

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**MEDICARE ADVANTAGE
COMPLIANCE AUDIT OF SPECIFIC
DIAGNOSIS CODES THAT SELECTCARE
OF TEXAS, INC. (CONTRACT H4506)
SUBMITTED TO CMS**

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Report in Brief

Date: November 2023

Report No. A-06-19-05002

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



Why OIG Did This Audit

Under the Medicare Advantage (MA) program, 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.

For this audit, we reviewed one MA organization, SelectCare of Texas, Inc. (SelectCare), and focused on 10 groups of high-risk diagnosis codes.

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

How OIG Did This Audit

We sampled 285 unique enrollee-years with the high-risk diagnosis codes for which SelectCare 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 \$689,604.

Medicare Advantage Compliance Audit of Specific Diagnosis Codes That SelectCare of Texas, Inc. (Contract H4506) Submitted to CMS

What OIG Found

With respect to the 10 high-risk groups covered by our audit, most of the selected diagnosis codes that SelectCare submitted to CMS for use in CMS's risk adjustment program did not comply with Federal requirements. Specifically, for 220 of the 285 enrollee-years, the diagnosis codes that SelectCare submitted to CMS were not supported in the medical records and resulted in net overpayments of \$482,601. As demonstrated by the errors in our sample, the policies and procedures that SelectCare used to prevent, detect, and correct noncompliance with CMS's program requirements could be improved. On the basis of our sample results, we estimated that SelectCare received at least \$5.1 million in net overpayments for 2015 and 2016.

What OIG Recommends and SelectCare Comments

We recommend that SelectCare (1) refund to the Federal Government the \$482,601 in net overpayments; (2) identify, for the high-risk diagnoses included in this report, similar instances of noncompliance that occurred before and after our audit period and refund any resulting overpayments to the Federal Government; and (3) review its existing compliance procedures to identify potential 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 any necessary steps to enhance those current procedures.

SelectCare disagreed with some of our findings and recommendations and provided additional information for certain sampled enrollee-years. SelectCare also disagreed with our audit methodology and stated that we improperly implied that MA organizations are expected to assure that 100 percent of the diagnosis codes received from providers and submitted to CMS are accurate. SelectCare added that it would consider our third recommendation to evaluate and enhance its compliance procedures.

After reviewing SelectCare's comments and the additional information that it provided, we revised the number of enrollee-years in error and reduced the amount in our first recommendation. We made no changes to our second and third recommendations.

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INTRODUCTION

WHY WE DID THIS AUDIT

Under the Medicare Advantage (MA) program, the Centers for Medicare & Medicaid Services (CMS) makes monthly payments to MA organizations based in part on the characteristics of the enrollees being covered. Using a system of risk adjustment, CMS pays MA organizations the anticipated cost of providing Medicare benefits to a given enrollee, depending on such risk factors as the age, gender, and health status of that individual. Accordingly, MA organizations are paid more for providing benefits to enrollees with diagnoses associated with more intensive use of health care resources relative 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.¹ We are auditing MA organizations because some diagnoses are at higher risk for being miscoded, which may result in overpayments from CMS.

This audit is part of a series of audits in which we are reviewing the accuracy of diagnosis codes that MA organizations submitted to CMS.² Using data mining techniques and considering discussions with medical professionals, we identified diagnoses that were at higher risk for being miscoded and consolidated those diagnoses into specific groups. (For example, we consolidated 29 major depressive disorder diagnoses into 1 group.) This audit covered SelectCare of Texas, Inc. (SelectCare), for contract number H4506 and focused on 10 groups of high-risk diagnosis codes for payment years 2015 and 2016.³

OBJECTIVE

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

¹ The providers code diagnoses using the International Classification of Diseases (ICD), Clinical Modification (CM), *Official Guidelines for Coding and Reporting* (ICD Coding Guidelines). The ICD is a coding system that physicians and other health care providers use to classify and code all diagnoses, symptoms, and procedures. Effective October 1, 2015, CMS transitioned from the ninth revision of the ICD coding guidelines (ICD-9-CM) to the tenth revision (ICD-10-CM). Each revision includes different diagnosis code sets.

² See Appendix B for a list of related Office of Inspector General reports.

³ In April 2017, WellCare Health Plans, Inc. (WellCare), acquired SelectCare. In March 2019, Centene Corporation (Centene) acquired WellCare. We worked with both WellCare and Centene officials during our audit. As such, all subsequent references to SelectCare in this report refer solely to contract number H4506.

BACKGROUND

Medicare Advantage Program

The MA program offers people eligible for Medicare managed care options by allowing them to enroll in private health care plans rather than having their care covered through Medicare's traditional fee-for-service program.⁴ Individuals who enroll in these plans are known as enrollees. To provide benefits to enrollees, CMS contracts with MA organizations, which in turn contract with providers (including hospitals) and physicians.

Under the MA program, CMS makes advance payments each month to MA organizations for the expected costs of providing health care coverage to enrollees. These payments are not adjusted to reflect the actual costs that the organizations incurred for providing benefits and services. Thus, MA organizations will either realize profits if their actual costs of providing coverage are less than the CMS payments or incur losses if their costs exceed the CMS payments.

For 2021, CMS paid MA organizations \$349.9 billion, which represented 42 percent of all Medicare payments for that year.

Risk Adjustment Program

Federal requirements mandate that payments to MA organizations be based on the anticipated cost of providing Medicare benefits to a given enrollee and, in doing so, also account for variations in the demographic characteristics and health status of each enrollee.⁵

CMS uses two principal components to calculate the risk-adjusted payment that it will make to an MA organization for an enrollee: a base rate that CMS sets using bid amounts received from the MA organization and the risk score for that enrollee. These are described as follows:

- *Base rate*: Before the start of each year, each MA organization submits bids to CMS that reflect the MA organization's estimate of the monthly revenue required to cover an enrollee with an average risk profile.⁶ CMS compares each bid to a specific benchmark amount for each geographic area to determine the base rate that an MA organization is paid for each of its enrollees.⁷

⁴ The Balanced Budget Act of 1997, P.L. No. 105-33, as modified by section 201 of the Medicare Prescription Drug, Improvement, and Modernization Act, P.L. No. 108-173, established the MA program.

⁵ The Social Security Act (the Act) §§ 1853(a)(1)(C) and (a)(3); 42 CFR § 422.308(c).

⁶ The Act § 1854(a)(6); 42 CFR § 422.254 *et seq.*

⁷ CMS's bid-benchmark comparison also determines whether the MA organization must offer supplemental benefits or must charge a basic enrollee premium for the benefits.

- *Risk score:* A risk score is a relative measure that reflects the additional or reduced costs that each enrollee is expected to incur compared with the costs incurred by enrollees on average. CMS calculates risk scores based on an enrollee's health status (discussed below) and demographic characteristics (such as the enrollee's age and gender). This process results in an individualized risk score for each enrollee, which CMS calculates annually.

To determine an enrollee's health status for purposes of calculating the risk score, CMS uses diagnoses that the enrollee receives from acceptable data sources, including certain physicians and hospitals. MA organizations collect the diagnosis codes from providers based on information documented in the medical records and submit these codes to CMS. CMS then maps certain diagnosis codes, on the basis of similar clinical characteristics and severity and cost implications, into Hierarchical Condition Categories (HCCs).⁸ Each HCC has a factor (which is a numerical value) assigned to it for use in each enrollee's risk score.

As a part of the risk adjustment program, CMS consolidates certain HCCs into related-disease groups. Within each of these groups, CMS assigns an HCC for only the most severe manifestation of a disease in a related-disease group. Thus, if MA organizations submit diagnosis codes for an enrollee that map to more than one of the HCCs in a related-disease group, only the most severe HCC will be used in determining the enrollee's risk score.

For enrollees who have certain combinations of HCCs (in either the Version 12 model or the Version 22 model), CMS assigns a separate factor that further increases the risk score. CMS refers to these combinations as disease interactions. For example, if MA organizations submit diagnosis codes (in the Version 12 model) for an enrollee that map to the HCCs for acute stroke, acute myocardial infarction, and chronic obstructive pulmonary disease (COPD), CMS assigns a separate factor for this disease interaction. By doing so, CMS increases the enrollee's risk score for each of the three HCC factors and by an additional factor for the disease interaction.

The risk adjustment program is prospective. Specifically, CMS uses the diagnosis codes that the enrollee received for one calendar year (known as the service year) to determine HCCs and calculate risk scores for the following calendar year (known as the payment year). Thus, an enrollee's risk score does not change for the year in which a diagnosis is made. Instead, the risk score changes for the entirety of the year after the diagnosis has been made. Further, the risk score calculation is an additive process: As HCC factors (and, when applicable, disease interaction factors) accumulate, an enrollee's risk score increases, and the monthly risk-adjusted payment to the MA organization also increases. In this way, the risk adjustment

⁸ CMS transitioned from one HCC payment model to another during our audit period. As part of this transition, for 2015, CMS calculated risk scores based on both payment models. CMS refers to these models as the Version 12 model and the Version 22 model, each of which has unique HCCs. CMS blended the two separate risk scores into a single risk score that it used to calculate a risk-adjusted payment. Accordingly, for 2015, an enrollee's blended risk score is based on the HCCs from both payment models. For 2016, CMS calculated risk scores based on the Version 22 model.

program compensates MA organizations for the additional risk for providing coverage to enrollees expected to require more health care resources.

CMS multiplies the risk scores by the base rates to calculate the total Medicare monthly payment that an MA organization receives for each enrollee before applying the budget sequestration reduction.⁹ Thus, if the factors used to determine an enrollee's risk score are incorrect, CMS will make an improper payment to an MA organization. Specifically, if medical records do not support the diagnosis codes that an MA organization submitted to CMS, the HCCs are unvalidated, which causes overstated enrollee risk scores and overpayments from CMS.¹⁰ Conversely, if medical records support the diagnosis codes that an MA organization did not submit to CMS, validated HCCs may not have been included in enrollees' risk scores, which may cause those risk scores to be understated and may result in underpayments.

High-Risk Groups of Diagnoses

Using data mining techniques and discussions with medical professionals, we identified diagnoses that were at higher risk for being miscoded and consolidated those diagnoses into specific groups. For this audit, we focused on 10 high-risk groups:¹¹

- *Acute Stroke*: An enrollee received one acute stroke diagnosis (that mapped to the HCC for Ischemic or Unspecified Stroke) on only one physician claim during the service year but did not have that diagnosis on a corresponding inpatient or outpatient hospital claim. In these instances, a diagnosis of history of stroke (which does not map to an HCC) typically should have been used.
- *Acute Heart Attack*: An enrollee received one diagnosis during the service year that mapped to either the HCC for Acute Myocardial Infarction or to the HCC for Unstable Angina and Other Acute Ischemic Heart Disease (Acute Heart Attack HCCs) on only one physician or outpatient claim during the service year but did not have that diagnosis on a corresponding inpatient hospital claim (either within 60 days before or 60 days after

⁹ Budget sequestration refers to automatic spending cuts that occurred through the withdrawal of funding for certain Federal Government programs, including the MA program, as provided in the Budget Control Act of 2011 (BCA) (P.L. No. 112-25 (Aug. 2, 2011)). Under the BCA, the sequestration of mandatory spending began in April 2013.

¹⁰ 42 CFR § 422.310(e) requires MA organizations (when undergoing an audit conducted by the Secretary of the Department of Health and Human Services) to submit "medical records for the validation of risk adjustment data." For purposes of this report, we use the terms "supported" or "unsupported" to denote whether the reviewed diagnoses were evidenced in the medical records. If our audit determines that the diagnoses are supported or unsupported, we accordingly use the terms "validated" or "unvalidated" with respect to the associated HCC.

¹¹ Unless otherwise specified, the HCCs described in this report have the same name under both the Version 12 and Version 22 models.

the physician or outpatient claim). In these instances, a diagnosis for a less severe manifestation of a disease in the related-disease group typically should have been used.

