For the 4 remaining enrollee-years (of the 52 enrollee-years), the independent medical review contractor’s determinations agreed with those of the Essence internal coding review.

⁷ Section IV of the ICD Coding Guidelines states (for non-inpatient providers): “Coding guidelines for inconclusive diagnoses (probable, suspected, rule out, etc.) were developed for inpatient reporting [documenting] and do not apply to outpatients.”

As a result of these errors, the HCCs for Ischemic or Unspecified Stroke were not validated, and Essence received \$96,355 of overpayments for these 48 sampled enrollee-years.

Incorrectly Submitted Diagnosis Codes for Major Depressive Disorder

Essence incorrectly submitted diagnosis codes for major depressive disorder for 27 of the 166 sampled enrollee-years. The medical records did not support these diagnosis codes.⁸ Specifically:

- For 23 of the enrollee-years, the Essence internal coding review classified a major depressive disorder as unsupported when the medical records either lacked statements that the patients had a major depressive disorder or did not indicate any treatment plan for the major depressive disorder. Specifically, the Essence internal coding review noted that the physicians should have documented a diagnosis code for a less severe form of depression, instead of one for a major depressive disorder, on the medical record.

For 1 enrollee-year, the Essence internal coding review determined that the medical record supported a “[d]epressive disorder . . . which does not risk adjust.” For another enrollee-year, the Essence internal coding review noted that the medical record “used incorrect code; no treatment plan.”

A diagnosis for a less severe form of depression does not map to an HCC; therefore, Essence should not have received an increased payment for major depressive disorder for these enrollee-years.

- For 4 of the enrollee-years, Essence could not locate the medical records from which the diagnosis code for major depressive disorder originated. Specifically:
 - for 3 of the enrollee-years, the entity that processed behavioral health claims on behalf of Essence ceased doing business during 2014 and
 - for the remaining enrollee-year, Essence contacted the provider several times, but the medical record was never produced.

Because the original medical records could not be located, the diagnosis codes could not be supported. Therefore, Essence should not have received an increased payment for major depressive disorder for these enrollee-years.

As a result of these errors, the HCCs for Major Depressive, Bipolar, and Paranoid Disorders were not validated, and Essence received \$62,549 of overpayments for these 27 sampled enrollee-years.

⁸ The Essence internal coding review made this determination for all 27 of the enrollee-years in error.

THE POLICIES AND PROCEDURES THAT ESSENCE USED TO DETECT AND CORRECT NONCOMPLIANCE WITH FEDERAL REQUIREMENTS WERE NOT ALWAYS EFFECTIVE

These errors occurred because the policies and procedures that Essence had to detect and correct noncompliance with CMS's program requirements, as mandated by Federal regulations (42 CFR § 422.503(b)(4)(vi) (Appendix B)), were not always effective.

Essence had procedures to determine whether the diagnosis codes that it submitted to CMS to calculate risk-adjusted payments were correct. Essence selected specific providers and then compared the diagnosis codes that were on those providers' claims with the diagnosis codes that were documented on the associated medical records. If Essence detected compliance problems with any of these diagnosis codes, it then took steps to make corrections for these problematic diagnosis codes at providers that it had not initially selected. However, these procedures were limited and not always effective, because although Essence had a procedure based on its review and analysis of selected providers, it did not have a parallel procedure under which it would detect and correct problematic diagnosis codes on claims submitted by all providers. For this reason, Essence could not always determine whether other diagnosis codes were at risk for noncompliance.

Essence officials stated that Essence's analyses did not detect and correct the errors noted in this report because the associated diagnosis codes, according to Essence officials, "did not trend, were targeted for review or audit in a prior year, or the prevalence of the code was minimal." An example of the limitations in Essence's policies and procedures and in its analyses was reflected in the fact that Essence officials said that they were not aware that its providers were confused about the use of acute stroke and history of stroke diagnosis codes.

As a result, Essence received \$158,904 of overpayments for the 75 enrollee-years.

