

Report in Brief

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



Why OIG Did This Audit

Under the Medicare Advantage (MA) program, the Centers for Medicare & Medicaid Services (CMS) makes 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 enrollees with diagnoses associated with more intensive use of health care resources than to healthier enrollees, who would be expected to require fewer health care resources.

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, Blue Cross Blue Shield of Michigan (BCBSM), and focused on seven groups of high-risk diagnosis codes. Our objective was to determine whether selected diagnosis codes that BCBSM submitted to CMS for use in CMS's risk adjustment program complied with Federal requirements.

How OIG Did This Audit

We sampled 248 unique enrollee-years with the high-risk diagnosis codes for which BCBSM received higher payments for 2015 through 2016. We limited our review to the portions of the payments that were associated with these high-risk diagnosis codes, which totaled \$963,544.

Medicare Advantage Compliance Audit of Specific Diagnosis Codes That Blue Cross Blue Shield of Michigan (Contract H9572) Submitted to CMS

What OIG Found

Most of the selected diagnosis codes that BCBSM submitted to CMS for use in CMS's risk adjustment program did not comply with Federal requirements. For 188 of the 248 enrollee-years, the diagnosis codes that BCBSM submitted to CMS were not supported in the medical records and resulted in net overpayments of \$668,264.

These errors occurred because the policies and procedures that BCBSM had to detect and correct noncompliance with CMS's program requirements, as mandated by Federal regulations, were not always effective. On the basis of our sample results, we estimated that BCBSM received at least \$14.5 million of net overpayments for these high-risk diagnosis codes in 2015 and 2016.

What OIG Recommends and BCBSM Comments

We recommend that BCBSM (1) refund to the Federal Government the \$14.5 million of net overpayments; (2) identify, for the high-risk diagnoses included in this report, similar instances of noncompliance that occurred before or after our audit period and refund any resulting overpayments to the Federal Government; and (3) examine its existing compliance procedures to identify areas where improvements can be made to ensure diagnosis codes that are at high risk for being miscoded comply with Federal requirements and take the necessary steps to enhance those procedures.

In written comments on our draft report, BCBSM concurred with our recommendations and described actions it has taken and plans to take to address them. Specifically, BCBSM indicated that it will refund \$14.5 million to the Federal Government but noted that it submitted "delete files" to CMS totaling \$406,237 for our audit period and that it will work with CMS on the remaining amount to effectuate timely repayment. BCBSM also stated that it will review high-risk diagnoses for years prior to and after our audit period and consider any resulting overpayments. Lastly, BCBSM described the improvements it has made and plans to make to ensure high-risk diagnosis codes comply with Federal requirements. We commend BCBSM for the actions it has taken and plans to take to address our recommendations.