- *Major Depressive Disorder*: An enrollee received one major depressive disorder diagnosis (that mapped to the HCC for Major Depressive, Bipolar, and Paranoid Disorders) on only one claim during the service year but did not have an antidepressant medication dispensed on his or her behalf. In these instances, the major depressive disorder diagnoses may not be supported in the medical records.
- *Embolism*: An enrollee received one diagnosis that mapped to either the HCC for Vascular Disease or to the HCC for Vascular Disease With Complications (Embolism HCCs) on only one claim during the service year but did not have an anticoagulant medication dispensed on his or her behalf. An anticoagulant medication is typically used to treat an embolism. In these instances, a diagnosis of history of embolism (an indication that the provider is evaluating a prior acute embolism diagnosis, which does not map to an HCC) typically should have been used.
- *Vascular Claudication*: An enrollee received one diagnosis related to vascular claudication (that mapped to the HCC for Vascular Disease) on only one claim during the service year but had not received one of these diagnoses during the 2 preceding years but had medication dispensed on his or her behalf that is frequently dispensed for a diagnosis of neurogenic claudication.¹² In these instances, the diagnosis related to vascular claudication diagnoses may not be supported in the medical records.
- *Lung Cancer*: An enrollee received one lung cancer diagnosis (that mapped to one of the Lung Cancer HCCs)¹³ on only one claim during the service year but did not have surgical therapy, radiation treatments, or chemotherapy drug treatments administered within a 6-month period either before or after the diagnosis. In these instances, a diagnosis of history of lung cancer (which does not map to an HCC) typically should have been used.
- *Breast Cancer*: An enrollee received one breast cancer diagnosis (that mapped to one of the Breast Cancer HCCs)¹⁴ on only one claim during the service year but did not have surgical therapy, radiation treatments, or chemotherapy drug treatments administered

¹² Vascular claudication and neurogenic claudication are different diagnoses. Vascular claudication is a condition that can result in leg pain while an individual is walking and is caused by insufficient blood flow. Neurogenic claudication is a condition that can also result in leg pain but is caused by damage to the neurological system, namely the spinal cord and nerves.

¹³ The Lung Cancer HCCs included the HCC for Lung, Upper Digestive Tract, and Other Severe Cancers from the Version 12 model and the HCC for Lung and Other Severe Cancers from the Version 22 model.

¹⁴ The Breast Cancer HCCs included the HCC for Breast, Prostate, Colorectal, and Other Cancers and Tumors from the Version 12 model and the HCC for Breast, Prostate, and Other Cancers and Tumors from the Version 22 model.

within a 6-month period before or after the diagnosis. A diagnosis of history of breast cancer (which does not map to an HCC) typically should have been used.

- *Colon Cancer:* An enrollee received one colon cancer diagnosis (that mapped to one of the Colon Cancer HCCs)¹⁵ on only one claim during the service year but did not have surgical therapy, radiation treatments, or chemotherapy drug treatments administered within a 6-month period before or after the diagnosis. A diagnosis of history of colon cancer (which does not map to an HCC) typically should have been used.
- *Prostate Cancer:* An enrollee received one prostate cancer diagnosis (that mapped to one of the Prostate Cancer HCCs)¹⁶ on only one claim during the service year but did not have surgical therapy, radiation treatments, or chemotherapy drug treatments administered within a 6-month period before or after the diagnosis. A diagnosis of history of prostate cancer (which does not map to an HCC) typically should have been used.
- *Potentially Mis-keyed Diagnosis Codes:* An enrollee received multiple diagnoses for a condition but received only one—potentially mis-keyed—diagnosis for an unrelated condition (which mapped to a possibly unvalidated HCC). For example, ICD-9 diagnosis code 250.00 (which maps to the HCC for Diabetes Without Complication) could be transposed as diagnosis code 205.00 (which maps to the HCC for Metastatic Cancer and Acute Leukemia and in this example would be unvalidated). Using an analytical tool that we developed, we identified 832 scenarios in which diagnosis codes could have been mis-keyed because of data transposition or other data entry errors, which could have resulted in the assignment of an unvalidated HCC.

In this report, we refer to the diagnosis codes associated with these groups as “high-risk diagnosis codes.”

SelectCare of Texas, Inc.

SelectCare is an MA organization based in Houston, Texas. As of December 31, 2016, SelectCare provided coverage under contract number H4506 to approximately 65,600 enrollees. For the 2015 and 2016 payment years (audit period),¹⁷ CMS paid SelectCare

¹⁵ The Colon Cancer HCCs included the HCC for Breast, Prostate, Colorectal, and Other Cancers and Tumors from the Version 12 model and the HCC for Colorectal, Bladder, and Other Cancers from the Version 22 model.

¹⁶ The Prostate Cancer HCCs included the HCC for Breast, Prostate, Colorectal, and Other Cancers and Tumors from the Version 12 model and the HCC for Breast, Prostate, and Other Cancers and Tumors from the Version 22 model.

¹⁷ The 2015 and 2016 payment year data were the most recent data available at the start of the audit.

approximately \$1.5 billion to provide coverage to its enrollees.¹⁸ In April 2017, WellCare Health Plans, Inc. (WellCare), acquired SelectCare. In March 2019, Centene Corporation acquired WellCare. For the purpose of this report, all references to SelectCare will encompass all three entities.

HOW WE CONDUCTED THIS AUDIT

Our audit included enrollees on whose behalf providers documented diagnosis codes that mapped to 1 of the 10 high-risk groups during the 2014 and 2015 service years, for which SelectCare received increased risk-adjusted payments for payment years 2015 and 2016, respectively. Because enrollees could be categorized into more than one high-risk group or could have high-risk diagnosis codes documented in more than 1 year, we classified these individuals according to the condition and the payment year, which we refer to as “enrollee-years.”

We identified 3,916 unique enrollee-years and limited our review to the portions of the payments that were associated with these high-risk diagnosis codes (\$8,331,060). We selected for audit a sample of 285 enrollee-years, which comprised (1) a stratified random sample of 270 (out of 3,901) enrollee-years for the first 9 high-risk groups and (2) 15 enrollee-years for the remaining high-risk group. Table 1 details the number of sampled enrollee-years for each high-risk group.

Table 1: Sampled Enrollee-Years

High Risk Group	Number of Sampled Enrollee Years
1. Acute stroke	30
2. Acute heart attack	30
3. Major depressive disorder	30
4. Embolism	30
5. Vascular claudication	30
6. Lung cancer	30
7. Breast cancer	30
8. Colon cancer	30
9. Prostate cancer	30
Total for Stratified Random Sample	270
10. Potentially mis-keyed diagnosis codes	15
Total for All High-Risk Groups	285

¹⁸ All of the payment amounts that CMS made to SelectCare and the net overpayment amounts that we identified in this report reflect the budget sequestration reduction.

SelectCare provided medical records as support for the selected diagnosis codes associated with 273 of the 285 enrollee-years.¹⁹ We used an independent medical review contractor to review the medical records to determine whether the HCCs associated with the sampled enrollee-years were validated. For the HCCs that were not validated, if the contractor identified a diagnosis code that should have been submitted to CMS rather than the selected diagnosis code, we included the financial impact of the resulting HCC (if any) in our calculation of overpayments.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Appendix A contains the details of our audit scope and methodology, Appendix C contains our statistical sampling methodology, Appendix D contains our sample results and estimates, and Appendix E contains the Federal regulations regarding MA organizations' compliance programs.

FINDINGS

With respect to the 10 high-risk groups covered by our audit, most of the selected diagnosis codes that SelectCare submitted to CMS for use in CMS's risk adjustment program did not comply with Federal requirements. For 65 of the 285 sampled enrollee-years, either the medical records validated the reviewed HCCs, or we identified another diagnosis code (on CMS's systems) that supported the HCC under review.²⁰ However, for 220 enrollee-years, the diagnosis codes were not supported in the medical records or could not be supported because SelectCare could not obtain the medical records from select providers, and the associated HCCs were therefore not validated. As a result, SelectCare received \$482,601 in net overpayments.

As demonstrated by the errors found in our sample, SelectCare's policies and procedures 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

¹⁹ SelectCare could not locate medical records for the remaining 12 sampled enrollee-years.

²⁰ For 2 of the 65 enrollee-years, SelectCare informed us that it could not locate the associated medical records because the records had either been destroyed in a natural disaster or were seized by the Federal Government. CMS provides guidance for medical records that are unavailable because of "extraordinary circumstances" (*Contract-Level Risk Adjustment Data Validation CMS Submission Instructions*). Based on our assessment of the information that SelectCare officials provided to us, we determined that an extraordinary circumstance prevented SelectCare from locating the medical records for these enrollee-years and, accordingly, we treated the sample items as non-errors.

that SelectCare received at least \$5.1 million in net overpayments for 2015 and 2016.²¹ Because of Federal regulations that limit the use of extrapolation in Risk Adjustment Data Validation (RADV) audits for recovery purposes to payment year 2018 and forward, we are reporting the overall estimated overpayment amount but are recommending a refund of \$482,601.

FEDERAL REQUIREMENTS

Payments to MA organizations are adjusted for risk factors, including the health status of each enrollee (the Social Security Act § 1853(a)). CMS applies a risk factor based on data obtained from the MA organizations (42 CFR § 422.308).

Federal regulations state that MA organizations must follow CMS's instructions and submit to CMS the data necessary to characterize the context and purposes of each service provided to a Medicare enrollee by a provider, supplier, physician, or other practitioner (42 CFR § 422.310(b)). MA organizations must obtain risk adjustment data required by CMS from the provider, supplier, physician, or other practitioner that furnished the item or service (42 CFR § 422.310(d)(3)).

Federal regulations also state that MA organizations are responsible for the accuracy, completeness, and truthfulness of the data submitted to CMS for payment purposes and that such data must conform to all relevant national standards (42 CFR §§ 422.504(l) and 422.310(d)(1)). In addition, MA organizations must contract with CMS and agree to follow CMS's instructions, including the *Medicare Managed Care Manual* (the Manual) (42 CFR § 422.504(a)).

CMS has provided instructions to MA organizations regarding the submission of data for risk scoring purposes (the Manual, chap. 7 (last rev. Sept. 19, 2014)). Specifically, CMS requires all submitted diagnosis codes to be documented on the medical record and to be documented as a result of a face-to-face encounter (the Manual, chap. 7, § 40). The diagnosis must be coded according to the International Classification of Diseases, Clinical Modification, *Official Guidelines for Coding and Reporting* (42 CFR § 422.310(d)(1) and 45 CFR §§ 162.1002(b)(1) and (c)(2)-(3)). Further, the MA organizations must implement procedures to ensure that diagnoses come only from acceptable data sources, which include hospital inpatient facilities, hospital outpatient facilities, and physicians (the Manual, chapter 7, § 40).

