

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, California Physicians' Service, Inc. (CPS), and focused on seven groups of high-risk diagnosis codes. Our objective was to determine whether selected diagnosis codes that CPS submitted to CMS for use in CMS's risk adjustment program complied with Federal requirements.

How OIG Did This Audit

We sampled 196 unique enrollee-years with the high-risk diagnosis codes for which CPS received higher payments for 2015 and 2016. We limited our review to the portions of the payments that were associated with these high-risk diagnosis codes, which totaled \$523,340.

Medicare Advantage Compliance Audit of Specific Diagnosis Codes That California Physicians' Service, Inc. (Contract H0504) Submitted to CMS

What OIG Found

With respect to the seven high-risk groups covered by our audit, most of the selected diagnosis codes that CPS submitted to CMS for use in CMS's risk adjustment program did not comply with Federal requirements. Specifically, for 117 of the 196 sampled enrollee-years, the diagnosis codes that CPS submitted to CMS were not supported in the medical records and resulted in net overpayments of \$319,945. As demonstrated by the errors in our sample, the policies and procedures that CPS used to prevent, detect, and correct noncompliance with CMS's program requirements, as mandated by Federal regulations, could be improved. On the basis of our sample results, we estimated that CPS received at least \$2 million of net overpayments for these high-risk diagnosis codes for 2015 and 2016.

What OIG Recommends and CPS Comments

We recommend that CPS: (1) refund to the Federal Government the \$2 million of estimated 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 that 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.

CPS disagreed with our findings and recommendations. Specifically, CPS disagreed with our findings for 5 sampled enrollee-years and provided additional explanations of why it believed that the medical records validated the diagnosis codes. CPS also disagreed with the methodologies that we used to review the selected diagnoses and to calculate net overpayments. Furthermore, CPS disagreed that it should conduct additional audits (to identify similar instances of noncompliance) and that it should examine its compliance procedures.

After consideration of CPS's comments, we revised our finding for 1 sampled enrollee-year and reduced the refund amount in our first recommendation from \$2,045,043 to \$2,033,039. We maintain that our findings and recommendations, as revised, are valid.