

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**MEDICARE ADVANTAGE COMPLIANCE
AUDIT OF SPECIFIC DIAGNOSIS CODES
THAT COVENTRY HEALTH CARE OF
MISSOURI, INC. (CONTRACT H2663)
SUBMITTED TO CMS**

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Office of Inspector General

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Report in Brief

Date: October 2021

Report No. A-07-17-01173

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



Why OIG Did This Audit

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

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

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

How OIG Did This Audit

We judgmentally selected 275 unique enrollee-years with the high-risk diagnosis codes for which Coventry received higher payments for 2014 through 2016. We limited our review to the portions of the payments that were associated with these high-risk diagnosis codes, which totaled \$701,593.

Medicare Advantage Compliance Audit of Specific Diagnosis Codes That Coventry Health Care of Missouri, Inc. (Contract H2663) Submitted to CMS

What OIG Found

Most of the selected diagnosis codes that Coventry submitted to CMS for use in CMS's risk adjustment program did not comply with Federal requirements. For 226 of the 275 enrollee-years, the diagnosis codes that Coventry submitted to CMS were not supported in the medical records.

These errors occurred because the policies and procedures that Coventry had to detect and correct noncompliance with CMS's program requirements, as mandated by Federal regulations, were not always effective. As a result, Coventry received \$548,852 of net overpayments for 2014 through 2016.

What OIG Recommends and Coventry's Comments

We recommend that Coventry refund to the Federal Government the \$548,852 of net overpayments; identify, for the diagnoses included in this report, similar instances of noncompliance that occurred during our audit period that we did not review and outside of our audit period and refund any resulting overpayments to the Federal Government; and enhance its compliance procedures to focus on diagnosis codes that are at high risk for being miscoded by: (1) educating its providers about the proper use and documentation of these diagnoses and (2) determining whether these diagnosis codes (when submitted to CMS for use in CMS's risk adjustment program) comply with Federal requirements.

Coventry agreed that most of the reviewed diagnosis codes were not supported by medical records and said that it had identified \$542,541 to refund to the Federal Government. However, Coventry did not agree with the other findings associated with our first recommendation and submitted additional documentation for our consideration. Coventry did not agree with our other recommendations and said that our report contained a number of serious flaws that fundamentally undermined our audit methodology, findings, and recommendations. Coventry also stated that it had made enhancements to its compliance processes since our audit period, including provider education.

After reviewing Coventry's comments and the additional documentation that it provided, we revised the number of enrollee-years in error. We followed a reasonable audit methodology, properly executed our sampling methodology, and correctly applied applicable Federal requirements underlying the MA program. We revised the recommendation to refund overpayments from \$584,005 (in our draft report) to \$548,852 and slightly revised some of the language in our third recommendation.

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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 codes¹ from their providers and submit these codes to CMS. 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. 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 27 major depressive disorder diagnoses into 1 group.) This audit covered Coventry Health Care of Missouri, Inc. (Coventry), for contract number H2663,² and focused on six groups of high-risk diagnosis codes.

OBJECTIVE

Our objective was to determine whether selected diagnosis codes that Coventry 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 is used by physicians and other health care providers 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 All subsequent references to "Coventry" in this report refer solely to contract number H2663.

BACKGROUND

Medicare Advantage Program

The MA program³ offers beneficiaries 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 (FFS) program. Beneficiaries 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 generally 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 2019, CMS paid MA organizations \$274 billion, which represented 34 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.⁴

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.⁵ 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.⁶

³ 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.

⁴ The Social Security Act (the Act) §§ 1853(a)(1)(C) and (a)(3); 42 CFR § 422.308(c).

⁵ The Act § 1854(a)(6); 42 CFR § 422.254.

⁶ CMS's bid-benchmark comparison also determines whether the MA organization must offer supplemental benefits or must charge a basic beneficiary 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).⁷ 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.

The risk adjustment program is prospective; CMS uses the diagnosis codes that the enrollee received for one year (known as the service year) to determine HCCs and calculate risk scores for the next 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, the enrollee's risk score increases, and the monthly risk-adjusted payment to the MA organization also increases. In this way, the risk adjustment 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 monthly Medicare payment that an MA organization receives for each enrollee before applying the budget

⁷ CMS transitioned from one HCC payment model to another during our audit period. As part of this transition, for 2014 and 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 2014 and 2015, an enrollee's blended risk score is based on the HCCs from both payment models. For 2016, CMS calculated risk scores on the Version 22 model.

sequestration reduction.⁸ Miscoded diagnoses submitted to CMS may result in HCCs that are not validated and incorrect enrollee risk scores, which may lead to improper payments (overpayments) from CMS to MA organizations. Conversely, correctly coded diagnoses that MA organizations do not submit to CMS may lead to improper payments (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 six high-risk groups:⁹

