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Issue Brief

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The Inability To Identify Denied Claims in Medicare Advantage Hinders Fraud Oversight

This issue brief summarizes results from our evaluation of Medicare Advantage (MA) encounter data and examines whether the lack of an indicator to identify payment denials in the data hinders efforts to combat fraud, waste, and abuse. (In this issue brief, we use the term "denied claim" to refer to a record that contains a service for which the payer denied payment to the provider.)

Key Takeaways

- Although most 2019 MA encounter records contained a payment adjustment, identifying whether these adjustments are payment denials is challenging and imprecise.
- Requiring MAOs to definitively identify payment denials on encounter records submitted for MA would enhance program oversight and help combat fraud.

Why OIG Did This Review

Detailed data about the services provided to enrollees are essential for combating fraud and abuse in Medicare and Medicaid. The oversight entities tasked with safeguarding these programs rely on service-level data to detect potentially inappropriate billing patterns and investigate suspected fraud and abuse. In the MA program, the Centers for Medicare & Medicaid Services (CMS) does not require MA organizations (MAOs) to include an indicator that identifies denied claims in their MA encounter data. Instead, MAOs must submit claim adjustment reason codes (hereafter adjustment codes) when MAOs do not pay the actual amount billed by the provider (e.g., the MAO pays a lesser amount). Adjustment codes explain reasons for any payment adjustments to the claim, including denials, reductions, or increases in payment. In contrast, for Medicare fee-for-service and Medicaid (including Medicaid managed care), CMS's records of services *do* include denied-claim indicators.

How OIG Did This Review

We analyzed 2019 MA encounter records to determine the extent to which these records contained adjustment codes. We reviewed adjustment code descriptions and MAO payment amounts to identify records that may contain payment denials. We interviewed and/or administered questionnaires to CMS staff regarding the methods used to identify payment denials in the Medicare and Medicaid data. To identify how the lack of a denied-claim indicator affects their work, we interviewed and/or administered questionnaires to staff from oversight entities tasked with safeguarding MA program integrity. These oversight entities include staff from CMS's Center for Program Integrity and the Medicare Drug Integrity Contractors (MEDICs) (hereafter CMS program integrity staff); OIG investigators and data analysts; and health care fraud staff at the Department of Justice (DOJ). Finally, we also interviewed staff from CMS's Medicare Plan Payment Group (hereafter CMS's MA payment group) to determine the reasons why CMS does not require MAOs to submit a denied-claim indicator on MA encounter records.

What OIG Found

We found that adjustment codes are not a definitive method for identifying denied claims in the MA encounter data. The descriptions for some adjustment codes are too vague to clearly identify whether

the MAO denied payment for a service. For example, adjustment code 261 ("The procedure or service is inconsistent with the patient's history") does not specify whether payment was denied. The descriptions for other adjustment codes seem to indicate that the MAO denied payment for the service, yet we found instances in which MAOs reported payments for these services. We also found that most 2019 MA encounter records contained at least 1 adjustment code and 55 million of these records contained codes that may indicate the denial of payments by MAOs. However, without a definitive method for identifying denied claims in the MA encounter data, the full scope of payment denials in the data is unclear.

In addition, oversight entities—including CMS program integrity staff; OIG investigators and analysts; and DOJ health care fraud staff—reported that a denied-claim indicator in the MA encounter data would improve the efficiency, scope, and accuracy of their efforts to combat fraud, waste, and abuse. Once identified, denied claims may be (1) analyzed to detect potential fraud schemes or (2) removed from analyses of inappropriate billing patterns among paid claims. Without an indicator, oversight entities must make separate requests to MAOs asking them to identify denied claims in a subset of their data, which adds time and burden to investigations. The lack of an indicator limits the scope of efforts to determine the full impact of potential fraud activities in MA. For example, without an indicator, it is challenging or impossible for oversight entities to:

- exclude denied claims and review only paid claims in the MA encounter data;
- calculate financial exposure due to fraud;
- investigate complaints that certain MAOs inappropriately deny payments to their providers; and
- examine suspected providers' billing activities across many plans.

However, for Medicare fee-for-service and Medicaid, oversight entities can use the available denied-claim indicators to analyze data and perform enhanced program oversight.

Despite oversight entities reporting the potential benefits of a denied-claim indicator to MA program integrity, CMS's MA payment group reported that MAOs are not required to submit a denied-claim indicator in MA because the MA payment group does not need this indicator to determine MA payments or to understand which services were provided to enrollees. CMS's MA payment group raised concerns about the potential burden on MAOs of requiring a denied-claim indicator on their encounter records. However, the private companies that cover most MA enrollees also have contracts for Medicaid managed care—where CMS requires a denied-claim indicator on encounter records—and thus have demonstrated their ability to make accommodations in their systems and report these indicators. Once any initial challenges of modifying MAOs' systems are addressed, the inclusion of a denied-claim indicator in the MA encounter data may reduce the burden on MAOs of providing denied-claim information to oversight entities for fraud analyses. Finally, CMS may eventually need a denied-claim indicator to determine MA payments if it transitions to using the MA encounter data to estimate costs and set MA payments as it has previously stated that it will do in the future.

What OIG Recommends

To strengthen MA program oversight and combat fraud, we recommend that CMS require MAOs to definitively indicate on MA encounter data records when they have denied payment for a service on a claim. CMS did not concur or nonconcur with our recommendation.

BACKGROUND

MAOs must submit claim adjustment reason codes on MA encounter records when MAOs deny claims billed by providers. These adjustment codes are used when MAOs deny payment, and also to explain any other changes the MAOs make to the billed amount when determining payment for the claim. CMS does not require MAOs to include an indicator to solely identify which services were denied payment. (In this issue brief, we use the term "denied claim" to refer to a record that contains a service for which the payer denied payment to the provider.)

This issue brief presents detailed findings on (1) whether there is a definitive method to identify denied claims in the MA encounter data; (2) how the lack of a denied-claim indicator affects the efforts of CMS program integrity staff, OIG investigators and analysts, and DOJ health care fraud staff who are tasked with safeguarding MA program integrity; and (3) the reasons why CMS has not required MAOs to submit denied-claim indicators.

Payments to MAOs and providers in the MA program

The MA program covered 27 million people in 2021 at a cost of $340 billion.[1] Under MA, CMS contracts with private companies, known as MAOs, to provide coverage of Part A and B services through private health plan options.[2] For each person enrolled, MAOs receive a capitated payment from CMS.[3] To calculate capitated payments, CMS requires MAOs to submit records of services provided to enrollees.[4] These encounter records often (though not always) begin as claims that health care providers submit to MAOs for payment. MAOs must submit records of *all* services to CMS, including records of denied claims—i.e., records that contain a service for which the payer denied payment to the provider for the service.[5]

CMS's payments to MAOs. CMS pays MAOs a capitated payment that reflects the predicted cost of providing care to each enrollee. CMS calculates risk-adjusted payments to pay MAOs more for enrollees with higher expected health care costs. For risk adjustment, MAOs submit encounter records to CMS's Encounter Data System that contain information on each service or medical item that an enrollee receives from a provider.[6] CMS uses these encounter records to identify diagnoses for calculating risk-adjusted payments. To estimate the expected health care costs associated with the diagnoses reported on MA encounter records, CMS currently uses health care costs for Medicare fee-for-service enrollees.[7] As early as 2010, CMS announced plans to eventually transition to using the MA encounter data to estimate these expected costs.[8] This transition has the potential to improve the accuracy of capitated payments to MAOs by compensating MAOs for the cost of providing care

to enrollees in MA, rather than in Medicare fee-for-service.[9, 10] CMS has not announced a specific proposal or timeline for this transition.