RECOMMENDATIONS

We recommend that Essence:

- refund to the Federal Government the \$158,904 in overpayments;
- identify, for the diagnoses included in this report, instances of noncompliance in the enrollee-years that occurred (1) during our audit period, but were not included in our judgmental sample, and (2) before and after our audit period, and refund any resulting overpayments to the Federal Government; and
- enhance its policies and procedures to detect and correct noncompliance with Federal requirements for all diagnosis codes used to calculate risk-adjusted payments.

AUDITEE COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

In written comments on our draft report, Essence concurred with our recommendations and described the steps that it had taken or planned to take to refund overpayments to the Federal Government. In addition, Essence said that it had already begun to enhance its policies and procedures, which would include targeting “high-risk diagnoses, with an emphasis on leveraging data analytics to help guide coding audits of these high-risk areas.”

Essence also noted that it had said to us “on several occasions that there is not a requirement for a [major depressive disorder] diagnosis to be submitted multiple times during the year in order to be supported. There is no link between the number of times a diagnosis code is submitted and illness severity.”

Essence’s comments appear in their entirety as Appendix C.

Although we appreciate Essence’s comment about major depressive disorder diagnoses, we did not use the number of times that a diagnosis code was submitted as the basis to consider any enrollee-year to be in error. Rather, we classified enrollee-years with a major depressive disorder diagnosis on one or two claims as a means to identify enrollee-years that *could* have been misdiagnosed. Ultimately, we relied on the results of Essence’s internal coding review for these findings. Accordingly, Essence’s comment did not cause us to make any revisions to our findings or recommendations.

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

CMS paid Essence \$1,330,526,860 to provide coverage to its enrollees from 2013 through 2015. Our audit included 7,639 unique enrollee-years on whose behalf providers documented high-risk diagnosis codes during the 2012 through 2014 service years, for which CMS paid Essence a total of \$110,314,120. Of these unique enrollee-years, we judgmentally selected 218 enrollee-years with payments totaling \$3,466,198.

The 218 enrollee-years included 52 acute stroke diagnoses and 166 major depressive disorder diagnoses. We limited our review to the portions of the payments that were associated with these high-risk diagnosis codes, which totaled \$515,325.

Our audit objective did not require an understanding or assessment of Essence's complete internal control structure, and we limited our review of internal controls to those directly related to our objective.

We performed audit work from May 2017 through August 2018.

METHODOLOGY

To accomplish our objective, we performed the following steps:

- We reviewed applicable Federal laws, regulations, and guidance.
- We discussed with CMS program officials the Federal requirements that MA organizations should follow when submitting diagnosis codes to CMS.
- We identified, through data mining and discussions with medical professionals at a Medicare administrative contractor, diagnosis codes and HCCs that were at risk for noncompliance. We also identified the diagnosis codes that potentially should have been used for cases in which the high-risk diagnoses were miscoded.
- We consolidated the high-risk diagnosis codes into specific groups, which included:
 - 3 diagnosis codes for acute stroke and
 - 14 diagnosis codes for major depressive disorder.
- We used CMS's systems to identify the enrollee-years on whose behalf providers documented the high-risk diagnosis codes. Specifically, we used extracts from CMS's:

- Risk Adjustment Processing System (RAPS)⁹ to identify enrollee-years that received high-risk diagnosis codes from a physician during the service years,
 - Risk Adjustment System (RAS)¹⁰ to identify enrollees who received an HCC for the high-risk diagnosis codes, and
 - Medicare Advantage Prescription Drug system (MARx)¹¹ to identify the total payments that CMS made to Essence for the payment years.
- We interviewed Essence officials to gain an understanding of (1) the policies and procedures that Essence followed to submit diagnosis codes to CMS for use in the risk adjustment program and (2) Essence’s monitoring of those diagnosis codes to identify and detect noncompliance with Federal requirements.
- We judgmentally selected 218 enrollee-years that had either:
 - an acute stroke diagnosis (which maps to the HCC entitled Ischemic or Unspecified Stroke) on 1 or 2 physician claims during the service year but did not have that diagnosis on a corresponding inpatient hospital claim (52 enrollee-years) or
 - a major depressive disorder diagnosis (which maps to the HCC entitled Major Depressive, Bipolar, and Paranoid Disorders) on 1 or 2 claims during the service year, rather than on several claims reflecting long-term treatment (166 enrollee-years).
- We requested that Essence obtain and perform an internal coding review of the medical records for the 218 enrollee-years to determine whether the high-risk diagnosis codes submitted to CMS complied with Federal requirements:
 - We reviewed the rationale that Essence used to perform its internal coding review and then relied on the results of those reviews for 211 of the 218 enrollee-years for this report.
 - For Essence’s internal coding reviews for 7 of the enrollee-years, Essence interpreted the ICD Coding Guidelines differently than we did. For that reason, we used an independent medical review contractor to perform a coding review

⁹ MA organizations use the RAPS to submit diagnosis codes to CMS.

¹⁰ The RAS identifies the HCCs that CMS factors into each enrollee’s risk score calculation.

¹¹ The MARx identifies the payments made to MA organizations.

for these 7 enrollee-years to determine whether the medical records supported the diagnosis codes.

- The independent medical review contractor’s coding review of the 7 enrollee-years followed a specific process to determine whether there was support for a diagnosis code and associated HCC that were at risk for noncompliance with Federal requirements:
 - If the first senior coder found support for the diagnosis code on the medical record, the HCC was considered validated.
 - If the first senior coder did not find support on the medical record, a second senior coder performed a separate review of the same medical record:
 - If the second senior coder also did not find support, the HCC was considered to be not validated.
 - If the second senior coder found support, then a physician independently reviewed the medical record to make the final determination.
 - If either the first or second senior coder asked a physician for assistance, the physician’s decision became the final determination.
- In accordance with CMS’s risk adjustment payment program, we used the results of Essence’s internal coding review, and those of the independent medical review contractor, to calculate the overpayments to Essence, and we discussed the results of our review with Essence officials on July 10, 2018.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

**APPENDIX B: FEDERAL REGULATIONS REGARDING COMPLIANCE PROGRAMS
THAT MEDICARE ADVANTAGE ORGANIZATIONS MUST FOLLOW**

Federal regulations (42 CFR § 422.503(b)) state:

Any entity seeking to contract as an MA organization must

(4) Have administrative and management arrangements satisfactory to CMS, as demonstrated by at least the following

(vi) Adopt and implement an effective compliance program, which must include measures that prevent, detect, and correct non-compliance with CMS' program requirements as well as measures that prevent, detect, and correct fraud, waste, and abuse. The compliance program must, at a minimum, include the following core requirements:

(A) Written policies, procedures, and standards of conduct that—

- (1) Articulate the organization's commitment to comply with all applicable Federal and State standards;
- (2) Describe compliance expectations as embodied in the standards of conduct;
- (3) Implement the operation of the compliance program;
- (4) Provide guidance to employees and others on dealing with potential compliance issues;
- (5) Identify how to communicate compliance issues to appropriate compliance personnel;
- (6) Describe how potential compliance issues are investigated and resolved by the organization; and
- (7) Include a policy of non-intimidation and non-retaliation for good faith participation in the compliance program, including but not limited to reporting potential issues, investigating issues, conducting self-evaluations, audits and remedial actions, and reporting to appropriate officials. . . .

(F) Establishment and implementation of an effective system for routine monitoring and identification of compliance risks. The system should include internal monitoring and audits and, as appropriate, external audits, to

evaluate the MA organization, including first tier entities', compliance with CMS requirements and the overall effectiveness of the compliance program.

(G) Establishment and implementation of procedures and a system for promptly responding to compliance issues as they are raised, investigating potential compliance problems as identified in the course of self-evaluations and audits, correcting such problems promptly and thoroughly to reduce the potential for recurrence, and ensure ongoing compliance with CMS requirements.