- *Acute stroke*: An enrollee received one acute stroke diagnosis (which maps to the HCC for Ischemic or Unspecified Stroke) on one physician claim during the service year but did not have that diagnosis on a corresponding inpatient hospital claim. 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 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 claim but did not have that diagnosis on a corresponding inpatient hospital claim (either within 60 days before or 60 days after the physician's claim). A diagnosis for a less severe manifestation of a disease in the related-disease group typically should have been used.
- *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) but did not have an anti-coagulant medication dispensed on his or her behalf. An anti-coagulant medication is typically used to treat an embolism. 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 (which maps to the HCC for Vascular Disease) but had medication dispensed on his or her behalf that is frequently dispensed for a diagnosis of neurogenic

⁸ Budget sequestration refers to automatic spending cuts that occurred through the withdrawal of funding for certain Federal 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.

⁹ Unless otherwise specified, the HCCs described in this report have the same name under both the Version 12 and Version 22 models.

claudication.¹⁰ Typically, the vascular claudication diagnoses may not be supported in the medical records. Further, in some of these instances, a diagnosis of neurogenic claudication (which does not map to an HCC) should have been used.

- *Major depressive disorder*: An enrollee received a major depressive disorder diagnosis (which maps to the HCC entitled Major Depressive, Bipolar, and Paranoid Disorders) on one claim during the service year but did not have an anti-depressant medication dispensed on his or her behalf. Typically, a diagnosis of a less severe form of depression (which does not map to an HCC) should have been used.
- *Potentially mis-keyed diagnosis codes*: An enrollee received multiple diagnoses for a condition but received only one—possibly 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 413 scenarios for the 2013 and 2014 service years in which ICD-9 diagnosis codes mis-keyed because of data transposition or other data entry errors could have resulted in the assignment of an unsupported HCC.

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

Coventry Health Care of Missouri, Inc.

Coventry is an MA organization based in Saint Louis, Missouri. As of December 31, 2016, Coventry provided coverage under contract number H2663 to approximately 54,000 enrollees, most of whom resided in Missouri.¹¹ For the 2014 through 2016 payment years (audit period), CMS paid Coventry approximately \$1.5 billion to provide coverage to its enrollees.¹²

HOW WE CONDUCTED THIS AUDIT

Our audit included enrollees on whose behalf providers documented high-risk diagnosis codes for the 2013 through 2015 service years, for which Coventry received increased risk-adjusted

¹⁰ Vascular claudication and neurogenic claudication are different diagnoses. Vascular claudication is a condition that can result in leg pain while 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.

¹¹ During 2013, Aetna, Inc. (Aetna), acquired Coventry. Although we are addressing this report to Aetna, we use “Coventry” throughout this report and in our findings and recommendations.

¹² All of the payment amounts that CMS made to Coventry and the adjustment amounts that we identified in this report reflect the budget sequestration reduction.

payments for payment years 2014 through 2016, respectively. Because enrollees could have high-risk diagnosis codes documented in more than 1 year, we classified the enrollees according to the condition and the payment year, which we refer to as “enrollee-years.” We identified 2,650 unique enrollee-years from which we judgmentally selected 275 unique enrollee-years with payments totaling \$4,597,079. We limited our review to the portions of the payments that were associated with these high-risk diagnosis codes, which totaled \$701,593. Table 1 breaks out the numbers of sampled enrollee-years (of the 275) associated with each of the 6 high-risk groups.

Table 1: Sampled Enrollee-Years

High-Risk Group	Number of Sampled Enrollee-Years
Acute stroke	98
Acute heart attack	71
Embolism	34
Vascular claudication	30
Major depressive disorder	12
Potentially mis-keyed diagnosis codes	30
Total	275

At our request, Coventry reviewed each of the 275 enrollee-years to determine whether the medical records supported the diagnosis code that it submitted to CMS. We refer to this as the Coventry internal coding review.

We evaluated each of the steps that Coventry took to perform its internal coding reviews and then relied on the results of those reviews for 240 of the 275 enrollee-years for this report. For the remaining 35 enrollee-years, we could not determine whether Coventry’s internal coding reviews adhered to International Classification of Diseases (ICD), Clinical Modification (CM), *Official Guidelines for Coding and Reporting* (ICD Coding Guidelines). For that reason, we used an independent medical review contractor to perform a coding review for these 35 enrollee-years to determine whether the medical records supported the diagnosis codes.

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.