MAOs' payments to providers. CMS requires MAOs to provide—or pay providers for—services covered by Medicare Parts A and B that are "reasonable and necessary" for the diagnosis, treatment, and prevention of medical conditions.[11] MAOs may contract with providers (i.e., in-network providers) through various provider payment arrangements based on (1) fee-for-service claims for services rendered (with or without links to quality and value), (2) alternative payment models that may include capitated payments, or (3) population-based payments that may include bundled services. Overall, MAOs predominantly use fee-for-service provider payment arrangements in which providers submit claims to MAOs for reimbursement of services rendered.[12]

CMS allows MAOs to deny payments to providers. When providers submit claims to MAOs, CMS allows MAOs to make decisions about whether to reimburse or deny payment for services that enrollees received.[13] MAOs may deny payment for various reasons,[14] such as lack of medical necessity, noncoverage by the plan, provider ineligibility, and administrative reasons. When an MAO denies payment to a provider after a service occurs, the enrollee may be required to pay for the service out of pocket, or the provider may never receive reimbursement for the service. Therefore, if MAOs inappropriately deny payments, this may contribute to financial harm to enrollees or providers and may discourage providers from ordering needed health care.[15]

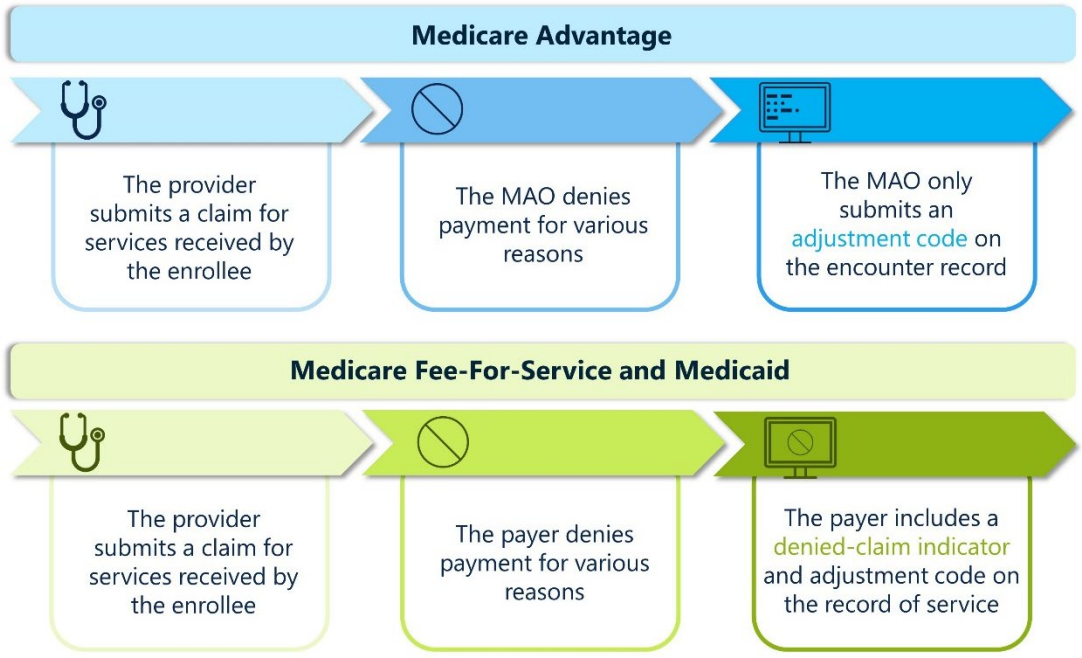
Denied claims in the Medicare and Medicaid data

Denied claims in the MA encounter data. Although CMS requires MAOs to submit records of services for which payment was denied to the Encounter Data System, it does not require MAOs to submit a denied-claim indicator on their MA encounter records that would identify the services for which the MAOs denied payment. MAOs include adjustment codes on MA encounter records that describe why they did not pay the actual amount billed by the provider. Adjustment codes explain reasons for *any* payment adjustments to the claim, including denials, reductions, or increases in payment.[16, 17] In cases in which MAOs deny claims billed by providers, MAOs are required to submit adjustment codes. CMS instructs MAOs to include any adjustment codes on the header portion of the encounter record or certain claim lines of the encounter record, as appropriate. As of October 2022, there were 294 active adjustment codes.[18, 19]

Denied claims in CMS's data for Medicare fee-for-service and Medicaid. For Medicare fee-for-service, CMS requires an indicator on records of services that definitively identifies claims for which CMS denied payment to the provider. For Medicaid (including Medicaid managed care and Medicaid fee-for-service), CMS

requires a denied-claim indicator on records of services that States submit to the Transformed Medicaid Statistical Information System (T-MSIS), as shown in Exhibit 1.[20] In addition to identifying whether the State or managed care plan denied payment for an entire record, CMS requires States to definitively identify when only certain portions (i.e., claim lines) of these records were denied. Although adjustment codes are not used to identify denied claims for Medicare fee-for-service and Medicaid, adjustment codes may be included on these records of services to explain any adjustments to the billed amounts.

Exhibit 1: CMS does not require a denied-claim indicator in MA, but does in Medicare fee-for-service and Medicaid.



Source: OIG summary of CMS's requirements for submitting records of service.
Note: The "payer" is CMS for Medicare fee-for-service and is the State or Medicaid managed care plan for Medicaid.

Using the MA encounter data for program oversight

Program integrity. To safeguard the integrity of the MA program, oversight entities rely on having comprehensive data about the services provided to MA enrollees. The MA encounter data are a tool used by CMS, OIG, DOJ, and other oversight entities to prevent and detect MA fraud, waste, and abuse, such as by investigating allegations of providers billing for services that were never provided. For example, CMS, OIG, and DOJ reviewed MA encounter data and Medicare fee-for-service claims data as part of their efforts to investigate companies and providers that potentially defrauded taxpayers out of $900 million.[21]

Prior OIG work identified the need for comprehensive encounter data to safeguard MA program integrity. CMS's MEDIC—the contractor tasked with detecting and preventing fraud, waste, and abuse in MA and Part D—may analyze MA encounter data to carry out its oversight activities, such as identifying providers that accepted more than one payment for the same service. However, a 2018 OIG report found that the MEDIC did not have access to certain variables in the MA encounter data needed to effectively carry out its activities.[22] At the time of this review, CMS contracted with a single MEDIC, but CMS now contracts with two MEDICs: the Program Plan Integrity MEDIC and the Investigations MEDIC. OIG recommended that CMS provide the MEDIC with centralized access to all MA encounter data. CMS concurred with this recommendation but has not yet implemented it.

Quality of care. CMS has the authority to use the MA encounter data to conduct quality review and improvement activities.[23] A 2017 Government Accountability Office (GAO) report noted that CMS was developing plans to use the MA encounter data to review how MA plans coordinate care.[24] However, CMS currently does not use MA encounter data to review enrollees' quality of care, including access to care, and instead uses other data sources. CMS has not yet determined whether it will use the MA encounter data to develop retrospective quality of care metrics.

Prior OIG work about MAOs' payment denials

The capitated payment model used in MA creates a potential incentive for MAOs to inappropriately deny payment for health care services in an attempt to increase their profits. A 2018 OIG report analyzed the annual performance data that MAOs submitted to CMS and found that MAOs denied 36 million payment requests in 2016 for services provided to enrollees.[25] This report found that a high percentage of appealed denials were overturned, which raises concerns that some providers were denied payments for services that MAOs are required to provide. A 2022 OIG evaluation conducted medical record reviews for a sample of MA denials of payments and services. This report found that 18 percent of payment denials were for services that met Medicare coverage rules and MAO billing rules and should have been approved by the MAOs.[26]

RESULTS

There is no definitive method to identify denied claims in the MA encounter data

Adjustment codes provide an imprecise and challenging method to identify denied claims in the MA encounter data because some adjustment code descriptions (1) are too vague or (2) seem to indicate that the MAO denied payment for a service even though MAOs also reported payment amounts for that service. When we requested a method from CMS to identify denied claims in the MA encounter data, CMS informed us that it did not have a list of definitive adjustment codes or other method for identifying denials.

Some adjustment code descriptions are too vague to clearly identify whether the MAO denied payment

Some adjustment codes provide little information regarding whether the billed amount was reduced, increased, or denied by the MAO. For example, adjustment codes 216 ("Based on the findings of a review organization") and 261 ("The procedure or service is inconsistent with the patient's history") are too ambiguous to indicate whether payment was denied.[27] Using only these vague adjustment code descriptions without a denied-claim indicator, one might inappropriately include or exclude these types of adjustment codes from any analyses of denied claims.

MAOs reported payment amounts for some services where they also reported adjustment codes that seemed to indicate denial of payment

MAOs reported payment amounts on millions of claim lines, despite these lines containing adjustment codes that seemed to indicate payment denials. For example, on 2.1 million encounter records, MAOs reported payment amounts for claim lines containing adjustment code A1 ("Claim/service denied"). These contradictions highlight the need for a more definitive way of identifying denied claims within MA encounter data.