Federal regulations state that MA organizations must monitor the data that they receive from providers and submit to CMS. Federal regulations also state that MA organizations must "adopt and implement an effective compliance program, which must include measures that prevent,

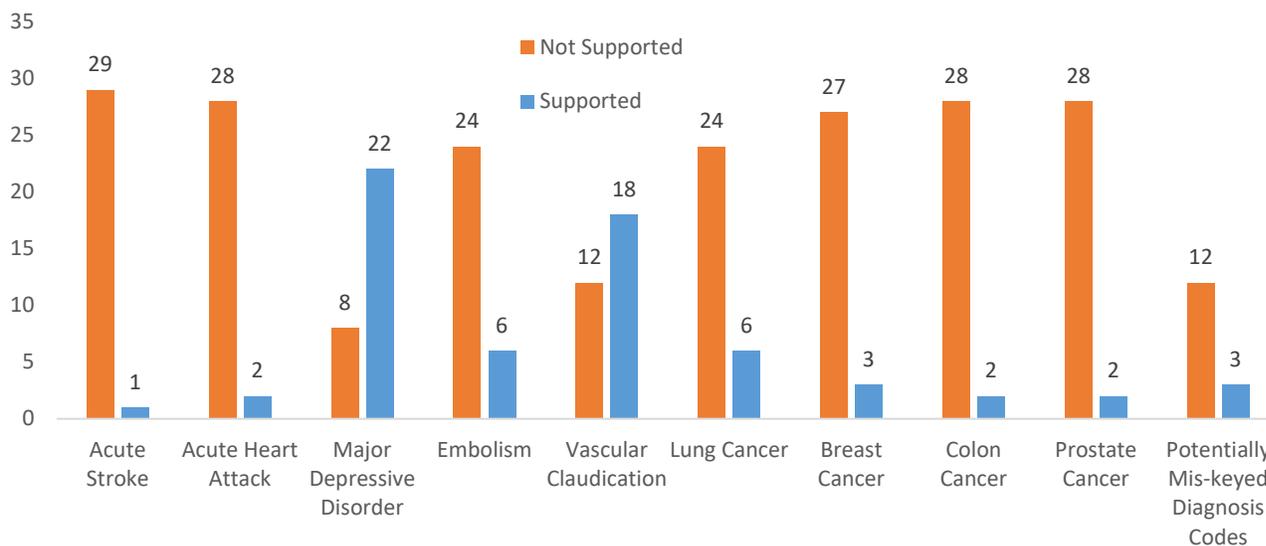
²¹ Specifically, we estimated that SelectCare received at least \$5,124,798 (\$5,076,793 for the statistically sampled groups plus \$48,005 for the group of potentially mis-keyed diagnosis codes) in net overpayments. To be conservative, we estimated net overpayments at the lower limit of a two-sided 90-percent confidence interval. Lower limits calculated in this manner are designed to be less than the actual overpayment total 95 percent of the time.

detect, and correct non-compliance with CMS’ program requirements” Further, MA organizations must establish and implement an effective system for routine monitoring and identification of compliance risks (42 CFR § 422.503(b)(4)(vi)).

MOST OF THE SELECTED HIGH-RISK DIAGNOSIS CODES THAT SELECTCARE OF TEXAS SUBMITTED TO CMS DID NOT COMPLY WITH FEDERAL REQUIREMENTS

Most of the selected high-risk diagnosis codes that SelectCare submitted to CMS for use in CMS’s risk adjustment program did not comply with Federal requirements. As shown in the figure below, the medical records for 220 of the 285 sampled enrollee-years did not support the diagnosis codes and should not have been submitted to CMS. In these instances, SelectCare received the resulting net overpayments.

Figure: Analysis of High-Risk Groups



Incorrectly Submitted Diagnosis Codes for Acute Stroke

SelectCare incorrectly submitted diagnosis codes for acute stroke for 29 of the 30 sampled enrollee-years. Specifically:

- For 25 enrollee-years, the medical records indicated in each case that the individual had previously had a stroke, but the records did not justify an acute stroke diagnosis at the time of the physician’s service.

For example, for 1 enrollee-year, the independent medical review contractor noted that “there is no evidence of an acute stroke or any related condition that result[s] in an assignment of the submitted HCC [for Ischemic or Unspecified Stroke] or a related HCC.

There is mention of [a] history of cerebrovascular accident but no description of residuals or sequelae²² that should be coded.” The history of stroke diagnosis code does not map to an HCC.

- For 4 enrollee-years, the medical records in each case did not contain sufficient information to support an acute stroke diagnosis.

For example, for 1 enrollee-year, the independent medical review contractor stated that “there is no evidence of an acute stroke or any related condition that would result in an assignment of the submitted HCC [for Ischemic or Unspecified Stroke] or a related HCC.”

As a result of these errors, the HCCs for Ischemic or Unspecified Stroke were not validated, and SelectCare received \$63,066 in overpayments for these 29 sampled enrollee-years.

Incorrectly Submitted Diagnosis Codes for Acute Heart Attack

SelectCare incorrectly submitted diagnosis codes for acute heart attack for 28 of the 30 sampled enrollee-years. Specifically:

- For 16 enrollee-years, the medical records in each case did not support the submitted diagnosis that mapped to an Acute Heart Attack HCC. However, for each of these enrollee-years, we identified support for another diagnosis that mapped to an HCC for a less severe manifestation of the related-disease group. Accordingly, SelectCare should not have received an increased payment for an Acute Heart Attack HCC but should have received a lesser increased payment for the less severe diagnosis.

Table 2 identifies the HCCs for the less severe manifestation of the related-disease groups that were supported for the 16 enrollee-years.

Table 2: HCCs for a Less Severe Manifestation of the Related-Disease Group That Were Supported (Instead of an Acute Heart Attack HCC)

Count of Enrollee-Years	Less Severe Hierarchical Condition Category
8	Angina Pectoris/Old Myocardial Infarction (Version 12 model)
5	Angina Pectoris/Old Myocardial Infarction (Version 12 model) and Angina Pectoris (Version 22 model)
3	Angina Pectoris (Version 22 model)

²² Residuals or sequelae are the remaining medical or pathological conditions resulting from a prior disease, injury, or attack.

- For 7 enrollee-years, the medical records in each case did not support a diagnosis that mapped to an Acute Heart Attack HCC or a diagnosis of a less severe manifestation of the related-disease group.

For example, for 1 enrollee-year, the independent medical review contractor stated that “there is no documentation of any condition that will result in assignment of [the Unstable Angina and Other Acute Ischemic Heart Disease] HCC.”

- For 5 enrollee-years, which occurred in 2016, the medical records in each case did not support an acute myocardial infarction diagnosis; however, we identified support for an old myocardial infarction diagnosis that did not map to an HCC.²³ Accordingly, SelectCare should not have received an increased payment for acute myocardial infarction.

As a result of these errors, the Acute Heart Attack HCCs were not validated, and SelectCare received \$40,158 in overpayments for these 28 sampled enrollee-years.

Incorrectly Submitted Diagnosis Codes for Major Depressive Disorder

SelectCare incorrectly submitted diagnosis codes for major depressive disorder for 8 of the 30 sampled enrollee-years. Specifically:

- For 6 enrollee-years, the medical records in each case did not support a major depressive disorder diagnosis.

For example, for 1 enrollee-year, the independent medical review contractor noted that “there is no documentation of any condition that will result in the assignment of [the Major Depressive, Bipolar, and Paranoid Disorders] HCC. There is documentation of [d]epression that does not result in an HCC.”

- For the remaining 2 enrollee-years, SelectCare in each case could not locate any medical records to support the major depressive disorder diagnosis; therefore, the HCCs for Major Depressive, Bipolar, and Paranoid Disorder were not validated.

As a result of these errors, the HCCs for Major Depressive, Bipolar, and Paranoid Disorder were not validated, and SelectCare received \$18,545 in overpayments for these eight sampled enrollee-years.

²³ In contrast to the enrollee-years that occurred in 2015 (for which CMS used the Version 12 model, for 2016, CMS used only the Version 22 model, which did not include an HCC for Old Myocardial Infarction, to calculate risk scores (footnote 7). An “old myocardial infarction” is a distinct diagnosis that represents a myocardial infarction that occurred more than 4 weeks previously, has no current symptoms directly associated with that myocardial infarction, and requires no current care.

Incorrectly Submitted Diagnosis Codes for Embolism

SelectCare incorrectly submitted diagnosis codes for embolism for 24 of the 30 sampled enrollee-years. Specifically:

- For 12 enrollee-years, the medical records indicated in each case that the individual had previously had an embolism, but the records did not justify an embolism diagnosis at the time of the physician’s service.

For example, for 1 enrollee-year, the independent medical review contractor noted that “there is no documentation of any condition that will result in [the] assignment of [an Embolism] HCC. There is documentation of a past medical history of deep vein thrombosis²⁴ that does not result in an [Embolism] HCC.”

- For 11 enrollee-years, the medical records in each case did not support the embolism diagnosis.

For example, for 1 enrollee-year, the independent medical review contractor noted that “there is no documentation of any condition that will result in the assignment of [an Embolism] HCC. There is documentation of a right upper extremity superficial thrombosis²⁵ that does not result in an [Embolism] HCC.”

- For the remaining 1 enrollee-year, SelectCare could not locate any medical records to support the embolism diagnosis; therefore, the HCCs for Embolism were not validated.

As a result of these errors, the Embolism HCCs were not validated, and SelectCare received \$47,507 in overpayments for these 24 sampled enrollee-years.

Incorrectly Submitted Diagnosis Codes for Vascular Claudication

SelectCare incorrectly submitted diagnosis codes for vascular claudication for 12 of the 30 sampled enrollee-years. Specifically:

- For 11 enrollee-years, the medical records in each case did not support a vascular claudication diagnosis.

For example, for 1 enrollee-year, the independent medical review contractor noted that “there is no documentation of any condition that will result in the assignment of [the

²⁴ Deep vein thrombosis is a blood clot in one or more of the deep veins, usually in the legs.

²⁵ Superficial venous thrombosis in the upper extremity is a blood clot in a superficial vein that most commonly results from IV infusions or catheterization.

Vascular Disease] HCC. There is documentation of ruled out deep vein thrombosis that would not be coded based on outpatient guidelines of [the] suspected/ruled out diagnoses.”

- For the remaining 1 enrollee-year, SelectCare could not locate any medical records to support the vascular claudication diagnosis; therefore, the HCCs for Vascular Disease were not validated.

As a result of these errors, the HCCs for Vascular Disease were not validated, and SelectCare received \$27,098 in overpayments for these 12 sampled enrollee-years.

Incorrectly Submitted Diagnosis Codes for Lung Cancer

SelectCare incorrectly submitted diagnosis codes for lung cancer for 24 of the 30 sampled enrollee-years.²⁶ Specifically:

- For 12 enrollee-years, the medical records indicated in each case that the individual previously had lung cancer, but the records did not justify a lung cancer diagnosis at the time of the physician’s service.

For example, for 1 enrollee-year, the independent medical review contractor noted that “there is no documentation of any condition that will result in the assignment of [the Lung Cancer] HCC. There is documentation of a past medical history of lung cancer that does not result in an HCC.”

- For 7 enrollee-years, the medical records in each case did not support the submitted lung cancer diagnosis. However, we identified support for another diagnosis that mapped to an HCC for a less severe manifestation of the related-disease group. Accordingly, SelectCare should not have received an increased payment for the submitted lung cancer diagnosis. Rather, it should have received a lesser increased payment for the other diagnosis identified.

Table 3 on the next page identifies the HCCs for the less severe manifestation of the related-disease groups that were supported for the 7 enrollee-years.

²⁶ For 1 of the 6 enrollee-years for which we found support, the independent medical review contractor found support for another diagnosis code that should have been submitted instead of the reviewed diagnosis code. This caused an underpayment for this enrollee-year, and we account for the difference in our net overpayment calculations.

Table 3: HCCs for a Less Severe Manifestation of the Related-Disease Group That Were Supported (Instead of a Lung Cancer HCC)

Count of Enrollee-Years	Less Severe Hierarchical Condition Category
2	Breast, Prostate, Colorectal and Other Cancers and Tumors (Version 12 model) and Colorectal, Bladder and Other Cancers (Version 22 model)
2	Lymphoma and Other Cancers (Version 22 model)
1	Breast, Prostate, Colorectal and Other Cancers and Tumors (Version 12 model) and Breast, Prostate and Other Cancers and Tumors (Version 22 model)
1	Colorectal, Bladder and Other Cancers (Version 22 model)
1	Breast, Prostate and Other Cancers and Tumors (Version 22 model)

- For 4 enrollee-years, the medical records in each case did not contain sufficient information to support a lung cancer diagnosis.

