

## Report in Brief

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Report No. A-03-19-00001

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 diagnosis codes are at higher risk for being miscoded, which may result in overpayments from CMS. For this audit, we reviewed one MA organization, Highmark Senior Health Company.

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

### How OIG Did This Audit

We sampled 226 unique enrollee condition and payment years (enrollee-years) with the high-risk diagnosis codes for which Highmark received higher payments for 2015 and 2016. We limited our review to the portion of the payments that were associated with these high-risk diagnosis codes, which totaled \$801,166.

## Medicare Advantage Compliance Audit of Specific Diagnosis Codes That Highmark Senior Health Company (H3916) Submitted to CMS

### What OIG Found

With respect to the six high-risk groups covered by our audit, most of the selected diagnosis codes that Highmark submitted to CMS for use in CMS's risk adjustment program did not comply with Federal requirements. For 160 of the 226 sampled enrollee-years, the diagnosis codes were not supported in the medical records.

These errors occurred because the policies and procedures that Highmark had to prevent, detect, and correct noncompliance with CMS's program requirements, as mandated by Federal regulations, could be improved. As a result, the Hierarchical Condition Categories (diagnosis code groupings based on similarity of clinical characteristics, severity, and cost implications) for these high-risk diagnosis codes were not validated. On the basis of our sample results, we estimated that Highmark received at least \$6.2 million of net overpayments for 2015 and 2016.

### What OIG Recommends and Highmark Comments

We recommend that Highmark: (1) refund to the Federal Government the \$6.2 million of estimated net overpayments; (2) identify, for the high-risk diagnoses included in the report, similar instances of noncompliance that occurred before or after our audit period and refund any resulting overpayments to the Federal Government; and (3) continue its examination of 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 (when submitted to CMS for use in CMS's risk adjustment program) and take the necessary steps to enhance those procedures.

In written comments on our draft report, Highmark disagreed with our findings and recommendations. Highmark provided additional information for two medical records that it said substantiated specific Hierarchical Condition Categories. Highmark also questioned our audit and statistical sampling methodologies and stated that it had a robust compliance program. After reviewing Highmark's comments and the additional information provided, we revised our findings and recommendations as appropriate. We maintain that our methodologies were reasonable and properly executed.