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 Regence BlueCross BlueShield of Oregon (Contract H3817) 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, Regence BlueCross BlueShield of Oregon (Regence), and focused on seven groups of high-risk diagnosis codes. Our objective was to determine whether selected diagnosis codes that Regence submitted to CMS for use in CMS's risk adjustment program complied with Federal requirements.

How OIG Did This Audit

We sampled 179 unique enrollee-years with the high-risk diagnosis codes for which Regence received higher payments for 2015 and 2016. We limited our review to the portions of the payments that were associated with these high-risk diagnosis codes, which totaled $462,043.

What OIG Found

With respect to the seven high-risk groups covered by our audit, most of the selected diagnosis codes that Regence submitted to CMS for use in CMS's risk adjustment program did not comply with Federal requirements. Specifically, for 111 of the 179 sampled enrollee-years, the diagnosis codes that Regence submitted to CMS were not supported in the medical records and resulted in net overpayments of $248,885. As demonstrated by the errors in our sample, the policies and procedures that Regence used to prevent, detect, and correct noncompliance with CMS's program requirements, as mandated by Federal regulations, could be improved. On the basis of our sample results, we estimated that Regence received at least $1.8 million of net overpayments for these high-risk diagnosis codes for 2015 and 2016.

What OIG Recommends and Regence Comments

We recommend that Regence: (1) refund to the Federal Government the $1.8 million of estimated net overpayments; (2) identify, for the high-risk diagnoses included in this report, similar instances of noncompliance that occurred before or after our audit period and refund any resulting overpayments to the Federal Government; and (3) continue to examine its existing compliance procedures to identify areas where improvements can be made to ensure that diagnosis codes that are at high risk for being miscoded comply with Federal requirements (when submitted to CMS for use in CMS's risk adjustment program) and take the necessary steps to enhance those procedures.

Regence disagreed with our findings and did not concur with our recommendations. However, Regence agreed to submit data corrections to CMS for 108 of 111 enrollee-years questioned in our draft report. Regence stated that it did not plan to submit data corrections for the remaining 3 enrollee-years and provided additional explanations as to why it believes the medical records validated the diagnosis codes. Regence also disagreed with our extrapolated repayment calculation. Furthermore, Regence disagreed that it should conduct additional audits (to identify similar instances of noncompliance) and that it should examine its compliance procedures. After reviewing Regence's comments, we maintain that our findings and recommendations are valid.