For example, for 1 enrollee-year, the independent medical review contractor noted that “there is no documentation of any condition that will result in the assignment of [the Lung Cancer] HCC. There is documentation of a lung mass [diagnosis] which does not result in an HCC.”²⁷

- For the remaining 1 enrollee-year, the independent medical review contractor determined that SelectCare should have submitted a diagnosis code to CMS for a secondary malignant neoplasm of lung diagnosis (which was supported in the medical record) instead of the reviewed diagnosis (which was not supported in the medical record). The supported diagnosis mapped to an HCC for a more severe manifestation of the disease in the related-disease group (footnote 30) than what was originally included in the enrollee-year’s risk score and resulted in an underpayment.

As a result of these errors, the Lung Cancer HCCs were not validated, and SelectCare received \$118,172 in net overpayments for these 24 sampled enrollee-years.

²⁷ A lung mass is an abnormal spot or area in the lungs larger than 3 centimeters, about 1.5 inches, in size.

Incorrectly Submitted Diagnosis Codes for Breast Cancer

SelectCare incorrectly submitted diagnosis codes for breast cancer for 27 of the 30 sampled enrollee-years. Specifically:

- For 23 enrollee-years, the medical records indicated in each case that the individual had previously had breast cancer, but the records did not justify a breast cancer diagnosis at the time of the physician’s service.

For example, for 1 enrollee-year, the independent medical review contractor noted that “there is no documentation of any condition that will result in the assignment of [the Breast Cancer] HCC. There is documentation of a history of breast cancer, which does not result in an HCC.”

- For 2 enrollee-years, the medical records in each case did not contain sufficient information to support a breast cancer diagnosis.

For example, for 1 enrollee-year, the independent medical review contractor noted that “there is no documentation of any condition that will result in the assignment of [the Breast Cancer] HCC.”

- For the remaining 2 enrollee-years, SelectCare could not locate any medical records to support the breast cancer diagnosis; therefore, the Breast Cancer HCCs were not validated.

As a result of these errors, the Breast Cancer HCCs were not validated, and SelectCare received \$32,408 in overpayments for these 27 sampled enrollee-years.

Incorrectly Submitted Diagnosis Codes for Colon Cancer

SelectCare incorrectly submitted diagnosis codes for colon cancer for 28 of the 30 sampled enrollee-years. Specifically:

- For 23 enrollee-years, the medical records indicated in each case that the individual had previously had colon cancer, but the records did not justify a colon cancer diagnosis at the time of the physician’s service.

For example, for 1 enrollee-year, the independent medical review contractor noted that “there is no documentation of any condition that will result in the assignment of [the Colon Cancer] HCC. There is documentation of a personal history of neoplasm of colon²⁸ [diagnosis] that does not result in an HCC.”

²⁸ Colon neoplasm is an abnormal mass of tissue that forms when cells grow and divide more than they should or do not die when they should. Neoplasms can be benign (not cancer) or malignant (cancer).

- For 3 enrollee-years, the medical records did not contain sufficient information to support a colon cancer diagnosis.

For example, for 1 enrollee-year, the independent medical review contractor noted that “there is no documentation of any condition that will result in assignment of [the Colon Cancer] HCC.”

- For the remaining 2 enrollee-years, SelectCare could not locate any medical records to support the colon cancer diagnosis; therefore, the Colon Cancer HCCs were not validated.

As a result of these errors, the Colon Cancer HCCs were not validated, and SelectCare received \$54,855 in overpayments for these 28 sampled enrollee-years.

Incorrectly Submitted Diagnosis Codes for Prostate Cancer

SelectCare incorrectly submitted diagnosis codes for prostate cancer for 28 of the 30 sampled enrollee-years. Specifically:

- For 16 enrollee-years, the medical records indicated in each case that the individual had previously had prostate cancer, but the records did not justify a prostate cancer diagnosis at the time of the physician’s service.

For example, for 1 enrollee-year, the independent medical review contractor noted that “there is no documentation of any condition that will result in the assignment of [the Prostate Cancer] HCC. There is documentation of a past medical history of prostate cancer [diagnosis] that does not result in an HCC.”

- For 11 enrollee-years, the medical records in each case did not contain sufficient information to support a prostate cancer diagnosis.

For example, for 1 enrollee-year, the independent medical review contractor noted that “there is no documentation of any condition that will result in the assignment of [the Prostate Cancer] HCC. There is no sufficient documentation to support active or history of prostate cancer.”

- For the remaining 1 enrollee-year, SelectCare could not locate any medical records to support the prostate cancer diagnosis; therefore, the Prostate Cancer HCC was not validated.

As a result of these errors, the Prostate Cancer HCCs were not validated, and SelectCare received \$32,787 in overpayments for these 28 sampled enrollee-years.

Potentially Mis-keyed Diagnosis Codes

SelectCare submitted potentially mis-keyed diagnosis codes for 12 of the 15 enrollee-years. In each of these cases, the enrollee-years received multiple diagnoses for a condition but received only one—potentially mis-keyed—diagnosis for an unrelated condition. Appendix F contains the potentially mis-keyed diagnosis codes that we identified for the 12 enrollee-years.

- For 10 enrollee-years, the medical records did not support the diagnosis for the unrelated condition. Because of these errors, SelectCare submitted to CMS unsupported diagnosis codes that mapped to unvalidated HCCs.

For example, for 1 enrollee-year, SelectCare submitted 11 diagnosis codes for unspecified inflammatory polyarthropathy (714.9) and only 1 diagnosis code for malignant neoplasm of the breast (174.9) to CMS. The independent medical review contractor limited its review to the malignant neoplasm of the breast diagnosis, for which it did not find support.

- For 1 enrollee-year, the medical records supported a different diagnosis code for the unrelated condition that mapped to another HCC (in the Version 22 model) of a less severe manifestation of the related-disease group. The independent medical review contractor noted that “there is no documentation of any condition that will result in the assignment of [the Diabetes with Acute Complications] HCC. There is documentation of [a] diabetic nephropathy, uncontrolled [diagnosis] resulting in [the Diabetes with Chronic Complications] HCC.” Because the supported HCC had the same numerical factor as the unsupported HCC, there was no payment effect.
- For the remaining 1 enrollee-year, SelectCare could not locate any medical records to support the potentially mis-keyed diagnosis code; therefore, the HCC associated with the potentially mis-keyed diagnosis code was not validated.

Appendix F contains the HCCs that were not validated for the 12 enrollee-years (Table 7) and the HCC for the comparable manifestation of the related-disease group that was supported for the 1 enrollee-year (Table 8).

As a result of these errors, the HCCs associated with the potentially mis-keyed diagnosis codes were not validated, and SelectCare received \$48,005 in overpayments for these 12 enrollee-years.

Summary of Net Overpayments for Incorrectly Submitted Diagnosis Codes

In summary, and with respect to the 10 high-risk groups covered by our audit, SelectCare received \$482,601 in net overpayments for the 220 sampled enrollee-years.

THE POLICIES AND PROCEDURES THAT SELECTCARE OF TEXAS HAD TO PREVENT, DETECT, AND CORRECT NONCOMPLIANCE WITH FEDERAL REQUIREMENTS COULD BE IMPROVED

As demonstrated by the errors found in our sample, the policies and procedures that SelectCare had to prevent, detect, and correct noncompliance with CMS's program requirements, as mandated by Federal regulations (42 CFR § 422.503(b)(4)(vi)), could be improved.

SelectCare had compliance procedures in place for our audit period that were designed to determine whether the diagnosis codes that it submitted to CMS for use in CMS's risk adjustment program were correct. Specifically, SelectCare selected certain claims and then reviewed the associated medical records to determine whether the diagnosis codes that it submitted to CMS were supported. In doing so, SelectCare provided guidance to its coding staff to accurately and consistently code diagnoses to the highest known specificity at the time of the visit to reflect the more accurate status of the enrollee. However, those procedures did not focus on specific high-risk diagnosis codes, including those codes we identified as being at a higher risk for being incorrect.

However, SelectCare officials explained to us that SelectCare's current compliance program has changed under new ownership (footnote 3) and that it has policies and procedures in place designed to ensure that it submits complete and accurate Risk Adjustment information to CMS. SelectCare officials also explained that SelectCare has established a Risk Adjustment Team consisting of certified medical coders, referred to as Risk Adjustment Coders, who review medical records to confirm the propriety of coding based on applicable coding standards and guidelines, taking appropriate corrective action when warranted. This corrective action could result in deleting certain diagnosis codes from CMS's risk adjustment systems. In this manner, SelectCare's procedure state that "[t]his delete process is inclusive of the high-risk diagnoses included in OIG audits." Additionally, SelectCare conducts routine audits of medical charts that the Risk Adjustment Team coded to determine the accuracy of the diagnosis coding based on underlying clinical documentation.

Regarding the 10 sampled enrollee-years for which SelectCare could not locate any medical records to support the diagnosis codes that it submitted to CMS, SelectCare officials explained to us that, in some instances, providers' old electronic medical record systems could not be accessed or were corrupted. SelectCare officials also told us that, in other instances, provider offices were permanently closed, or medical records were missing or could not be located for the appropriate time period.

SELECTCARE OF TEXAS RECEIVED NET OVERPAYMENTS

As a result of the errors we identified, the HCCs for these high-risk diagnosis codes were not validated. On the basis of our sample results, we estimated that SelectCare received at least \$5,124,798 in net overpayments for 2015 and 2016. (See Appendix D for sample results and estimates.)

Because of Federal regulations that limit the use of extrapolation in Risk Adjustment Data Validation (RADV) audits for recovery purposes to payment year 2018 and forward, we are reporting the estimated net overpayment amount but are recommending a refund of only the \$482,601 in net overpayments that SelectCare received for the 220 sampled enrollee-years.²⁹

RECOMMENDATIONS

We recommend that SelectCare of Texas, Inc.:

- refund to the Federal Government the \$482,601 in net overpayments;
- identify, for the high-risk diagnoses included in this report, similar instances of noncompliance that occurred before and after our audit period and refund any resulting overpayments to the Federal Government; and
- review its existing compliance procedures to identify potential 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 any necessary steps to enhance those current procedures.

SELECTCARE OF TEXAS COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

In written comments on our draft report, SelectCare did not agree with our findings and recommendations. With regard to our first recommendation, SelectCare provided additional information regarding why it believed that either the associated HCCs were validated or an HCC for a more severe manifestation of the related-disease group was validated for 4 of the 222 enrollee-years identified as errors in our draft report. However, SelectCare did not provide any new records or information to support the associated HCCs for the remaining 218 enrollee-years.

SelectCare also stated that our audit methodology was flawed because we did not permit appeals of audit findings and applied standards that were not promulgated pursuant to legal requirements. Further, SelectCare stated that we improperly implied that it was expected to assure the accuracy of 100 percent of the diagnosis codes that it received from providers and submitted to CMS. Although SelectCare asked us to revise our second and third recommendations, it stated that it would consider our third recommendation and that it "is engaged in a continual process of evaluating and enhancing its compliance procedures."

After reviewing SelectCare's comments and the additional information it provided, we reduced the number of enrollee-years in error from 222 to 220 and adjusted our calculation of net

²⁹ CMS updated Federal regulations that limit the use of extrapolation in RADV audits to payment years 2018 and forward (88 Fed. Reg. 6643, (Feb. 1, 2023)).

overpayments. Accordingly, we reduced the amount conveyed in our first recommendation from \$501,412 to \$482,601 for this final report. We made no changes to our second and third recommendations.

A summary of SelectCare's comments and our responses follows. SelectCare's comments are included in their entirety as Appendix G.

SELECTCARE DID NOT AGREE WITH THE OFFICE OF INSPECTOR GENERAL'S FINDINGS FOR 4 SAMPLED ENROLLEE-YEARS

SelectCare Comments

SelectCare did not agree with our draft report findings for 4 sampled enrollee-years (in the prostate cancer, major depressive disorder, vascular claudication, and lung cancer high-risk groups) and requested that we reconsider our findings.

For 3 of the 4 sampled enrollee-years, SelectCare provided additional information (including medical records and explanations) supporting its belief that the HCCs for the sampled enrollee-years were validated. For 1 of the 4 enrollee-years, SelectCare stated that there was support for a diagnosis that mapped to an HCC for a more severe manifestation of the related-disease group.³⁰ SelectCare's explanations are shown in Appendix G (Appendix A of its comments).

