

## Report in Brief

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



### Why OIG Did This Audit

This audit involved individuals eligible for Medicare who were covered under traditional Medicare in one year but chose to enroll in Medicare Advantage (MA) the following year (transferred enrollees). The Centers for Medicare & Medicaid Services (CMS) maps certain diagnosis codes into Hierarchical Condition Categories (HCCs). For transferred enrollees who, while covered under traditional Medicare, receive a diagnosis that maps to an HCC, CMS makes higher payments to MA organizations for the following year.

Through data mining and discussions with medical professionals, we have identified several diagnosis codes that were at high risk of being miscoded and resulting in inaccurate payments. For this audit, we focused only on selected acute stroke diagnosis codes (which map to the Ischemic or Unspecified Stroke HCC) that were reported on one physician's claim without being reported on a corresponding inpatient claim.

Our objective was to determine whether selected acute stroke diagnosis codes submitted by physicians under traditional Medicare that CMS later used to make payments to MA organizations on behalf of transferred enrollees complied with Federal requirements.

### How OIG Did This Audit

We reviewed 582 of 8,437 transferred enrollees (that we selected with a stratified random sample) who received one instance of a high-risk acute stroke diagnosis code during 2014 or 2015. We had reviews performed to determine whether the medical records supported the submitted diagnosis codes. We relied on these reviews as the basis for our conclusions.

## Incorrect Acute Stroke Diagnosis Codes Submitted by Traditional Medicare Providers Resulted in Millions of Dollars in Increased Payments to Medicare Advantage Organizations

### What OIG Found

Almost all of the selected acute stroke diagnosis codes that physicians submitted to CMS under traditional Medicare and that CMS later used to make payments to MA organizations for 2015 or 2016 on behalf of the 582 transferred enrollees did not comply with Federal requirements. For 580 of the transferred enrollees, the medical records did not support the acute stroke diagnosis codes. Thus, the Ischemic or Unspecified Stroke HCCs were not validated.

These errors originated from physicians submitting incorrect acute stroke diagnosis codes on claims billed under traditional Medicare. However, these errors were unnoticed and caused inaccurate payments in MA because CMS did not have policies and procedures to (1) identify beneficiaries who transferred from traditional Medicare to MA, and (2) evaluate whether the acute stroke diagnosis codes submitted under traditional Medicare on their behalf complied with Federal requirements. As a result, we estimated that CMS made inaccurate payments of just over \$14.4 million to MA organizations.

### What OIG Recommends and CMS Comments

We recommend that CMS (1) educate physicians on how to correctly submit acute stroke diagnosis codes and how these diagnosis codes may impact the MA program, and (2) develop and implement policies and procedures to identify beneficiaries transferring from traditional Medicare to MA and evaluate whether the acute stroke diagnosis codes submitted under traditional Medicare comply with Federal requirements.

CMS concurred with our recommendations and described actions that it had taken or planned to take to address them. Specifically, CMS stated that it would continue to educate physicians on how to correctly submit acute stroke diagnosis codes, including updated information on how these codes may impact the MA program. CMS also stated that although our findings account for less than 0.5 percent of all transferred enrollees, it would review its existing policies and procedures to evaluate whether any further clarification is needed with regards to acute stroke diagnoses.