Fifty-five million MA encounter records contained adjustment codes that may indicate a payment denial

Without a definitive method for identifying denied claims, the full scope of payment denials in the data is unclear. Of the 772 million MA encounter records submitted by MAOs to CMS for 2019, 86 percent contained at least 1 adjustment code.[28] From

these records, we identified 55 million records with an adjustment code that may indicate that the MAO denied payment for the service. We excluded adjustment codes with vague descriptions when selecting our list of 55 codes that may signal payment denials, even though such excluded codes may have represented actual denials. Among the top 5 adjustment codes that may indicate a potential payment denial, MAOs reported code 96 ("Noncovered charge(s)") on nearly 16 million encounter records submitted for 4.9 million enrollees, as shown in Exhibit 2. Appendix A contains a full list of the 269 adjustment codes which appeared on 2019 MA encounter records, including the 55 codes that may indicate payment denials.

Exhibit 2: Millions of encounter records contained one of the top five adjustment codes that may indicate that MAOs denied payments to providers.

Adjustment Code	Description	Number of 2019 MA Encounter Records[1]
96	Noncovered charge(s).	15,810,573
18	Exact duplicate claim/service.	7,911,595
A1	Claim/service denied.	6,881,112
50	These are noncovered services because this is not deemed a "medical necessity" by the payer.	4,332,382
B13	Previously paid. Payment for this claim/service may have been provided in a previous payment.	3,143,094

Source: OIG analysis of MA encounter records for 2019 from CMS's Integrated Data Repository.
[1] These are the number of MA encounter records that contained an adjustment code on the header and/or claim line portion of the record.

The lack of a denied-claim indicator in the MA encounter data hinders program integrity oversight

> Currently, we wouldn't know if anything is paid or denied, given the lack of a denied indicator. That leads to an inability to rely on information for clinical review, law enforcement referrals, or analyses.
>
> -CMS program integrity staff

The lack of a denied-claim indicator in the MA encounter data creates challenges for the CMS program integrity staff; OIG investigators and data analysts; and DOJ health care fraud staff who use MA encounter data to combat MA fraud, waste, and abuse. Efforts to identify denied claims add time and burden to their analyses and investigations. Further, because they are unable to definitively identify denied claims throughout the MA data, oversight entities are unable to obtain a complete and accurate understanding of billing and payment patterns across paid and/or denied MA claims for all plans and providers.

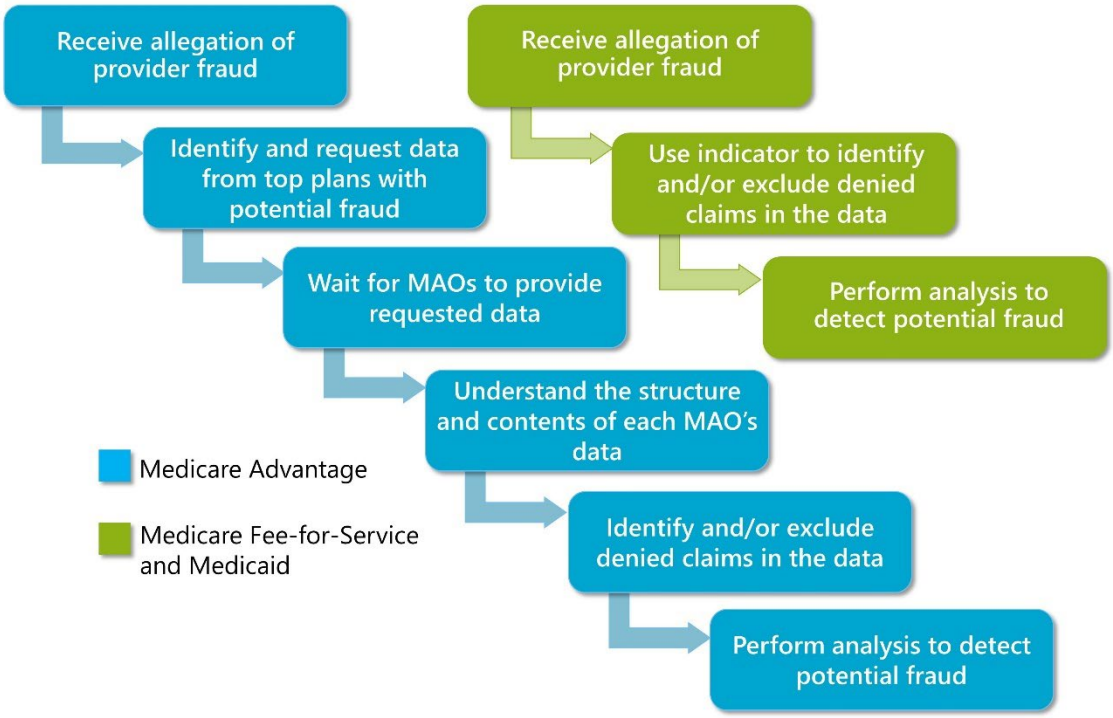
Oversight entities noted that certain types of analyses are challenging or impossible to perform due to the lack of a denied-claim indicator in the MA data, including analyses that:

- exclude denied claims and review only paid claims in the MA encounter data to accurately identify inappropriate payments to providers;
- calculate financial exposure due to fraud;
- investigate complaints that certain MAOs inappropriately deny payments to their providers;
- examine suspected providers' billing activities across many plans;
- determine accurately whether known fraud schemes from other health care programs are occurring in MA; and
- analyze MAOs' reasons for denial of certain procedures and compare this information across plans in a particular geographic area to understand fraud patterns and alert plans to potential schemes.

The lack of a denied-claim indicator in MA substantially increases the time and resources needed for program integrity activities, such as investigating allegations of provider fraud. Any attempts by oversight staff to identify denied claims in the MA program increase staff workload, as shown in Exhibit 3. To definitively identify denied claims in the MA encounter data, the MEDICs, OIG, and DOJ must request that MAOs (or providers) identify the denied claims in a subset of MA encounter data. While able to furnish this information, MAOs vary in the timeframe needed to gather and submit this information to oversight entities. The MEDICs estimated that it may take up to 60 days or more for MAOs to provide the requested data. In addition, the type and format of data provided vary across MAOs, requiring even more time for oversight entities to decipher data formats and identify denied claims.

> If the MA data included a denied-claim indicator, we could have started our analysis of allegations using the denied-claim indicator in the MA data—potentially avoiding the need to obtain data from the provider and MA plan.
>
> -DOJ health care fraud staff

Exhibit 3: The lack of a denied-claim indicator necessitates additional steps to investigate allegations of provider fraud in MA as compared to CMS's other health care programs.



Source: OIG analysis of oversight entities' responses to 2022 OIG interviews and questionnaires.

The lack of a denied-claim indicator limits the scope and accuracy of efforts to conduct analyses and detect fraud, waste, and abuse. Because MA encounter data do not contain a denied-claim indicator, oversight entities are unable to use MA encounter data to obtain a complete and accurate picture of billing and payment patterns across numerous plans and/or providers.[29] Without requesting and receiving data from MAOs, oversight staff are unable to accurately distinguish between paid and denied claims. When requesting that MAOs identify their denied claims, staff must limit their data request to select MAOs. For example, the MEDICs may request data from only the top three to five plans impacted by potential fraud due to the time and resources involved in requesting, understanding, and analyzing MAOs' data. This limits the scope of program integrity contractors' efforts to determine the full impact of a provider's fraud activities across all plans. In addition, without removing denied claims from their analyses of the MA encounter data, the MEDICs may not be able to accurately identify the top plans impacted by potential fraud.

Oversight entities rely on denied-claim indicators in Medicare fee-for-service and Medicaid to enhance program oversight

Although CMS does not require a denied-claim indicator on MA encounter records, it does for records of services for other health care programs. To conduct analyses to combat fraud, waste, and abuse in the Medicare fee-for-service and Medicaid programs, CMS program integrity staff; OIG investigators and data analysts; and DOJ health care fraud staff use denied-claim indicators to identify denied claims in the payment data. Once identified, these denied claims may be (1) analyzed to detect potential fraud schemes or (2) removed from analyses of inappropriate billing patterns among paid claims. When such analyses are conducted, denied-claim indicators provide an efficient and definitive method to identify denied claims in the Medicare fee-for-service and Medicaid data.

For other CMS health care programs, oversight entities use denied-claim indicators to identify and analyze denied claims for known or potential fraud schemes. CMS, OIG, and DOJ review denied claims in their efforts to identify providers that engage in fraud. A claim can be denied for various reasons, and the denial may indicate an intent by the provider to engage in fraud. For example, as part of the national enforcement initiative known as "Operation Brace Yourself," CMS, OIG, and DOJ reviewed denied claims in Medicare fee-for-service to identify medical equipment suppliers that billed for services that were never provided. OIG routinely identifies these types of fraudulent billing practices in medical equipment fraud investigations. For other analyses, CMS and OIG may use denied claims to understand the provider's intent or to predict and/or identify potential fraud. CMS may also detect potential fraud by analyzing the percentage of denied claims occurring within a certain timeframe for a provider. The use of denied-claim indicators enhances the scope of oversight activities for these other CMS health care programs.