Office of Inspector General Response

For the 3 sampled enrollee-years for which SelectCare provided additional information, our independent medical review contractor found support for diagnoses that validated two of the HCCs under review (from the Major Depressive Disorder and Vascular Claudication high-risk groups). However, the contractor did not find support for the other HCC under review (from the prostate cancer high-risk group). Specifically, the contractor upheld its original decision that the HCC was not validated and noted:

Decision upheld at reconsideration. There is documentation of a past medical history of prostate cancer which does not result in an HCC. The provider has documented, 'S/P Prostate Ca'. The Surgical History section of the note documents treatment completed a year prior to the date of service. There is no indication that the prostate cancer is still active or is recurring. Patient awaiting follow up surveillance prophylactically.

³⁰ SelectCare previously provided a medical record, for an enrollee in the Lung Cancer high-risk group, it believed supported a diagnosis of metastatic pulmonary disease, which translates to the assignment of an HCC for Metastatic Cancer and Acute Leukemia, a more severe HCC in the same hierarchy as the HCC under review for Lung, Upper Digestive Tract, and Other Severe Cancers.

For the remaining enrollee-year (from the lung cancer high-risk group), the independent medical review contractor determined that SelectCare should have submitted a diagnosis code to CMS for a secondary malignant neoplasm of lung diagnosis (which was supported in the medical record) instead of the reviewed diagnosis (which was not supported in the medical record). The supported diagnosis mapped to an HCC for a more severe manifestation of disease in the related-disease group (footnote 30) than what was originally included in the enrollee-year's risk score and resulted in an underpayment. Although we adjusted our calculation of net overpayments, we did not reduce the number of errors for this enrollee-year because the HCC under review was not validated.

The independent medical review contractor confirmed that SelectCare's comments, including the additional information provided in its Appendix A, had no impact on the decisions that the contractor made for other sampled enrollee-years and stated that there were no "systemic issues identified" in its reviews.

As a result, we reduced the number of enrollee-years in error from 222 (as reported in our draft report) to 220. We also revised our findings and reduced the associated monetary recommendation.

SELECTCARE HAD LEGAL CONCERNS WITH THE OFFICE OF INSPECTOR GENERAL'S AUDIT METHODOLOGY

SelectCare Comments

SelectCare stated that it had legal concerns with our audit methodology, which according to SelectCare was flawed, and made the following two points:

- SelectCare stated that we did not provide a process for appealing the medical record review findings and that this is contrary to CMS's standard appeals process. To this point, SelectCare referred to Federal regulations that, according to SelectCare, established that MA organizations "that do not agree with RADV results may appeal, including for disputes related to medical record review determinations and payment error calculations."
- SelectCare also stated that our audit "methodology applied substantive standards that were not promulgated pursuant to the notice-and-comment requirements set forth in *Azar v. Allina Health Services*."³¹ In this regard, SelectCare said that "the Supreme Court held that substantive standards governing payments under Medicare must be promulgated pursuant to notice-and-comment rulemaking." SelectCare also stated that it "reserves all rights with respect to substantive standards set forth in the *Medicare Managed Care Manual*, the *Risk Adjustment Training Manual*, and

³¹ *Azar v. Allina Health Services*, 139 S. Ct. 1804 (2019).

other documents that were not promulgated in accordance with 42 U.S.C. § 1395hh(b) and notice-and-comment requirements.”

Office of Inspector General Response

We disagree with the legal concerns that SelectCare referred to in its comments:

- OIG audit findings and recommendations do not represent final determinations by CMS. Action officials at CMS will determine whether an overpayment exists and will recoup any overpayments consistent with its policies and procedures. In accordance with 42 CFR § 422.311, which addresses audits conducted by the Secretary (including those conducted by OIG), if a disallowance is taken, MA organizations have the right to appeal the determination that an overpayment occurred through the Secretary’s RADV appeals process.
- We disagree with SelectCare’s assertion that our audit methodology applied substantive standards that were not promulgated pursuant to the notice-and-comment requirements set forth in *Azar v. Allina Health Services*. Specifically, the Manual is legally binding on an MA organization based not only on regulation, but also on its contract with CMS. Federal regulations state that MA organizations are responsible for the accuracy, completeness, and truthfulness of the data submitted to CMS for payment purposes and that such data must conform to all relevant national standards.³² In addition, MA organizations that contract with CMS must agree to follow CMS’s instructions, including the provisions of the Manual.³³ SelectCare agreed to comply with the Manual under the terms of its contract with CMS and is bound by the requirements of that contract, including any applicable provisions of the Manual.

SELECTCARE STATED THAT THE OFFICE OF INSPECTOR GENERAL’S FINDINGS AND RECOMMENDATIONS IMPROPERLY IMPLIED THAT IT IS EXPECTED TO ASSURE 100-PERCENT ACCURACY OF DIAGNOSIS CODES

SelectCare Comments

SelectCare said that “[v]arious aspects of [our report] imply that [MA organizations’] compliance efforts must assure [100-percent] accuracy with respect to the vast quantities of diagnosis codes they receive from providers and are required to submit to CMS.” In this respect, SelectCare said that our statement that its compliance procedures were not always effective should be eliminated because “no compliance program is reasonably expected to eliminate all types of errors.” To this point, SelectCare said that verifying 100 percent of the

³² 42 CFR §§ 422.504(l) and 422.310(d)(1).

³³ 42 CFR § 422.504(a).

risk adjustment data for the millions of claims that it receives from providers would be prohibitive for MA organizations.

Moreover, SelectCare stated that CMS has acknowledged that MA organizations “cannot reasonably be expected to know that every piece of data is correct.” SelectCare also said that the attestations that MA organizations make, as required by Federal regulations, with respect to risk adjustment data “[do] not impose a requirement for an [MA organization] to ensure that all submitted [diagnosis] codes are supported by medical records.” To support its position, SelectCare referred to a court case in which, according to SelectCare, the court stated that the 2014 Overpayment Rule required “insurers to refund amounts they *know* were overpayments, i.e., payments they *are aware* lack support in a beneficiary’s medical record. That limited scope does not impose a self-auditing mandate.”^{34, 35}

In this respect, SelectCare requested that our report “expressly include and acknowledge . . . that [MA organizations] do not have an obligation to identify and delete every erroneous diagnosis, or even a large fraction of them.” SelectCare also requested that we make corresponding revisions to our recommendations.

Office of Inspector General Response

SelectCare’s response implied that we opined on the effectiveness of its entire compliance program. That was not our intention or our focus for this audit. Rather, we limited the scope of our audit to selected diagnoses that we determined to be at high risk for being miscoded.

We do not fully agree with SelectCare’s interpretation of the Federal requirements. With regard to SelectCare’s statement that verifying 100 percent of submitted risk adjustment data would be prohibitive for MA organizations, we recognize that CMS applies a “good faith attestation” standard when MA organizations certify the large volume of data that they submit to CMS for use in the risk adjustment program.³⁶ We recognize as well that, as SelectCare said, the MA regulatory framework does not include an expectation or requirement that MA organizations ensure 100-percent medical record support for diagnosis codes submitted to CMS.

However, CMS has assigned the responsibility for dealing with potential compliance issues to the MA organizations. Federal regulations (42 CFR § 422.503(b)(4)(vi)) state that MA organizations must “implement an effective compliance program, which must include measures that prevent, detect, and correct noncompliance with CMS’ program requirements.”

³⁴ *UnitedHealthcare Ins. Co. v. Becerra*, 9 F.4th 868, 884, No. 18-5326 (D.C. Cir. Aug. 13, 2021) (emphasis in original).

³⁵ The 2014 Overpayment Rule that SelectCare references is 42 U.S.C. §§ 1301-1320d-8, 1395-1395hhh.

³⁶ 79 Fed. Reg. 29844, 29926 (May 23, 2014).

In this regard, CMS has provided additional guidance in chapter 7, § 40, of the Manual, which states:

If upon conducting an internal review of submitted diagnosis codes, the [MA organization] determines that any diagnosis codes that have been submitted do not meet risk adjustment submission requirements, the plan sponsor is responsible for deleting the submitted diagnosis codes as soon as possible. . . . Once CMS calculates the final risk scores for a payment year, [MA organizations] may request a recalculation of payment upon discovering the submission of inaccurate diagnosis codes that CMS used to calculate a final risk score for a previous payment year and that had an impact on the final payment. [MA organizations] must inform CMS immediately upon such a finding.

Further, Federal regulations require MA organizations to implement procedures and a system for investigating “potential compliance problems as identified in the course of self-evaluations and audits, correcting such problems promptly and thoroughly to reduce the potential for recurrence” (42 CFR § 422.503(b)(4)(vi)(G)). (See Appendix E.) Our audit revealed a significant number of errors (220 of 285 enrollee-years) with unsupported diagnosis codes for the high-risk areas we audited. (See Appendix D.) Thus, we did not change our recommendation for SelectCare to identify, for the high-risk diagnoses included in this report, similar instances of noncompliance that occurred before and after our audit period and refund any resulting overpayments to the Federal Government.

In addition, we do not fully agree with the statements that SelectCare made regarding the Overpayment Rule. We agree with SelectCare that the Overpayment Rule requires MA organizations to delete erroneous diagnoses when those errors are identified; however, we do not agree with SelectCare that the provisions of the Overpayment Rule limit an MA organization’s actions to only those overpayments. Specifically, the Overpayment Rule does not relieve an MA organization from the requirements of the Federal regulations to investigate potential compliance problems as identified in audits and to correct such problems.

In summary, these comments did not cause us to make any additional changes to our report, including our recommendations.

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

CMS paid SelectCare \$1,551,647,510 to provide coverage to its enrollees for 2015 and 2016. We identified a sampling frame of 3,916 unique enrollee-years on whose behalf providers documented high-risk diagnosis codes during the 2014 and 2015 service years; SelectCare received \$59,311,652 in payments from CMS for these enrollee-years for 2015 and 2016. We selected for audit 285 enrollee-years with payments totaling \$4,303,475.

The 285 enrollee-years included 30 acute stroke diagnoses, 30 acute heart attack diagnoses, 30 major depressive disorder diagnoses, 30 embolism diagnoses, 30 vascular claudication diagnoses, 30 lung cancer diagnoses, 30 breast cancer diagnoses, 30 colon cancer diagnoses, 30 prostate cancer diagnoses, and 15 potentially mis-keyed diagnoses. We limited our review to the portions of the payments that were associated with these high-risk diagnosis codes, which totaled \$689,604.

Our audit objective did not require an understanding or assessment of SelectCare's complete internal control structure, and we limited our review of internal controls to those directly related to our objective.

We performed audit work from June 2019 through April 2023.

