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

Medicare Advantage Compliance Audit of Specific Diagnosis Codes That Cigna-HealthSpring of Tennessee, Inc. (Contract H4454) Submitted to CMS

Why OIG Did This Audit

Under the Medicare Advantage (MA) program, the Centers for Medicare & Medicaid Services (CMS) makes monthly payments to MA organizations according to a system of risk adjustment that depends on the health status of each enrollee. Accordingly, MA organizations are paid more for providing benefits to enrollees with diagnoses associated with more intensive use of health care resources than to healthier enrollees, who would be expected to require fewer health care resources.

To determine the health status of enrollees, CMS relies on MA organizations to collect diagnosis codes from their providers and submit these codes to CMS. Some diagnoses are at higher risk for being miscoded, which may result in overpayments from CMS.

For this audit, we reviewed one MA organization, Cigna-HealthSpring of Tennessee, Inc. (Cigna), and focused on 10 groups of high-risk diagnosis codes. Our objective was to determine whether selected diagnosis codes that Cigna submitted to CMS for use in CMS's risk adjustment program complied with Federal requirements.

How OIG Did This Audit

We sampled 279 unique enrollee-years with the high-risk diagnosis codes for which Cigna received higher payments for 2016 through 2017. We limited our review to the portions of the payments that were associated with these high-risk diagnosis codes, which totaled $759,529.

What OIG Found

With respect to the 10 high-risk groups covered by our audit, most of the selected diagnosis codes that Cigna submitted to CMS for use in CMS's risk adjustment program did not comply with Federal requirements. For 195 of the 279 sampled enrollee-years, the medical records that Cigna provided did not support the diagnosis codes and resulted in $509,194 in overpayments.

As demonstrated by the errors found in our sample, Cigna'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 that Cigna received at least $5.9 million in overpayments for 2016 and 2017.

What OIG Recommends and Cigna Comments

We recommend that Cigna: (1) refund to the Federal Government the $5.9 million of estimated 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) continue its examination of its existing compliance procedures to identify areas where improvements can be made to ensure that diagnosis codes that are at high risk for being miscoded comply with Federal requirements (when submitted to CMS for use in CMS's risk adjustment program) and take the necessary steps to enhance those procedures.

Cigna did not concur with our recommendations and did not concur with our findings for 13 sampled enrollee-years which, according to Cigna, were supported by the diagnosis codes on the medical records. Cigna did not directly agree or disagree with our findings for the remaining enrollee-years. Cigna did not agree with our audit methodology, use of extrapolation, and standards for data accuracy, coding, and documentation requirements.

After reviewing Cigna's comments and the additional information that Cigna provided, we revised the number of enrollee-years in error from 201 to 195 for this final report. We also revised the amount of our first recommendation from $6.3 million (in our draft report) to $5.9 million but made no change to our other recommendations. We followed a reasonable audit methodology and correctly applied applicable Federal requirements underlying the MA program.