> There are some instances where we look at denied claims [in Medicare fee-for-service and Medicaid] to understand the provider's intent. There are occasions where we include denied claims to check for billing factors, like percent of denied claims in a time period. There are many reasons a claim could be denied, but there are some denials that can help us understand intent on the way to fraud and abuse detection.
>
> -CMS program integrity staff

To enhance the accuracy and efficiency of fraud analyses for other CMS health care programs, oversight entities often remove denied claims to focus only on paid claims. By focusing only on paid claims, CMS, OIG, and DOJ can more accurately identify inappropriate billing patterns or fraud schemes in which providers received compensation. Excluding denied claims can also be more efficient, as it reduces the volume of claims under review. In addition, oversight entities may remove denied claims from analyses to estimate the dollar amount that Medicare or

> Generally, we exclude the denied claims [in Medicare fee-for-service and Medicaid] as our focus points are the claims where providers receive payments. We need to be able to focus on paid claims.
>
> -CMS program integrity staff

Medicaid paid to providers or insurers due to fraudulent activities. For example, for purposes of a sentencing recommendation, understanding which claims were denied and which were paid would be helpful in determining loss amounts.

CMS's MA payment group reported that CMS does not require MAOs to submit a denied-claim indicator because such an indicator is not currently needed to determine payments to MAOs

According to CMS's MA payment group, CMS does not require MAOs to submit a denied-claim indicator because the MA payment group does not need this indicator to determine MA risk-adjusted payments or to understand what services have been provided to enrollees. CMS's MA payment group noted that it would be an unnecessary burden on MAOs to modify their systems to submit this information because the main purpose of the MA encounter data is to collect information on MA enrollees' service utilization and determine MA payments. Currently, the electronic form that MAOs use to submit encounter records to CMS does not contain a field for a denied-claim indicator. CMS's MA payment group said that to use this form to collect a denied-claim indicator, CMS would need to (1) explore repurposing an unused field on this electronic form or (2) request industry-wide modification to this electronic form. Notably, the private companies that cover most MA enrollees also have contracts to offer Medicaid managed care plans, and Medicaid requires the submission of denied-claim indicators. As such, MAOs that also have Medicaid lines of business have demonstrated their ability to make accommodations in their systems to meet this requirement for submitting denied-claim indicators for Medicaid managed care encounter data. In addition, an indicator in the MA encounter data may reduce the burden on MAOs to provide information on their denied claims to oversight entities.

Although CMS does not currently need a denied-claim indicator to determine risk-adjusted payments, such an indicator could be relevant to determining accurate MA payments if CMS transitions to using the MA encounter data—rather than Medicare fee-for-service data—to estimate expected health care costs. While CMS has not announced any specific plans or timeframes for making this transition, it has announced its intent to eventually use the MA encounter data to estimate these expected costs. This transition has the potential to improve the accuracy of capitated payments to MAOs by compensating MAOs for the cost of providing care to enrollees in MA, rather than in Medicare fee-for-service. If CMS goes forward with this transition, it will not be able to definitively exclude denied claims, which may lead to overestimating expected costs and limit potential cost savings to the MA program. Currently, when CMS estimates expected costs using Medicare fee-for-service data, it excludes denied claims from these calculations.

CONCLUSION AND RECOMMENDATIONS

Knowing whether MAOs paid or denied claims is critical for oversight entities that use the MA encounter data to detect inappropriate billing patterns and investigate fraud, waste, and abuse effectively and efficiently. However, CMS does not require MAOs to include a denied-claim indicator on encounter records to identify denied claims in the MA encounter data.

Requiring a denied-claim indicator on MA encounter data would enhance program oversight and be consistent with program integrity efforts in Medicare fee-for-service and Medicaid. For these other CMS health care programs, oversight entities rely on denied-claim indicators when using payment data to combat fraud, waste, and abuse. CMS program integrity staff; OIG investigators and data analysts; and DOJ health care fraud staff reported that the lack of a denied-claim indicator in the MA encounter data hinders the efficiency, scope, and accuracy of their program integrity oversight, rendering it more difficult to ensure that the MA program is operating properly. Requiring MAOs to submit a denied-claim indicator in the MA encounter data would enhance efforts to combat fraud, waste, and abuse in MA. A denied-claim indicator also could be leveraged to review potential concerns with access to care in MA, as inappropriate payment denials may discourage providers from ordering needed care. In addition, such an indicator in the MA encounter data may reduce the burden on MAOs of identifying their denied claims for oversight entities. Finally, in the future, a denied-claim indicator may also be needed if CMS implements its plan to use MA encounter data to enhance the accuracy of MA payments.

We recommend that CMS:

Require MAOs to definitively indicate on MA encounter data records when they have denied payment for a service on a claim

To enhance the MA program, CMS should implement changes in the way MAOs submit data so that it is apparent when the MAO has not paid a claim for a reported service. The lack of such an indicator in the MA encounter data limits the efficiency, scope, and accuracy of oversight entities' efforts to combat fraud, waste, and abuse in MA. Although changes in submission will necessitate changes to MAOs' systems, companies have demonstrated their ability to report these indicators for Medicaid managed care. Further, once any initial challenges are addressed, an indicator will greatly improve efforts to ensure the integrity of MA for the future—and may reduce the burden to MAOs of submitting denied-claim information to oversight entities for fraud analyses. Specifically, CMS could implement changes that would require MAOs to identify whether the MAO denied payment for the entire record or only certain

services (i.e., claim lines) included on the record. Finally, CMS should provide oversight entities, including the MEDICs and DOJ staff, with access to any data that identify when the MAO has denied payment for a claim.

AGENCY COMMENTS AND OIG RESPONSE

CMS did not concur or nonconcur with our recommendation to require MAOs to definitively indicate on MA encounter data records when they have denied payment for a service on a claim. Instead, CMS acknowledged the potential of this information to aid program integrity efforts but stated that it has not determined the feasibility and burden on MAOs of implementing this recommendation. CMS noted that to make this determination, it would need to assess what additional information MAOs would be able to provide, if any, given the existing format that MAOs use to report encounter data. CMS also stated that it will use the information in this report to enhance program integrity efforts as appropriate.

OIG understands CMS's need to balance administrative burden and reporting requirements with the program integrity benefits. With respect to requiring MAOs to definitively indicate when they have denied payment for a service on a claim, the program integrity benefits would be substantial. For example, the ability to identify denied claims in the MA encounter data is critical for detecting inappropriate billing patterns and pursuing fraud investigations. In addition, the availability of a denied-claim indicator in the MA encounter data may (1) enhance CMS's and other entities' ability to perform reviews of access to care in MA; (2) reduce some burden on MAOs of submitting denied-claim information to oversight entities for fraud analyses; and (3) be needed if CMS implements its plan to use MA encounter data to enhance the accuracy of MA payments. We also note that many of the companies that participate in MA have demonstrated their ability to report these indicators for their Medicaid managed care plans.

OIG encourages CMS to implement this recommendation. We ask that, in its Final Management Decision, CMS clarify its concurrence or nonconcurrence with our recommendation; provide the results of its assessments of feasibility and burden or its plans to make such assessments if they are needed; and detail its plans to enhance program integrity on the basis of this report.

The full text of CMS's comments can be found in Appendix B.

METHODOLOGY

Analysis of the 2019 MA encounter data

In May 2022, we extracted 772 million MA encounter records from CMS's Integrated Data Repository for all records with dates of service in 2019 to identify the 667 million encounter records that contained adjustment codes. We began this evaluation during the COVID-19 pandemic. Because this evaluation examined the volume of MA encounter records containing adjustment codes, we expected that if we selected a timeframe during the pandemic, our results might not be indicative of the full scope of payment adjustments in the MA encounter data. Therefore, we focused the analysis on records of services provided in 2019—the most recent full year that preceded the COVID-19 pandemic.

We summarized the number and types of reasons that MAOs gave for paying differently from providers billed for services provided to MA enrollees. Of the 755 MAOs that submitted MA encounter records for 2019, 51 did not submit any records containing an adjustment code.[30] Data elements for adjustment codes are located on both the header and claim line portion of the encounter record. While most MAOs either always or mainly reported their adjustment codes at the claim line level, other MAOs reported their codes at the header and/or line level.[31] We also determined the number and percentage of MA encounter records in which the MAO reported an adjustment code and a payment amount on the header portion of the record and/or the line portion of the record.