METHODOLOGY

To accomplish our objective, we performed the following steps:

- We reviewed applicable Federal laws, regulations, and guidance.
- We discussed with CMS program officials the Federal requirements that MA organizations should follow when submitting diagnosis codes to CMS.
- We identified, through data mining and discussions with medical professionals at a Medicare administrative contractor, diagnosis codes and HCCs that were at high risk for noncompliance. We also identified the diagnosis codes that potentially should have been used for cases in which the high-risk diagnoses were miscoded.
- We consolidated the high-risk diagnosis codes into specific groups, which included:
 - 6 diagnosis codes for acute stroke,
 - 35 diagnosis codes for acute heart attack,
 - 29 diagnosis codes for major depressive disorder,
 - 51 diagnosis codes for embolism,
 - 4 diagnosis codes for vascular claudication,

- 24 diagnosis codes for lung cancer,
 - 65 diagnosis codes for breast cancer,
 - 20 diagnosis codes for colon cancer, and
 - 2 diagnosis codes for prostate cancer.
- We developed an analytical tool that identified 832 scenarios in which either ICD-9 or ICD-10 diagnosis codes, when mis-keyed into an electronic claim because of a data transposition or other data entry error, could result in the assignment of an incorrect HCC to an enrollee’s risk score. For each of the 832 occurrences, the tool identified a potentially mis-keyed diagnosis code and the likely correct diagnosis code. Accordingly, we considered the mis-keyed diagnosis codes to be high risk.
 - We used CMS’s systems to identify the enrollee-years on whose behalf providers documented the high-risk diagnosis codes. Specifically, we used extracts from CMS’s:
 - Risk Adjustment Processing System (RAPS)³⁷ to identify enrollees who received high-risk diagnosis codes from a physician during the service years;
 - Risk Adjustment System (RAS)³⁸ to identify enrollees who received an HCC for the high-risk diagnosis codes;
 - Medicare Advantage Prescription Drug System (MARx)³⁹ to identify enrollees for whom CMS made monthly Medicare payments to SelectCare, before applying the budget sequestration reduction, for the relevant portions of the service and payment years;
 - Encounter Data System (EDS)⁴⁰ to identify enrollees who received specific procedures; and
 - Prescription Drug Event (PDE) file⁴¹ to identify enrollees who had Medicare claims with certain medications dispensed on their behalf.
 - We interviewed SelectCare officials to gain an understanding of (1) the policies and procedures that SelectCare followed to submit diagnosis codes to CMS for use in the

³⁷ MA organizations use the RAPS to submit diagnosis codes to CMS.

³⁸ The RAS identifies the HCCs that CMS factors into each enrollee’s risk score calculation.

³⁹ The MARx identifies the payments made to MA organizations.

⁴⁰ The EDS contains information on each item (including procedures) and service provided to enrollees.

⁴¹ The PDE file contains claims with prescription drugs that have been dispensed to enrollees through the Medicare Part D (prescription drug coverage) program.

risk-adjustment program and (2) SelectCare’s monitoring of those diagnosis codes to identify and detect noncompliance with Federal requirements.

- We selected for audit a sample of 285 enrollee-years that included (1) a stratified random sample of 270 enrollee-years and (2) 15 enrollee-years as identified by our analytical tool.
- We used an independent medical review contractor to perform a coding review for 273 of the 285 enrollee-years to determine whether the high-risk diagnosis codes submitted to CMS complied with Federal requirements.^{42, 43}
- The independent medical review contractor’s coding review followed a specific process to determine whether there was support for a diagnosis code and the associated HCC:
 - If the first senior coder found support for the diagnosis code on the medical record, the HCC was considered validated.
 - If the first senior coder did not find support on the medical record, a second senior coder performed a separate review of the same medical record:
 - If the second senior coder also did not find support, the HCC was not considered validated.
 - If the second senior coder found support, then a physician independently reviewed the medical record to make the final determination.
 - If either the first or second senior coder asked a physician for assistance, the physician’s decision became the final determination.
- We used the results of the independent medical review contractor and CMS’s systems to calculate overpayments or underpayments (if any) for each enrollee-year. Specifically, we calculated:
 - a revised risk score in accordance with CMS’s risk adjustment program and
 - the payment that CMS should have made for each enrollee-year.

⁴² Our independent medical review contractor used senior coders, all of whom possessed one or more of the following qualifications and certifications: Registered Health Information Technician (RHIT), Certified Coding Specialist (CCS), Certified Coding Specialist – Physician-Based (CCS-P), Certified Professional Coder (CPC), and Certified Risk Coder (CRC). RHITs have completed a 2-year degree program and have passed an American Health Information Management Association (AHIMA) certification exam. The AHIMA also credentials individuals with CCS and CCS-P certifications, and the American Academy of Professional Coders credentials both CPCs and CRCs.

⁴³ SelectCare could not locate medical records for the remaining 12 sampled enrollee-years.

- We estimated the total net overpayment made to SelectCare during the audit period.
- We limited the total net overpayments that we recommended for recovery to the sampled enrollee-years.⁴⁴
- We discussed the results of our audit with SelectCare officials.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

⁴⁴ Federal regulations (42 CFR § 422.311(a)) state: “. . . the Secretary annually conducts RADV audits to ensure risk-adjusted payment integrity and accuracy.” Recovery of improper payments from MA organizations will be conducted in accordance with the Secretary’s payment error extrapolation and recovery methodologies. CMS may apply extrapolation to audits for payment year 2018 and subsequent payment years (88 Fed. Reg. 6643, 6655 (Feb. 1, 2023)).

APPENDIX B: RELATED OFFICE OF INSPECTOR GENERAL REPORTS

Report Title	Report Number	Date Issued
<i>Medicare Advantage Compliance Audit of Specific Diagnosis Codes that Cigna-HealthSpring of Tennessee, Inc. (Contract H4454) Submitted to CMS</i>	<u>A-07-19-01193</u>	12/22/2022
<i>Medicare Advantage Compliance Audit of Specific Diagnosis Codes That BCBS of Rhode Island (Contract H4152) Submitted to CMS</i>	<u>A-01-20-00500</u>	11/16/2022
<i>Medicare Advantage Compliance Audit of Specific Diagnosis Codes That California Physician’s Service, Inc. (Contract H0504) Submitted to CMS</i>	<u>A-09-19-03001</u>	11/10/2022
<i>Medicare Advantage Compliance Audit of Specific Diagnosis Codes That HumanaChoice (Contract R5826) Submitted to CMS</i>	<u>A-05-19-00039</u>	9/30/2022
<i>Medicare Advantage Compliance Audit of Specific Diagnosis Codes That Highmark Senior Health Company (H3916) Submitted to CMS</i>	<u>A-03-19-00001</u>	9/29/2022
<i>Medicare Advantage Compliance Audit of Specific Diagnosis Codes That BlueCross BlueShield of Tennessee, Inc. (Contract (H7917) Submitted to CMS</i>	<u>A-07-19-01195</u>	9/29/2022
<i>Medicare Advantage Compliance Audit of Specific Diagnosis Codes That Regence BlueCross BlueShield of Oregon (Contract H3817) Submitted to CMS</i>	<u>A-09-20-03009</u>	9/13/2022
<i>Medicare Advantage Compliance Audit of Specific Diagnosis Codes That WellCare of Florida, Inc., (Contract H1032) Submitted to CMS</i>	<u>A-04-19-07084</u>	8/29/2022
<i>Medicare Advantage Compliance Audit of Specific Diagnosis Codes That Cariten Health Plan, Inc., (Contract H4461) Submitted to CMS</i>	<u>A-02-20-01009</u>	7/18/2022
<i>Medicare Advantage Compliance Audit of Specific Diagnosis Codes That Peoples Health Network (Contract H1961) Submitted to CMS</i>	<u>A-06-18-05002</u>	5/25/2022

APPENDIX C: STATISTICAL SAMPLING METHODOLOGY

SAMPLING FRAME

We identified SelectCare enrollees who (1) were continuously enrolled in SelectCare throughout all of the 2014 or 2015 service year and January of the following year, (2) were not classified as being enrolled in hospice or as having end-stage renal disease status at any time during 2014 or 2015 or in January of the following year, and (3) received a high-risk diagnosis during 2014 or 2015 that caused an increased payment to SelectCare for 2015 or 2016, respectively.

We presented the data for these enrollees to SelectCare for verification and performed an analysis of the data included in CMS's systems to ensure that the high-risk diagnosis codes increased CMS's payments to SelectCare. After we performed these steps, our finalized sampling frame consisted of 3,916 enrollee-years.

SAMPLE UNIT

The sample unit was an enrollee-year, which covered either payment year 2015 or 2016.

SAMPLE DESIGN

The design for our statistical sample comprised nine strata of enrollee-years with either:

- an acute stroke diagnosis (that mapped to the HCC for Ischemic or Unspecified Stroke) on only one physician claim during the service year but did not have that diagnosis on a corresponding inpatient or outpatient hospital claim (1,001 enrollee-years);
- a diagnosis (that mapped to an Acute Heart Attack HCC) on only one physician or outpatient claim during the service year but did not have that diagnosis on a corresponding inpatient hospital claim either 60 days before or 60 days after the physician or outpatient claim (505 enrollee-years);
- a major depressive disorder diagnosis (which maps to the HCC for Major Depressive, Bipolar, and Paranoid Disorders) on only one claim during the service year but did not have an antidepressant medication dispensed on his or her behalf (834 enrollee-years);
- a diagnosis (that mapped to an Embolism HCC) on only one claim during the service year but did not have an anticoagulant medication dispensed on his or her behalf (247 enrollee-years);
- a vascular claudication diagnosis (that mapped to the HCC for Vascular Disease) on only one claim during the service year but for which medication was dispensed for neurogenic claudication (399 enrollee-years);

- a lung cancer diagnosis (that mapped to the HCC for Lung and Other Severe Cancers) on only one claim during the service year but did not have surgical therapy, radiation treatments, or chemotherapy drug treatments related to the lung cancer diagnosis administered within a 6-month period before or after the diagnosis (95 enrollee-years);
- a breast cancer diagnosis (that mapped to the HCC for Breast, Prostate, and Other Cancers and Tumors) on only one claim during the service year but did not have surgical therapy, radiation treatments, or chemotherapy drug treatments related to the breast cancer diagnosis administered within a 6-month period before or after the diagnosis (358 enrollee-years);
- a colon cancer diagnosis (that mapped to the HCC for Colorectal, Bladder, and Other Cancers) on only one claim during the service year but did not have surgical therapy, radiation treatments, or chemotherapy drug treatments administered within a 6-month period before or after the diagnosis (213 enrollee-years); or
- a prostate cancer diagnosis (that mapped to the HCC for Breast, Prostate, and Other Cancers and Tumors) on only one claim during the service year but did not have surgical therapy, radiation treatments, or chemotherapy drug treatments administered within a 6-month period before or after the diagnosis (249 enrollee-years).

The specific strata are shown in Table 4.

Table 4: Sample Design for Audited High-Risk Groups

Stratum (High-Risk Groups)	Frame Count of Enrollee-Years	CMS Payment for HCCs in Audited High-Risk Groups*	Sample Size
1 – Acute stroke	1,001	\$2,246,278	30
2 – Acute heart attack	505	950,726	30
3 – Major depressive disorder	834	1,998,078	30
4 – Embolism	247	518,965	30
5 – Vascular claudication	399	845,963	30
6 – Lung cancer	95	589,033	30
7 – Breast cancer	358	422,854	30
8 – Colon cancer	213	409,569	30
9 – Prostate cancer	249	290,122	30
Total – First Nine Strata	3,901	\$8,271,588	270

*Rounded to the nearest whole dollar amount.

After we selected the 270 enrollee-years, we identified an additional group of 15 enrollee-years that represented individuals who received 1 of the 832 potentially mis-keyed diagnosis codes (which mapped to a potentially unvalidated HCC) and multiple instances of diagnosis codes that were likely keyed correctly. Thus, we selected for audit a total of 285 enrollee-years.

SOURCE OF RANDOM NUMBERS

We generated the random numbers with the Office of Inspector General (OIG), Office of Audit Services (OAS), statistical software.

METHOD FOR SELECTING SAMPLE ITEMS

We sorted the items in each stratum by enrollee identifier and payment year and then consecutively numbered the items in each stratum in the stratified sampling frame. We generated the random numbers for our sample according to our sample design, and we then selected the corresponding frame items for review. We also selected all 15 items from the potentially mis-keyed group.

ESTIMATION METHODOLOGY

We used the OIG/OAS statistical software to estimate the total amount of net overpayments to SelectCare at the lower limit of the two-sided 90-percent confidence interval (Appendix D). Lower limits calculated in this manner are designed to be less than the actual overpayment total 95 percent of the time. We also identified the overpayments from the 15 potentially mis-keyed diagnosis codes and added that amount to the estimate for the statistical sample to obtain the total net overpayments.

