

Report in Brief

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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.