Identification of adjustment codes that indicate potential denied claims. To identify potential denied claims, we identified 55 million records containing adjustment codes (1) with descriptions that reasonably indicate that the MAO may have denied payment for the service, and (2) for which MAOs did not report payment to providers on more than half of the records that contained the adjustment code.

Interviews and questionnaires

To determine whether there is a definitive method to identify denied claims in the MA encounter data, we summarized responses to interviews and/or questionnaires administered to CMS (including program integrity staff and its MA payment group). In addition, we summarized responses to interviews and/or questionnaires administered to CMS (including program integrity staff and Medicaid data staff) regarding methods for identifying denied claims in the Medicare fee-for-service and Medicaid data.

To identify whether the lack of a denied-claim indicator on services in the MA encounter data hinders MA program oversight, we summarized responses to interviews and questionnaires administered to CMS (including program integrity staff

and the MEDICs); OIG investigators and data analysts; and DOJ health care fraud staff, regarding:

- their use of denied-claim indicators in Medicare fee-for-service and Medicaid data to conduct analyses to detect and prevent fraud, waste, and abuse; and
- the impact that the lack of a denied-claim indicator in MA has on their ability to conduct analyses to detect and prevent fraud, waste, and abuse.

We also summarized responses from CMS's MA payment group to questions that addressed:

- CMS's reasons for not requiring a denied-claim indicator in the MA encounter data; and
- the potential challenges of requiring a denied-claim indicator in the MA encounter data.

Standards

We conducted this study in accordance with the *Quality Standards for Inspection and Evaluation* issued by the Council of the Inspectors General on Integrity and Efficiency.

APPENDIX A

List of 269 adjustment codes included on MA encounter records submitted by MAOs to CMS for 2019

We identified 269 adjustment codes that appeared on MA encounter records submitted by MAOs to CMS for 2019. As shown in Exhibit A-1, the number of records with each code ranged from almost 540 million to just 1 record. The 55 adjustment codes that OIG identified as indicators of potential denied claim encounters are identified in the table by a blue highlight.

Exhibit A-1: Number of 2019 MA encounter records that contained an adjustment code

Adjustment Code	Description	Number of 2019 MA Encounter Records with Adjustment Codes[1]
45	Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement.	538,277,812
3	Co-payment amount.	182,907,217
253	Sequestration - reduction in Federal payment.	171,992,197
2	Coinsurance amount.	54,577,461
24	Charges are covered under a capitation agreement/managed care plan.	46,072,731
131	Claim specific negotiated discount.	21,608,675
97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.	17,926,544
96	Noncovered charge(s).	15,810,573
94	Processed in excess of charges.	15,135,161
1	Deductible amount.	12,988,531
59	Processed based on multiple or concurrent procedure rules (For example multiple surgery or diagnostic imaging, concurrent anesthesia).	12,426,279
246	This nonpayable code is for required reporting only.	10,612,553
16	Claim/service lacks information or has submission/billing error(s).	8,825,406
18	Exact duplicate claim/service.	7,911,595
23	The impact of prior payer(s) adjudication including payments and/or adjustments.	7,709,108
104	Managed care withholding.	7,301,122
A1	Claim/service denied.	6,881,112
234	This procedure is not paid separately.	5,596,714
223	Adjustment code for mandated Federal, State, or local law/regulation that is not already covered by another code and is mandated before a new code can be created.	5,489,008

50	These are non-covered services because this is not deemed a "medical necessity" by the payer.	4,332,382
B13	Previously paid. Payment for this claim/service may have been provided in a previous payment.	3,143,094
29	The time limit for filing has expired.	2,780,330
4	The procedure code is inconsistent with the modifier used.	2,686,536
225	Penalty or interest payment by payer.	2,497,563
252	An attachment/other documentation is required to adjudicate this claim/service.	2,237,899
197	Precertification/authorization/notification/pre-treatment absent.	2,095,508
204	This service/equipment/drug is not covered under the patient's current benefit plan.	1,547,601
102	Major medical adjustment.	1,450,018
B9	Patient is enrolled in a hospice.	1,400,268
242	Services not provided by network/primary care providers.	1,227,822
11	The diagnosis is inconsistent with the procedure.	1,190,175
243	Services not authorized by network/primary care providers.	1,170,363
109	Claim/service not covered by this payer/contractor. You must send the claim/service to the correct payer/contractor.	1,160,412
119	Benefit maximum for this time period or occurrence has been reached.	1,018,597
22	This care may be covered by another payer per coordination of benefits.	785,529
222	Exceeds the contracted maximum number of hours/days/units by this provider for this period. This is not patient specific.	723,684
B11	The claim/service has been transferred to the proper payer/processor for processing. Claim/service not covered by this payer/processor.	721,835
151	Payment adjusted because the payer deems the information submitted does not support this many/frequency of services.	692,499
272	Coverage/program guidelines were not met.	642,528
B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated.	616,142
228	Denied for failure of this provider, another provider or the subscriber to supply requested information to a previous payer for their adjudication.	601,228
143	Portion of payment deferred.	581,616
5	The procedure code/type of bill is inconsistent with the place of service.	525,403
B7	This provider was not certified/eligible to be paid for this procedure/service on this date of service.	475,740
6	The procedure/revenue code is inconsistent with the patient's age.	435,712
170	Payment is denied when performed/billed by this type of provider.	392,344
256	Service not payable per managed care contract.	392,050
182	Procedure modifier was invalid on the date of service.	388,790
288	Referral absent.	334,652
150	Payer deems the information submitted does not support this level of service.	325,294
186	Level of care change adjustment.	299,443
226	Information requested from the billing/rendering provider was not provided or not provided timely or was insufficient/incomplete.	278,929
144	Incentive adjustment, e.g. preferred product/service.	259,933

B16	"New patient" qualifications were not met.	247,896
39	Services denied at the time authorization/pre-certification was requested.	219,565
55	Procedure/treatment/drug is deemed experimental/investigational by the payer.	218,582
167	This (these) diagnosis(es) is (are) not covered.	212,389
185	The rendering provider is not eligible to perform the service billed.	202,652
273	Coverage/program guidelines were exceeded.	196,378
297	Claim received by the medical plan, but benefits not available under this plan. Submit these services to the patient's vision plan for further consideration.	192,532
181	Procedure code was invalid on the date of service.	181,633
146	Diagnosis was invalid for the date(s) of service reported.	178,318
237	Legislated/regulatory penalty.	171,227
236	This procedure or procedure/modifier combination is not compatible with another procedure or procedure/modifier combination provided on the same day according to the National Correct Coding Initiative or workers compensation State regulations/ fee schedule requirements.	170,529
192	Nonstandard adjustment code from paper remittance.	167,228
203	Discontinued or reduced service.	162,812
198	Precertification/notification/authorization/pre-treatment exceeded.	161,957
133	The disposition of this service line is pending further review.	152,712
245	Provider performance program withhold.	146,630
95	Plan procedures not followed.	145,625
147	Provider contracted/negotiated rate expired or not on file.	130,146
58	Treatment was deemed by the payer to have been rendered in an inappropriate or invalid place of service.	114,618
P7	The applicable fee schedule/fee database does not contain the billed code. Please resubmit a bill with the appropriate fee schedule/fee database code(s) that best describe the service(s) provided and supporting documentation if required.	114,478
193	Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.	109,607
161	Provider performance bonus.	109,168
107	The related or qualifying claim/service was not identified on this claim.	92,929
108	Rent/purchase guidelines were not met.	91,720
231	Mutually exclusive procedures cannot be done in the same day/setting.	91,474
271	Prior contractual reductions related to a current periodic payment as part of a contractual payment schedule when deferred amounts have been previously reported.	88,821
137	Regulatory surcharges, assessments, allowances or health related taxes.	88,195
B10	Allowed amount has been reduced because a component of the basic procedure/test was paid. The beneficiary is not liable for more than the charge limit for the basic procedure/test.	86,826
8	The procedure code is inconsistent with the provider type/specialty (taxonomy).	84,203
284	Precertification/authorization/notification/pre-treatment number may be valid but does not apply to the billed services.	81,303
129	Prior processing information appears incorrect.	76,863