APPENDIX D: SAMPLE RESULTS AND ESTIMATES

Table 5: Sample Results

Audited High-Risk Groups	Frame Size	CMS Payment for HCCs in Audited High-Risk Groups (for Enrollee-Years in Frame)	Sample Size	CMS Payment for HCCs in Audited High-Risk Groups (for Sampled Enrollee-Years)	Number of Sampled Enrollee-Years With Unvalidated HCCs	Net Overpayment for Unvalidated HCCs (for Sampled Enrollee-Years)
1 – Acute stroke	1,001	\$2,246,278	30	\$65,244	29	\$63,066
2 – Acute heart attack	505	950,726	30	56,786	28	40,158
3 – Major depressive disorder	834	1,998,078	30	71,707	8	18,545
4 – Embolism	247	518,965	30	58,208	24	47,507
5 – Vascular claudication	399	845,963	30	66,155	12	27,098
6 – Lung cancer	95	589,033	30	181,781	24	118,172
7 – Breast cancer	358	422,854	30	36,193	27	32,408
8 – Colon cancer	213	409,569	30	58,781	28	54,855
9 – Prostate cancer	249	290,122	30	35,276	28	32,787
Total – First Nine Strata	3,901	\$8,271,588	270	\$630,131	208	\$434,596
10 – Potentially mis-keyed diagnoses	15	\$59,472	15	\$59,472	12	\$48,005
Total – All Strata	3,916	\$8,331,060	285	\$689,604*	220	\$482,601⁴⁵

* Difference in total is due to rounding.

⁴⁵ This dollar amount includes the financial impact for the 1 enrollee-year from the lung cancer high-risk diagnosis group for which the independent medical review contractor found support for another diagnosis code that should have been submitted instead of the reviewed diagnosis code, which caused an underpayment (footnote 26).

**Table 6: Estimated Net Overpayments in the Sampling Frame
(Limits Calculated at the 90-Percent Confidence Level)**

	Estimated Net Overpayment for Statistical Sample	Overpayment for Potentially Mis-keyed Diagnosis Group	Total Estimated Net Overpayments
Point estimate	\$5,469,937	\$48,005	\$5,517,942
Lower limit	\$5,076,793	\$48,005	\$5,124,798
Upper limit	\$5,863,082	\$48,005	\$5,911,087

**APPENDIX E: FEDERAL REGULATIONS REGARDING COMPLIANCE PROGRAMS
THAT MEDICARE ADVANTAGE ORGANIZATIONS MUST FOLLOW**

Federal regulations (42 CFR § 422.503(b)) state:

Any entity seeking to contract as an MA organization must

(4) Have administrative and management arrangements satisfactory to CMS, as demonstrated by at least the following

(vi) Adopt and implement an effective compliance program, which must include measures that prevent, detect, and correct non-compliance with CMS' program requirements as well as measures that prevent, detect, and correct fraud, waste, and abuse. The compliance program must, at a minimum, include the following core requirements:

(A) Written policies, procedures, and standards of conduct that—

(1) Articulate the organization's commitment to comply with all applicable Federal and State standards;

(2) Describe compliance expectations as embodied in the standards of conduct;

(3) Implement the operation of the compliance program;

(4) Provide guidance to employees and others on dealing with potential compliance issues;

(5) Identify how to communicate compliance issues to appropriate compliance personnel;

(6) Describe how potential compliance issues are investigated and resolved by the organization; and

(7) Include a policy of non-intimidation and non-retaliation for good faith participation in the compliance program, including but not limited to reporting potential issues, investigating issues, conducting self-evaluations, audits and remedial actions, and reporting to appropriate officials

(F) Establishment and implementation of an effective system for routine monitoring and identification of compliance risks. The

system should include internal monitoring and audits and, as appropriate, external audits, to evaluate the MA organization, including first tier entities', compliance with CMS requirements and the overall effectiveness of the compliance program.

- (G) Establishment and implementation of procedures and a system for promptly responding to compliance issues as they are raised, investigating potential compliance problems as identified in the course of self-evaluations and audits, correcting such problems promptly and thoroughly to reduce the potential for recurrence, and ensure ongoing compliance with CMS requirements.
- (1) If the MA organization discovers evidence of misconduct related to payment or delivery of items or services under the contract, it must conduct a timely, reasonable inquiry into that conduct.
 - (2) The MA organization must conduct appropriate corrective actions (for example, repayment of overpayments, disciplinary actions against responsible employees) in response to the potential violation referenced in paragraph (b)(4)(vi)(G)(1) of this section.
 - (3) The MA organization should have procedures to voluntarily self-report potential fraud or misconduct related to the MA program to CMS or its designee.

APPENDIX F: BREAKOUT OF POTENTIALLY MIS-KEYED DIAGNOSIS CODES

Table 7: Potentially Mis-keyed Diagnosis Codes and Associated Overpayments

Number of Sampled Enrollee-Years	One Diagnosis for a Condition (Determined To Be Incorrect)			Multiple Diagnoses for a Condition (Not Reviewed)		Overpayment
	Diagnosis Code	Diagnosis Code Description	Hierarchical Condition Category That Was Not Validated	Diagnosis Code	Diagnosis Code Description	
2	402.01	Malignant Hypertensive Heart Disease With Heart Failure	Congestive Heart Failure	402.10	Benign Hypertensive Heart Disease Without Heart Failure	\$6,742
2	482.0	Pneumonia Due to Klebsiella Pneumoniae	Aspiration and Specified Bacterial Pneumonias	428.0	Congestive Heart Failure, Unspecified	9,693
1	174.0	Malignant Neoplasm of Nipple and Areola of Female Breast	Breast, Prostate, Colorectal and Other Cancers and Tumors	714.0	Rheumatoid Arthritis	1,224
1	174.9	Malignant Neoplasm of Breast, Unspecified	Breast, Prostate, Colorectal and Other Cancers and Tumors	714.9	Unspecified Inflammatory Polyarthropathy	1,358
1	205.00	Acute Myeloid Leukemia	Metastatic Cancer and Acute Leukemia	250.00	Diabetes Mellitus Without Complications	15,880
1	249.10	Secondary Diabetes Mellitus With Ketoacidosis	Diabetes With Acute Complications	294.10	Dementia Without Behavior Disturbance	3,769
1	250.10	Diabetes With Ketoacidosis, Type II Or Unspecified Type	Diabetes With Acute Complications	205.10	Chronic Myeloid Leukemia, Without Mention of Having Achieved Remission	0

Number of Sampled Enrollee-Years	One Diagnosis for a Condition (Determined To Be Incorrect)			Multiple Diagnoses for a Condition (Not Reviewed)		Overpayment
	Diagnosis Code	Diagnosis Code Description	Hierarchical Condition Category That Was Not Validated	Diagnosis Code	Diagnosis Code Description	
1	433.01	Occlusion and Stenosis of Basilar Artery With Cerebral Infarction	Ischemic or Unspecified Stroke	433.10	Occlusion and Stenosis of Carotid Artery Without Mention of Cerebral Infarction	1,778
1	493.20	Chronic Obstructive Asthma, Unspecified	Chronic Obstructive Pulmonary Disease	493.02	Extrinsic Asthma With Exacerbation	4,741
1	714.9	Unspecified Inflammatory Polyarthropathy	Rheumatoid Arthritis and Inflammatory Connective Tissue Disease	174.9	Malignant Neoplasm of Breast, Unspecified	2,820
12						\$48,005

Table 8: Hierarchical Condition Category That Was Not Validated, But We Found Support for an HCC With the Same Manifestation of the Related-Disease Group

Count of Enrollee-years	Hierarchical Condition Category That Was Not Validated	Hierarchical Condition Category That Was Supported
1	Diabetes With Acute Complications	Diabetes With Chronic Complications

APPENDIX G: SELECTCARE OF TEXAS COMMENTS

June 5, 2023

Via Email and Overnight Delivery

Ms. Patricia Wheeler
Regional Inspector General for Audit Services
Office of Audit Services, Region VI
1100 Commerce Street, Room 632
Dallas, TX 75242

Re: SelectCare of Texas, Inc. Response to Draft Audit Report No. A-06-19-05002

Dear Ms. Wheeler:

SelectCare of Texas, Inc. (“SelectCare”) appreciates the opportunity to respond to the United States Department of Health and Human Services (“HHS”) Office of Inspector General’s (“OIG”) Draft Report No. A-06-19-05002, entitled *Medicare Advantage Compliance Audit of Specific Diagnosis Codes that SelectCare of Texas, Inc., (Contract H4506) Submitted to CMS* (the “Draft Report” or “OIG Draft Report”), which was provided to SelectCare on April 5, 2023.

For the reasons set forth below, SelectCare respectfully submits that OIG should not finalize the Draft Report or its recommendations:

- **The Audit Methodology is Flawed:** OIG should permit appeals of audit findings prior to finalizing its recommendations, as is standard for CMS reviews, and should only apply standards promulgated pursuant to legal requirements;
- **Medical Record Documentation Supported Certain Diagnoses:** OIG incorrectly concluded that medical record documentation did not support certain diagnoses when, in fact, it did; and
- **OIG Applied an Improper Standard:** OIG’s findings and recommendations improperly imply that plans are expected to assure 100% accuracy of provider-submitted codes, whereas the proper standard should be whether the plans made good faith efforts to certify the accuracy, completeness, and truthfulness of encounter data submitted.

SelectCare has made significant investments in its Medicare risk adjustment compliance program, and we remain committed to improving the quality of data submitted. We have established robust policies and procedures related to risk adjustment and we continue to refine our practices to keep pace with evolving industry standards. We therefore request that OIG reconsider its recommendations, and work closely with SelectCare to address the issues identified in our response letter before finalizing its Draft Report.

SelectCare welcomes the opportunity to discuss OIG’s methodology, findings, and recommendations.

I. Error Determinations for Hierarchical Condition Categories

A. Legal Concerns with OIG's Methodology.

i. OIG's Processes Do Not Allow for Appeals that Are Standard for Other CMS Reviews.

As a threshold matter, SelectCare believes it is unfair that, beyond this opportunity to comment on OIG's Draft Report, OIG does not provide a process for appealing the medical record review findings.

Appeal processes, which afford an opportunity for challenging the agency's findings and conclusions, are standard in other CMS reviews. For example, 42 C.F.R. § 422.311 establishes that MAOs that do not agree with their RADV audit results may appeal, including for disputes related to medical record review determinations and payment error calculations.¹ MAOs may even request a RADV hearing to be conducted by a Hearing Officer with formal proceedings.²

Beyond CMS's RADV process, under 42 C.F.R. § 422.330, when CMS identifies overpayments associated with payment data submitted by MAOs, it sends a data correction notice to the MAO and conducts a payment offset.³ If the MAO does not agree with the payment offset, it may appeal under a three-level appeal process.⁴

Recognizing the complexities involved in medical record documentation and MA payments, appeal processes that allow MAOs to challenge findings are a standard of CMS reviews, and customary in the industry. SelectCare submits it is unfair not to include such a formal appeal opportunity here and urges OIG to reconsider its findings as to SelectCare in that vein.

ii. The Audit Applied Review Standards that Were Not Promulgated Pursuant to Legal Requirements.

We note as well, as other MAOs have,⁵ that the audit's methodology applied substantive standards that were not promulgated pursuant to the notice-and-comment requirements set forth in *Azar v. Allina Health Services*, 139 S. Ct. 1804 (2019), and the subsequent implementation memorandum from the HHS Office of the General Counsel.⁶ In *Allina*, the Supreme Court held that substantive standards governing payments under Medicare must be promulgated pursuant to notice-and-comment rulemaking under 42 U.S.C. § 1395hh(b), regardless of whether such standards are

¹ 42 C.F.R. § 422.311(c).

² *Id.*

³ 42 C.F.R. § 422.330.