(1) If the MA organization discovers evidence of misconduct related to payment or delivery of items or services under the contract, it must conduct a timely, reasonable inquiry into that conduct.

(2) The MA organization must conduct appropriate corrective actions (for example, repayment of overpayments, disciplinary actions against responsible employees) in response to the potential violation referenced in paragraph (b)(4)(vi)(G)(1) of this section.

(3) The MA organization should have procedures to voluntarily self-report potential fraud or misconduct related to the MA program to CMS or its designee.



March 11, 2019

Patrick J. Cogley, Regional Inspector General for Audit Services
Office of Inspector General
Office of Audit Services, Region VII
601 East 12th Street, Room 0429
Kansas City, MO 64106

RE: Report Number: A-07-17-01170

Mr. Cogley,

In response to your letter and draft audit report dated February 12, 2019, please find below Essence Healthcare, Inc.'s (Essence) response to the report and the noted recommendations.

Comments to the Report

In several places in the report that discuss the findings on the major depression codes, there is language suggesting that the frequency of the codes in the medical records should equate or support the severity of the diagnosis. For example the language below from page 3 of the report:

"Major depressive disorder: An enrollee received a major depressive disorder diagnosis (which maps to the HCC entitled Major Depressive, Bipolar, and Paranoid Disorders) on one or two claims during the service year, *rather than on several claims, which would have reflected long-term treatment*. It is possible that a diagnosis of a less severe form of depression (which does not map to an HCC) should have been used." (Emphasis added).

We discussed with the review team on several occasions that there is not a requirement for a diagnosis to be submitted multiple times during the year in order to be supported. There is no link between the number of times a diagnosis code is submitted and illness severity. We respectfully request that this language be modified accordingly or that our objection to such conclusions noted.

OIG Recommendations

1. Refund to the Federal Government the \$158,904 in overpayments

Concur: Essence concurs with the total amount of overpayments as calculated but notes that \$37,695.96 related to Payment Year 2014 was paid back to CMS during the course of the audit through the standard risk adjustment submission process in October 2017. As it relates to the remaining amount, we will follow the established risk adjustment and/or overpayment processes and timelines with CMS to complete the pay back.

2. Identify, for the diagnoses included in this report, instances of noncompliance in the enrollee-years that occurred (1) during our audit period, but were not included in our judgmental sample, and (2) before and after our audit period, and refund any resulting overpayments to the Federal Government

Concur: Essence concurs with this recommendation to review and consider any overpayments related to these high risk codes for the years under audit, as well as the years preceding and subsequent to the years of audit. Essence has already initiated a review and sweep of these years and will continue to systematically remove high risk codes without supporting documentation from CMS' risk-adjustment systems in accordance with CMS instruction.

3. Enhance its policies and procedures to detect and correct noncompliance with Federal requirements for all diagnosis codes used to calculate risk-adjusted payments.

Concur: Essence concurs with this recommendation. As a result of the interim findings during the audit, we began to enhance our policies and procedures, including additional training for providers on the appropriate use of these high risk codes. Generally, Essence continues to promote a risk adjustment process that takes a multi-disciplinary approach to aid efforts in ensuring complete and accurate diagnosis codes throughout the life cycle, including provider education, claims processing, assessment and analysis, patient and provider outreach, and appropriate documentation. We will continue to refine our risk-adjustment program to include other risk-mitigation steps, specifically targeting high-risk diagnoses, with an emphasis on leveraging data analytics to help guide coding audits of these high-risk areas. Additionally, we will continue to enhance our educational information to aid efforts in ensuring complete and accurate diagnosis codes, especially for those codes that are historically difficult to document with accuracy. .

We appreciate the efforts and collaboration of the OIG during the audit. Please advise if there are any questions on the above.

Sincerely,



Erin A. Venable
VP, Internal Audit & Chief Compliance Officer