209	Per regulatory or other agreement. The provider cannot collect this amount from the patient. However, this amount may be billed to subsequent payer. Refund to patient if collected.	75,415
280	Claim received by the medical plan, but benefits not available under this plan. Submit these services to the patient's pharmacy plan for further consideration.	72,796
49	This is a non-covered service because it is a routine/preventive exam or a diagnostic/screening procedure done in conjunction with a routine/preventive exam.	72,441
100	Payment made to patient/insured/responsible party.	71,372
31	Patient cannot be identified as our insured.	69,878
163	Attachment/other documentation referenced on the claim was not received.	63,894
216	Based on the findings of a review organization.	63,794
B20	Procedure/service was partially or fully furnished by another provider.	58,005
44	Prompt-pay discount.	56,028
105	Tax withholding.	53,374
27	Expenses incurred after coverage terminated.	46,905
78	Non-covered days/room charge adjustment.	45,219
35	Lifetime benefit maximum has been reached.	43,425
152	Payer deems the information submitted does not support this length of service.	42,424
251	The attachment/other documentation that was received was incomplete or deficient. The necessary information is still needed to process the claim.	41,398
54	Multiple physicians/assistants are not covered in this case.	39,601
115	Procedure postponed, canceled, or delayed.	39,589
189	"Not otherwise classified" or "unlisted" procedure code (CPT/HCPCS) was billed when there is a specific procedure code for this procedure/service.	38,598
101	Predetermination: anticipated payment upon completion of services or claim adjudication.	38,335
172	Payment is adjusted when performed/billed by a provider of this specialty.	35,513
20	This injury/illness is covered by the liability carrier.	33,149
7	The procedure/revenue code is inconsistent with the patient's gender.	32,334
190	Payment is included in the allowance for a Skilled Nursing Facility (SNF) qualified stay.	30,609
B12	Services not documented in patient's medical records.	29,500
B14	Only one visit or consultation per physician per day is covered.	29,222
56	Procedure/treatment has not been deemed "proven to be effective" by the payer.	25,877
171	Payment is denied when performed/billed by this type of provider in this type of facility.	25,692
121	Indemnification adjustment - compensation for outstanding member responsibility.	24,652
P14	The benefit for this service is included in the payment/allowance for another service/procedure that has been performed on the same day.	24,581
208	National Provider Identifier - not matched.	24,032
60	Charges for outpatient services are not covered when performed within a period of time prior to or after inpatient services.	23,882

89	Professional fees removed from charges.	22,813
70	Cost outlier - adjustment to compensate for additional costs.	22,802
201	Patient is responsible for amount of this claim/service through "set aside arrangement" or other agreement.	21,908
199	Revenue code and procedure code do not match.	21,838
202	Noncovered personal comfort or convenience services.	19,643
21	This injury/illness is the liability of the no-fault carrier.	19,268
10	The diagnosis is inconsistent with the patient's gender.	17,518
19	This is a work-related injury/illness and thus the liability of the worker's compensation carrier.	17,392
215	Based on subrogation of a third-party settlement.	14,743
9	The diagnosis is inconsistent with the patient's age.	14,368
142	Monthly Medicaid patient liability amount.	13,560
140	Patient/Insured health identification number and name do not match.	12,873
227	Information requested from the patient/insured/responsible party was not provided or was insufficient/incomplete.	12,855
26	Expenses incurred prior to coverage.	12,657
169	Alternate benefit has been provided.	11,957
183	The referring provider is not eligible to refer the service billed.	11,735
206	National Provider Identifier – missing.	11,137
B22	This payment is adjusted based on the diagnosis.	10,883
40	Charges do not meet qualifications for emergent/urgent care.	9,501
103	Provider promotional discount (e.g., senior citizen discount).	9,348
235	Sales tax.	8,573
110	Billing date predates service date.	8,052
249	This claim has been identified as a readmission.	7,876
135	Interim bills cannot be processed.	7,555
A8	Ungroupable DRG.	6,859
164	Attachment/other documentation referenced on the claim was not received in a timely fashion.	6,506
148	Information from another provider was not provided or was insufficient/incomplete.	6,465
132	Prearranged demonstration project adjustment.	6,365
250	The attachment/other documentation that was received was the incorrect attachment/document. The expected attachment/document is still missing.	5,349
210	Payment adjusted because pre-certification/authorization not received in a timely fashion.	5,229
B8	Alternative services were available, and should have been utilized.	5,066
B1	Non-covered visits.	4,796
287	Referral exceeded.	4,704
178	Patient has not met the required spend down requirements.	4,569
274	Fee/Service not payable per patient Care Coordination arrangement.	4,482
134	Technical fees removed from charges.	3,954
153	Payer deems the information submitted does not support this dosage.	3,797
149	Lifetime benefit maximum has been reached for this service/benefit category.	3,200
195	Refund issued to an erroneous priority payer for this claim/service.	2,823
130	Claim submission fee.	2,598

177	Patient has not met the required eligibility requirements.	2,528
112	Service not furnished directly to the patient and/or not documented.	2,527
69	Day outlier amount.	2,435
296	Precertification/authorization/notification/pre-treatment number may be valid but does not apply to the provider.	1,904
91	Dispensing fee adjustment.	1,799
239	Claim spans eligible and ineligible periods of coverage. Rebill separate claims.	1,791
291	Claim received by the medical plan, but benefits not available under this plan. Claim has been forwarded to the patient's dental plan for further consideration.	1,735
300	Claim received by the medical plan, but benefits not available under this plan. Claim has been forwarded to the patient's Behavioral Health Plan for further consideration.	1,634
136	Failure to follow prior payer's coverage rules.	1,319
270	Claim received by the medical plan, but benefits not available under this plan. Submit these services to the patient's dental plan for further consideration.	1,104
85	Patient interest adjustment.	1,084
B4	Late filing penalty.	1,079
261	The procedure or service is inconsistent with the patient's history.	1,071
200	Expenses incurred during lapse in coverage.	1,023
184	The prescribing/ordering provider is not eligible to prescribe/order the service billed.	1,005
B23	Procedure billed is not authorized per your Clinical Laboratory Improvement Amendment (CLIA) proficiency test.	959
224	Patient identification compromised by identity theft. Identity verification required for processing this and future claims.	844
51	These are non-covered services because this is a pre-existing condition.	770
179	Patient has not met the required waiting requirements.	750
106	Patient payment option/election not in effect.	702
118	ESRD network support adjustment.	642
286	Appeal time limits not met.	622
299	The billing provider is not eligible to receive payment for the service billed.	615
187	Consumer Spending Account payments (includes but is not limited to Flexible Spending Account, Health Savings Account, Health Reimbursement Account, etc.).	568
282	The procedure/revenue code is inconsistent with the type of bill.	467
211	National Drug Codes (NDC) not eligible for rebate, are not covered.	448
298	Claim received by the medical plan, but benefits not available under this plan. Claim has been forwarded to the patient's vision plan for further consideration.	439
207	National Provider identifier - invalid format.	421
155	Patient refused the service/procedure.	418
166	These services were submitted after this payer's responsibility for processing claims under this plan ended.	392
160	Injury/illness was the result of an activity that is a benefit exclusion.	375
173	Service/equipment was not prescribed by a physician.	375

A5	Medicare claim PPS capital cost outlier amount.	366
276	Services denied by the prior payer(s) are not covered by this payer.	332
257	The disposition of the claim/service is undetermined during the premium payment grace period, per Health Insurance Exchange requirements. This claim/service will be reversed and corrected when the grace period ends (due to premium payment or lack of premium payment).	330
P8	Claim is under investigation.	326
P21	Payment denied based on the Medical Payments Coverage (MPC) and/or Personal Injury Protection (PIP) benefits jurisdictional regulations, or payment policies.	306
12	The diagnosis is inconsistent with the provider type.	284
32	Our records indicate the patient is not an eligible dependent.	271
139	Contracted funding agreement - subscriber is employed by the provider of services.	268
13	The date of death precedes the date of service.	264
114	Procedure/product not approved by the Food and Drug Administration.	227
P2	Not a work-related injury/illness and thus not the liability of the workers' compensation carrier.	215
233	Services/charges related to the treatment of a hospital-acquired condition or preventable medical error.	212
A0	Patient refund amount.	202
258	Claim/service not covered when patient is in custody/incarcerated. Applicable Federal, State or local authority may cover the claim/service.	165
260	Processed under Medicaid ACA Enhanced Fee Schedule.	157
34	Insured has no coverage for newborns.	144
14	The date of birth follows the date of service.	140
240	The diagnosis is inconsistent with the patient's birth weight.	135
P18	Procedure is not listed in the jurisdiction fee schedule. An allowance has been made for a comparable service.	114
111	Not covered unless the provider accepts assignment.	113
268	The Claim spans two calendar years. Please resubmit one claim per calendar year.	104
265	Adjustment for administrative cost.	100
P23	Medical Payments Coverage (MPC) or Personal Injury Protection (PIP) benefits jurisdictional fee schedule adjustment.	99
P5	Based on payer reasonable and customary fees. No maximum allowable defined by legislated fee arrangement.	94
279	Services not provided by preferred network providers.	92
267	Claim/service spans multiple months.	87
266	Adjustment for compound preparation cost.	80
301	Claim received by the medical plan, but benefits not available under this plan. Submit these services to the patient's Behavioral Health Plan for further consideration.	80
P16	Medical provider not authorized/certified to provide treatment to injured workers in this jurisdiction.	76
188	This product/procedure is only covered when used according to FDA recommendations.	75