⁴ *Id.*

⁵ *Medicare Advantage Compliance Audit of Specific Diagnosis Codes That Coventry Health Care of Missouri, Inc (Contract H2663) Submitted to CMS, A-07-17-01173* (Oct. 2021) ("Coventry Audit"), Appendix D, available at <https://oig.hhs.gov/oas/reports/region7/71701173.pdf>; *Medicare Advantage Compliance Audit of Specific Diagnosis Codes That Healthfirst Health Plan, Inc., (Contract H3359) Submitted to CMS, A-02-18-01029* (Jan. 2022) ("Healthfirst Audit"), Appendix G, available at <https://oig.hhs.gov/oas/reports/region2/21801029.pdf>.

⁶ Impact of *Allina* on Medicare Payment Rules at 1-3. Accessible at <https://www.law360.com/articles/1222453/attachments/0>.

framed as rules, policies, or otherwise. The HHS Office of the General Counsel has advised CMS that it may not bring enforcement actions for overpayment collections based on substantive standards in audits that have not been properly promulgated.⁷ OIG's audits, of course, must similarly apply only properly promulgated and binding legal standards.

In providing these comments and otherwise participating in these proceedings, SelectCare reserves all rights with respect to substantive standards set forth in the Medicare Managed Care Manual, the Risk Adjustment Training Manual, and other documents that were not promulgated in accordance with 42 U.S.C. § 1395hh(b) and notice-and-comment requirements.⁸

B. SelectCare Respectfully Requests That OIG Reconsider the Draft Report's Finding That Medical Records Do Not Substantiate Certain Audited HCCs.

OIG highlights examples of individual medical records where it believes the HCCs under review are not validated. However, even within the limitations of the audit procedures and review standards that OIG applied, as discussed above, the medical record documentation provided clearly supports the HCCs highlighted in at least four instances. These HCCs are discussed in Appendix A. We respectfully request that OIG at least reconsider its findings for these four HCCs.

II. Standards and Expectations

Various aspects of the Draft Report imply that MAOs' compliance efforts must assure 100% accuracy with respect to the vast quantities of diagnosis codes they receive from providers and are required to submit to CMS. For example, the Draft Report's finding that "the policies and procedures that SelectCare had to prevent, detect, and correct noncompliance with CMS's program requirements, as mandated by Federal regulations (42 CFR § 422.503(b)(4)(vi)), could be improved"⁹ might be read to suggest that OIG believes SelectCare is required to have policies and procedures in place that eliminate *all* unsupported codes. SelectCare requests that OIG eliminate this finding. While SelectCare strives to identify and eliminate unsupported codes, no compliance program is reasonably expected to eliminate all types of errors. Even where an audit reveals some errors, that does not mean policies and procedures were not effective.

MAOs receive millions of claims from the providers rendering care to their members. Typically, these claims reflect multiple diagnoses assigned by the providers, and result in an enormous volume of data that MAOs must receive and submit to CMS.¹⁰ Verifying 100% of submitted risk adjustment data would be prohibitive for MAOs (and place extraordinary additional burdens on providers).

The MA regulatory framework, accordingly, does not include an expectation or requirement that MAOs ensure 100% medical record support for codes. As this absence acknowledges, such a

⁷ *Id.*

⁸ OIG has responded in other audit reports that MAOs' contracts with CMS call for adherence to CMS instructions and guidance. However, CMS remains subject to the statutory requirements, which may not be avoided through language in a form agreement which may itself conflict with statutory requirements.

⁹ Draft Report at 18.

¹⁰ 42 CFR § 422.310(b) and 42 CFR § 422.310(d)(3).

mandate would be impractical, financially unsustainable for MAOs, and inconsistent with the goal of administrative simplicity that underlies the HCC model.

In recognition of these facts, CMS has acknowledged that MAOs “cannot reasonably be expected to know that every piece of data is correct, nor is that the standard that [CMS], the OIG, and DOJ believe is reasonable to enforce.”¹¹ Federal regulations require that MAOs submit all risk adjustment data from healthcare providers and requires an attestation of risk adjustment data. However, that attestation does not impose a requirement for an MAO to ensure that all submitted codes are supported by medical records. Rather, MAOs will only “be held responsible for making good faith efforts to certify the accuracy, completeness, and truthfulness of encounter data submitted.” OIG itself has acknowledged that MAOs are not able to provide an “absolute guarantee of accuracy.”¹²

Moreover, an expectation to ensure 100% accuracy would disregard the known presence of unsubstantiated codes in the traditional Medicare data and would render the risk adjustment system actuarially inequivalent. In its appeal of the district court’s ruling in *UnitedHealthcare Ins. Co. v. Azar*, the United States recognized that broad monitoring obligations would implicate actuarial equivalence. The United States defended an asserted obligation to delete unsupported codes on grounds that the obligation was limited: “the [2014] Overpayment Rule requires only that insurers delete erroneous diagnoses when those errors are identified, *not that insurers conduct comprehensive audits.*”¹³ The government conceded that MAOs do not have an obligation to identify and delete “all erroneous diagnosis, or even a large fraction of them.”¹⁴ The court of appeals cited the government’s representation in its ruling, stating that the “[Overpayment] Rule only requires insurers to refund amounts they *know* were overpayments, i.e., payments they *are aware* lack support in a beneficiary’s medical record. That limited scope does not impose a self-auditing mandate.”¹⁵

SelectCare respectfully requests that the final report acknowledge the more limited scope of MAOs’ obligations. In particular, SelectCare requests that the final report expressly include and acknowledge statements made by the United States in the *UnitedHealthcare* litigation that MAOs do not have an obligation to identify and delete every erroneous diagnosis, or even a large fraction of them. SelectCare respectfully requests corresponding revisions to the Draft Report’s recommendations, which we believe could be read in a manner that misstates the nature and extent of MAOs’ obligations.

¹¹ 65 Fed. Reg. 40170, 40268 (June 29, 2000).

¹² *Id.* at 40268; *see also id.* at 40250-40252 (“Attestation of encounter data is essential for guaranteeing the accuracy and completeness of data submitted for payment purposes, and to allow us to pursue penalties . . . where it can be proven that a plan knowingly submitted false data. However, in response to concerns from M+C organizations, we have restricted the attestation requirement to confirmation of the completeness of the data and the accuracy of coding . . . the attestation requirement is thus in no way a legal trap”).

¹³ *UnitedHealthcare*, No. 18-5326, Brief for Appellants, at 2-3 (D.C. Cir. Apr. 1, 2020) (emphasis added).

¹⁴ *See id.* at 39-40.

¹⁵ *UnitedHealthcare Ins. Co. v. Becerra*, 9 F.4th 868, 884, No. 18-5326 (D.C. Cir. Aug. 13, 2021) (emphasis in original). The Draft Report also says that “Federal regulations state that MA organizations must monitor the data that they receive from providers and submit to CMS.” However, we note that no regulation is cited for this statement, particularly to the extent it implies an obligation to assure 100% accuracy.

III. Response to Recommendations

SelectCare does not agree with OIG's findings regarding the overpayment amount, as we believe many of the specific HCCs identified as unsupported by the OIG's audit are actually supported by the medical record as discussed above.

SelectCare will consult with CMS about mechanisms for addressing OIG's findings. SelectCare will also review the codes CMS found were not supported in the medical records. For any such codes where SelectCare agrees with CMS's conclusion, it will take appropriate steps to address that issue.

Regarding the recommendation to improve policies and procedures, SelectCare is engaged in a continual process of evaluating and enhancing its compliance procedures and will consider this recommendation. We also look forward to working with CMS and the OIG to better understand the specific improvements SelectCare should make, and their views regarding required compliance efforts and obligations within the actuarial and legal context discussed above.

IV. Conclusion

SelectCare appreciates the opportunity to comment on the Draft Report. We look forward to receiving the final report after OIG has had an opportunity to consider the issues we have raised. If you have any questions concerning this response letter, please do not hesitate to contact me.

Sincerely,

A handwritten signature in black ink, appearing to read "Lori-Don Gregory", with a long horizontal flourish extending to the right.

Lori-Don Gregory
Vice President, Medicare Compliance Officer

Appendix A

As discussed in Section I.B. of its response letter, SelectCare believes that, even aside from the issues with the audit procedures and review standards discussed in the response letter, the medical record documentation SelectCare provided clearly supports the HCCs highlighted in at least the following four instances:

i. Lung Cancer

The OIG identified one enrollee-year (Sample 188) with “no documentation of any condition that will result in the assignment of HCC 8/9. There is documentation of a past medical history of breast cancer (V10.3) that does not result in an HCC. Provider has noted, ‘Consideration of the primary lung disease versus recurrent breast cancer.’ As per outpatient coding guidelines a preliminary diagnosis is a working diagnosis which should not be assigned as an established diagnosis.”

SelectCare respectfully disagrees with this decision as the medical record supported HCC 7/8, a higher-level HCC within the hierarchy. The section labeled ‘Impression and Recommendations’ lists “Metastatic pulmonary disease. Consideration of the primary lung disease versus recurrent breast cancer.” The provider’s final diagnosis is, unequivocally, metastatic pulmonary disease. While questions remain regarding the original (primary) site of malignancy, its metastasis to the lungs is clearly established. As such, metastatic pulmonary disease is reportable per outpatient coding guidelines. This diagnosis maps to ICD-9-CM code 197.0 and HCC 7/8.

ii. Major Depressive Disorder

The OIG identified one enrollee-year (Sample 10) with “no documentation of any condition that will result in the assignment of HCC 55/58. There is assessment of Depression, NEC (311) which does not link to an HCC.”

SelectCare respectfully disagrees with this decision. While Depression, NEC is found in the medical record, the same document also shows that the patient is taking both Bupropion (XL) and Fluoxetine for the treatment of “MDD”, a standard abbreviation for major depressive disorder. As major depressive disorder describes the nature of the patient’s condition to a greater level of detail than Depression, NEC, it would be appropriate to report major depressive disorder for this date of service. This more specific diagnosis results in ICD-9-CM code 296.20 and HCC 55/58.

iii. Prostate Cancer

The OIG identified one enrollee-year (Sample 173) where “there is no documentation of any condition that will result in assignment of an ICD-9-CM code that translates to the assignment of HCC 12. The medical documentation does support a history of prostate cancer (V10.46), which does not result in an HCC.”

SelectCare respectfully disagrees with this decision. The documentation does not support a history of prostate cancer. According to FY 2015 ICD-10-CM Official Guidelines for Coding and Reporting Section I.C.2.d., history of cancer is reported when “a primary malignancy has been previously excised or eradicated from its site and there is no further treatment directed to that site and there is no evidence of any existing primary malignancy.”

A review of the medical record reveals that the patient last saw the oncologist approximately 3 weeks prior to the present encounter, during which the patient received their “last injection”. Moreover, the patient has a follow up with the oncologist “next month...to see if it has progressed.” Moving further down the record to the Assessment, the documented diagnosis is active prostate cancer with the comment, “radiation and chemo completed. Awaiting first F/U visit.” While the patient has completed the scheduled program of therapy, the response has yet to be determined. In other words, this medical record does not support either the eradication of prostate cancer or the absolute completion of treatment. Until eradication can be confirmed, reporting a personal history of prostate cancer is premature. The appropriate ICD-10-CM code is C61, which maps to HCC 12.

iv. Vascular Claudication

The OIG identified one enrollee-year (Sample 162) where “Based on review of the medical record/s submitted for this HCC, there is no documentation of any condition that will result in the assignment of HCC 105/108.”

SelectCare respectfully disagrees with this decision. While ‘Peripheral vascular disease’ is documented in the Problem List, it was followed by a dash indicating “medical treatment.” Further, the Medications lists anticoagulants, beta blockers, and platelet inhibitors which were all refilled within days of the encounter and are used to improve blood flow and treat PVD. According to the 2015 ICD-9-CM Diagnostic Coding and Reporting Guidelines for Outpatient Services Section IV.J., one should code “all documented conditions that coexist at the time of the encounter/visit and require or affect patient care treatment or management.” Therefore, given that the documentation supports peripheral vascular disease as an active condition and receiving treatment, it is reportable for the encounter. Peripheral vascular disease maps to ICD-9-CM code 443.9 and HCC 105/108.