275	Prior payer's (or payers') patient responsibility (deductible, coinsurance, co-payment) not covered.	73
175	Prescription is incomplete.	66
33	Insured has no dependent coverage.	64
232	Institutional transfer amount.	49
174	Service was not prescribed prior to delivery.	47
P4	Workers' compensation claim adjudicated as non-compensable. This Payer not liable for claim or service/treatment.	42
53	Services by an immediate relative or a member of the same household are not covered.	37
P22	Payment adjusted based on the Medical Payments Coverage (MPC) and/or Personal Injury Protection (PIP) benefits jurisdictional regulations, or payment policies.	28
158	Service/procedure was provided outside of the United States.	22
P12	Workers' compensation jurisdictional fee schedule adjustment.	21
76	Disproportionate share adjustment.	17
194	Anesthesia performed by the operating physician, the assistant surgeon or the attending physician.	16
180	Patient has not met the required residency requirements.	15
P11	The disposition of the related property & casualty claim (injury or illness) is pending due to litigation.	14
128	Newborn's services are covered in the mother's allowance.	13
212	Administrative surcharges are not covered.	13
238	Claim spans eligible and ineligible periods of coverage, this is the reduction for the ineligible period.	13
P10	Payment reduced to zero due to litigation. Additional information will be sent following the conclusion of litigation.	12
74	Indirect medical education adjustment.	9
213	Non-compliance with the physician self-referral prohibition legislation or payer policy.	9
229	Partial charge amount not considered by Medicare due to the initial claim type of bill being 12X.	8
117	Transportation is only covered to the closest facility that can provide the necessary care.	7
292	Claim received by the medical plan, but benefits not available under this plan. Claim has been forwarded to the patient's pharmacy plan for further consideration.	7
P13	Payment reduced or denied based on workers' compensation jurisdictional regulations or payment policies, use only if no other code is applicable.	7
116	The advance indemnification notice signed by the patient did not comply with requirements.	6
176	Prescription is not current.	6
P9	No available or correlating CPT/HCPCS code to describe this service.	6
219	Based on extent of injury.	5
P24	Payment adjusted based on Preferred Provider Organization (PPO).	5
254	Claim received by the dental plan, but benefits not available under this plan. Submit these services to the patient's medical plan for further consideration.	4

295	Pharmacy Direct/Indirect Remuneration (DIR).	4
A6	Prior hospitalization or 30-day transfer requirement not met.	4
75	Direct medical education adjustment.	3
247	Deductible for professional service rendered in an institutional setting and billed on an institutional claim.	3
283	Attending provider is not eligible to provide direction of care.	3
285	Appeal procedures not followed.	3
P3	Workers' compensation case settled. Patient is responsible for amount of this claim/service through WC "Medicare set aside arrangement" or other agreement.	3
66	Blood deductible.	2
90	Ingredient cost adjustment.	2
263	Adjustment for shipping cost.	2
61	Adjusted for failure to obtain second surgical opinion.	1
157	Service/procedure was provided as a result of an act of war.	1
205	Pharmacy discount card processing fee.	1
241	Low Income Subsidy (LIS) co-payment amount.	1
248	Coinsurance for professional service rendered in an institutional setting and billed on an institutional claim.	1
264	Adjustment for postage cost.	1
269	Anesthesia not covered for this service/procedure.	1
277	The disposition of the claim/service is undetermined during the premium payment grace period, per Health Insurance SHOP Exchange requirements. This claim/service will be reversed and corrected when the grace period ends (due to premium payment or lack of premium payment).	1
278	Performance program proficiency requirements not met.	1
P1	State-mandated requirement for property and casualty, see claim payment remarks code for specific explanation.	1
P19	Procedure has a relative value of zero in the jurisdiction fee schedule, therefore no payment is due.	1
P6	Based on entitlement to benefits.	1

Source: OIG analysis of 2019 MA encounter records from CMS's Integrated Data Repository.

[1] These are the number of MA encounter records that contained an adjustment code on the header and/or line portion of the record.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Administrator
Washington, DC 20201

DATE: January 30, 2023

TO: Ann Maxwell
Deputy Inspector General for Evaluation and Inspections
Office of Inspector General

FROM: Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services

SUBJECT: Office of Inspector General (OIG) Draft Issue Brief: The Inability to Identify Denied Claims in Medicare Advantage Hinders Fraud Oversight (OEI-03-21-00380)

The Centers for Medicare & Medicaid Services (CMS) appreciates the opportunity to review and comment on the Office of Inspector General's (OIG) draft report. CMS is committed to its oversight and enforcement of the requirements of the Medicare Advantage program.

CMS pays each Medicare Advantage Organization (MAO) a monthly per-person amount for each beneficiary enrolled in its plan. The per-person amount is adjusted for the risk of the beneficiary, which takes into account differences in health status between enrolled beneficiaries. Beneficiary risk scores are calculated with diagnoses that MAOs report to CMS. Diagnosis codes used for risk adjustment must meet specific criteria, including that the diagnosis is documented in the medical record. MAOs must submit encounter data records to CMS in order to report each item and service furnished to an enrollee under the MA plan and provided to an enrollee, regardless of the payment status of any claim (i.e. regardless of whether a claim is accepted or denied for payment, as long as the item or service was received by the enrollee). A claim may be denied for many administrative or coverage reasons. A provider may correct and re-submit a claim that was denied for technical reasons, and the MAO may subsequently pay it. The MAO is not required to submit an update to CMS when the claim is paid because CMS collects encounter data for risk adjustment, and payment status of a claim is not relevant to risk adjustment. However, MAOs are required to submit adjustment reason codes when they have not paid the exact amount that the provider billed. These codes explain changes to the paid amount, such as a denial, reduction, or increase in payment.

To ensure that MAOs are being paid appropriately, CMS conducts annual audits of a sample of MAOs to evaluate compliance with the terms of the MAOs' contracts with CMS; in particular, the requirements associated with access to medical services, drugs, and other enrollee protections required by Medicare. CMS also targets audits to areas of concern, such as service types with a high rate of denial. CMS notifies plans of noncompliance, such as when it believes a plan's coverage is more restrictive than under original Medicare and represents a possible barrier to accessing care. MAOs are required to submit corrective action plans to address cited

deficiencies. Plans that are found to have repeated violations are subject to increasing penalties, including Civil Monetary Penalties, intermediate sanctions (suspension of payment, enrollment, and/or marketing activities), and even contract terminations. In recent years, CMS has increased the transparency of audit findings by publishing them on the Medicare.gov website and developing a publicly available audit annual report with best practices MAOs can adopt to continue improving performance. CMS is also committed to ensuring that diagnoses that MAOs submit for risk adjustment are accurate. For example, CMS uses contract-level Risk Adjustment Data Validation (RADV) audits to validate that diagnoses used for risk adjustment meet program rules. RADV audits measure the accuracy of the plan-submitted diagnostic information through medical record and coding reviews, and uses the results of these audits to identify overpayments for individual MA contracts.

CMS appreciates the OIG's efforts in assessing Medicare Advantage data and will consider how to use the information from the report to further enhance program integrity efforts.

OIG's recommendations and CMS' responses are below.

OIG Recommendation

CMS should require MAOs to definitively indicate on MA encounter data records when they have denied payment for a service on a claim.

CMS Response

CMS has focused on the collection of encounter data for risk adjustment purposes in the MA program. The payment status of a claim (i.e. whether a claim is accepted or denied for payment) for an item or service is not necessary for the purposes of risk adjustment. Further, a claim submitted by a provider may be denied by the MAO for many administrative or coverage reasons. In addition, the fields and codes on the encounter data submission form are industry standards that CMS does not have unilateral control over.

While this data could potentially be helpful for program integrity purposes, CMS has been mindful of balancing immediate needs with long-term goals for the use of the data, as well as plan burden. As a result, we have not made a determination regarding the feasibility and burden in definitively indicating on MA encounter data records when an MAO has denied payment for an item or service. CMS would need to assess what additional information plans would be able to provide, if any, given the existing format in use for plans to report encounters.

Finally, it is important to be aware of the fact that CMS does not receive all denied claims. For example, plans cannot submit encounters to CMS for denied claims in situations when the claim cannot be processed through a plan's adjudication system. Therefore, identifying records within the encounter data system will not provide agencies with information on all denied claims. Oversight agencies may still need to reach out to plans in order to obtain information on all denied claims. CMS will continue to focus data collection efforts on fields in the encounter data record necessary for risk adjustment purposes, but will use the information in this report to further enhance program integrity efforts as appropriate.

CMS thanks OIG for their efforts on this issue and looks forward to working with OIG on this and other issues in the future.

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This issue brief was prepared under the direction of David Tawes, Acting Regional Inspector General for Evaluation and Inspections in the Philadelphia regional office, and Joanna Bisgaier, Deputy Regional Inspector General.

Contact

To obtain additional information concerning this report, contact the Office of Public Affairs at Public.Affairs@oig.hhs.gov. OIG reports and other information can be found on the OIG website at oig.hhs.gov.

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ENDNOTES

[1] CMS, *CMS Financial Report Fiscal Year 2021*, November 2021, p. 46. Accessed at https://www.cms.gov/files/document/cms-financial-report-fiscal-year-2021.pdf on March 2, 2022.

[2] An MAO is the private entity that contracts with CMS to provide coverage of Medicare Part A and B services through private health plan options. MAOs do not cover hospice costs for enrollees—these costs are covered through Medicare fee-for-service. However, MAOs may provide supplemental benefits that are not included in Medicare fee-for-service. MAOs may also offer prescription drug coverage under Medicare Part D. MA is also known as Medicare Part C.

[3] CMS, *Medicare Managed Care Manual*, *Payments to Medicare Advantage Organizations*, Pub. No. 100-16 (Rev. 118, September 19, 2014), ch. 8, § 10. Accessed at https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/mc86c08.pdf on July 25, 2022.

[4] 42 CFR § 422.310(b); CMS, *Encounter Data Submission and Processing Guide, Medicare Advantage Program*, October 2020, ch. 3, p. 17. Accessed at https://www.csscoperations.com/internet/csscw3_files.nsf/F/CSSCED_Submission_Processing_Guide_20201009.pdf/$FILE/ED_Submission_Processing_Guide_20201009.pdf on May 17, 2021.

[5] CMS, *Encounter Data Submission and Processing Guide, Medicare Advantage Program*, October 2020, ch. 2, p. 7. Accessed at https://www.csscoperations.com/internet/csscw3_files.nsf/F/CSSCED_Submission_Processing_Guide_20201009.pdf/$FILE/ED_Submission_Processing_Guide_20201009.pdf on May 17, 2021.

[6] Social Security Act, § 1853(a)(3)(B); 42 CFR § 422.310(b).

[7] CMS, *Medicare Managed Care Manual, Risk Adjustment*, Pub. No. 100-16 (Rev. 118, September 19, 2014), ch. 7, § 70.1. Accessed at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/mc86c07.pdf on July 26, 2022.

[8] CMS, *Announcement of Calendar Year (CY) 2011 Medicare Advantage Capitation Rates and Medicare Advantage and Part D Payment Policies and Final Call Letter*, p. 19. Accessed at https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Downloads/Announcement2011.pdf on April 27, 2022.

[9] Urban Institute and American Action Forum, *Using Encounter Data in Medicare Advantage Risk Adjustment*, January 2019. Accessed at https://www.urban.org/sites/default/files/publication/99623/using_encounter_data_in_medicare_7.pdf on April 27, 2022.

[10] According to the Medicare Advisory Payment Commission (MedPAC), MA plans implement efficiencies that reduce their health care costs year over year. However, due to CMS's payment policies, these savings are not passed on to CMS. MedPAC estimates that CMS spends 4 percent more on MA than it would spend on Medicare fee-for-service. MedPAC, *Report to the Congress: Medicare Payment Policy, March 2022*, pp. 415-417. Accessed at https://www.medpac.gov/wp-content/uploads/2022/03/Mar22_MedPAC_ReportToCongress_SEC.pdf on April 27, 2022.

[11] 42 CFR § 422.100(a); CMS, *Medicare Managed Care Manual*, *Benefits and Beneficiary Protections*, Pub. No. 100-16 (Rev. 121, April 22, 2016), ch. 4, § 10.1-10.2. Accessed at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/mc86c04.pdf on September 20, 2022.

[12] CMS, *Report to Congress: Alternative Payment Models & Medicare Advantage*, January 2020, p. 29. Accessed at https://www.hhs.gov/guidance/sites/default/files/hhs-guidance-documents/APMs_and_MA_RTC_508.pdf on August 24, 2022.

[13] 42 CFR § 422.566(b)(3).

[14] 42 CFR § 422.566(a)-(b) and (d).

[15] OIG, *Medicare Advantage Appeal Outcomes and Audit Findings Raise Concerns About Service and Payment Denials*, OEI-09-16-00410, September 2018.

[16] CMS, *Medicare Claims Processing Manual*, *Remittance Advice*, Pub. No. 100-04 (Rev. 11414, May 12, 2022), ch. 22, § 60.2. Accessed at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c22pdf.pdf on June 30, 2022.

[17] CMS, *Encounter Data Submission and Processing Guide, Medicare Advantage Program*, October 2020, ch. 3, p. 6. Accessed at https://www.csscoperations.com/internet/csscw3_files.nsf/F/CSSCED_Submission_Processing_Guide_20201009.pdf/$FILE/ED_Submission_Processing_Guide_20201009.pdf on May 17, 2021.

[18] X12, *Claim Adjustment Reason Codes*. Accessed at https://x12.org/codes/claim-adjustment-reason-codes on October 25, 2022. X12 is chartered by the American National Standards Institute and maintains electronic data interchange standards for the health care industry, including external code lists distributed by the Washington Publishing Company.

[19] The Claim Adjustment Status and Reason Code Maintenance Committee maintains the adjustment code set and updates it three times a year.

[20] CMS, *CMS Guidance: Reporting Denied Claims and Encounter Records to T-MSIS*, May 2020. Accessed at https://www.medicaid.gov/medicaid/data-and-systems/macbis/tmsis/tmsis-blog/entry/53973 on July 20, 2021.

[21] OIG, *Nationwide Brace Scam*, April 2019. Accessed at https://oig.hhs.gov/newsroom/media-materials/nationwide-brace-scam/ on July 14, 2022.

[22] OIG, *The MEDIC Produced Some Positive Results but More Could Be Done to Enhance its Effectiveness*, OEI-03-17-00310, July 2018.

[23] 42 CFR § 422.310(f)(1)(iv).

[24] GAO, *Medicare Advantage: Limited Progress Made to Validate Encounter Data Used to Ensure Proper Payments*, January 2017, p. 18. Accessed at https://www.gao.gov/assets/gao-17-223.pdf on March 2, 2022.

[25] OIG, *Medicare Advantage Appeal Outcomes and Audit Findings Raise Concerns About Service and Payment Denials*, OEI-09-16-00410, September 2018.

[26] OIG, *Some Medicare Advantage Organization Denials of Prior Authorization Requests Raise Concerns About Beneficiary Access to Medically Necessary Care*, OEI-09-18-00260, April 2022. OIG identified these denials from datasets that we obtained directly from MAOs, not from the MA encounter data.

[27] In addition to the adjustment code, the payer may use a remittance advice remark code (hereafter remark code) to further explain the reason for the adjustment. However, some remark codes also provide little information about the status of the billed amount. For example, remark code N33 ("No record of health check prior to initiation of treatment") does not definitively identify whether the MAO denied payment for the claim. CMS, *Medicare Claims Processing Manual*, *Remittance Advice*, Pub. No. 100-04 (Rev. 11414, May 12, 2022), ch. 22, § 60.3. Accessed at https://www.cms.gov/regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c22pdf.pdf on June 30, 2022.

[28] We included records containing adjustment codes that appeared at the header and/or line portion of the record.

[29] In addition, the MEDICs and DOJ reported that they do not have access to all payment variables in the MA encounter data.

[30] We use the term MAO to refer to a unique MA contract.

[31] MAOs that mainly reported adjustment codes only at the line level did so on at least 90 percent of their encounter records that contained these codes. Just two MAOs always reported their codes only at the header level (and never at the line level).