FINDINGS

Most of the selected diagnosis codes that Coventry submitted to CMS for use in CMS's risk adjustment program did not comply with Federal requirements. For 49 of the 275 enrollee-years, the medical records validated the reviewed HCCs. For the remaining 226 enrollee-years, however, the diagnosis codes were not supported in the medical records.¹³

These errors occurred because the policies and procedures that Coventry had to detect and correct noncompliance with CMS's program requirements, as mandated by Federal regulations, were not always effective. As a result, the HCCs for these high-risk diagnosis codes were not validated, and Coventry received \$548,852 of net overpayments for 2014 through 2016.

FEDERAL REQUIREMENTS

Payments to MA organizations are adjusted for risk factors, including the health status of each enrollee (Social Security Act (the 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 add that if any related entity, subcontractor, or contractor generates such data, that entity is similarly responsible (42 CFR § 422.504(l)). CMS has provided instructions to MA organizations regarding the submission of data for risk scoring purposes (*Medicare Managed Care Manual* (the Manual) (last rev. Sept. 19, 2014), chap. 7).

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 ICD Coding Guidelines (42 CFR § 422.310(d)(1) and 45 CFR §§ 162.1002(b)(2)-(3) 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, chap. 7, § 40).

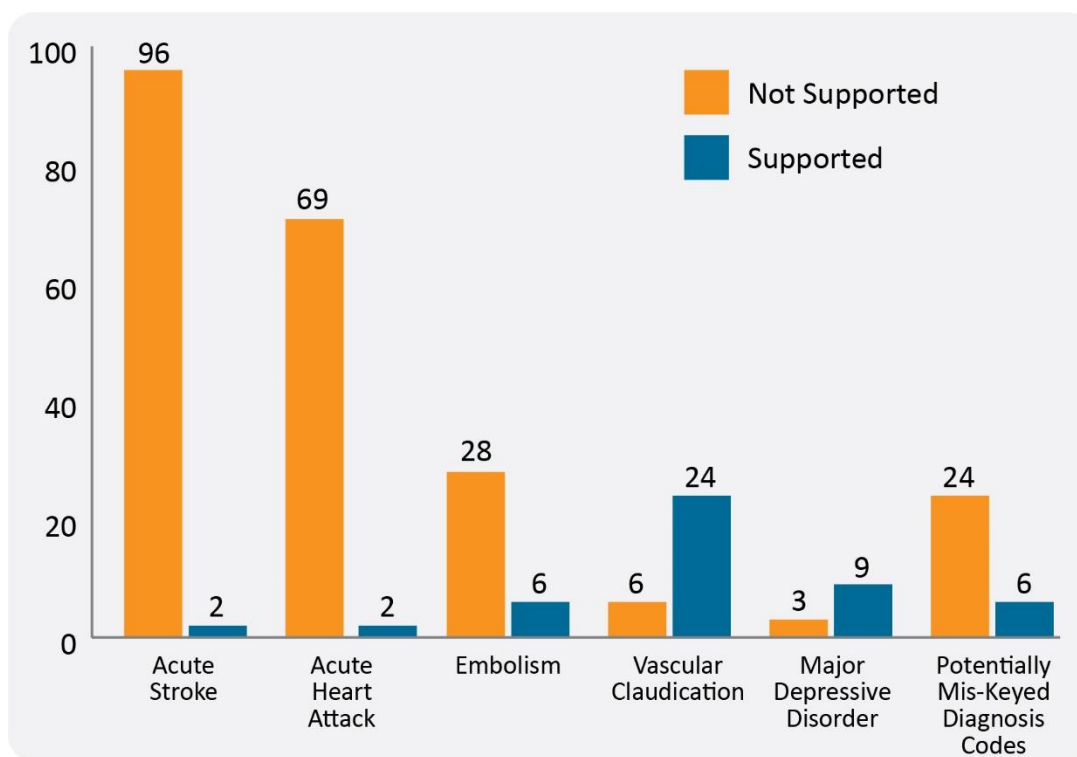
¹³ Of the 226 enrollee-years that were not supported in the medical records, the Coventry internal coding review identified 217 enrollee-years and the independent medical review contractor identified 9 enrollee-years.

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, 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); Appendix B).

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

Most of the selected high-risk diagnosis codes that Coventry submitted to CMS for use in CMS’s risk adjustment program did not comply with Federal requirements. Of the 275 enrollee-years sampled, 226 were not supported. In these instances, Coventry should not have: (1) submitted the diagnosis codes to CMS and (2) received the resulting increased payments for these enrollee-years. The Figure below breaks out, by high-risk group, the 226 enrollee-years that were not supported and the 49 enrollee-years that were supported.

Figure: Analysis of High-Risk Groups



Incorrectly Submitted Diagnosis Codes for Acute Stroke

Coventry incorrectly submitted diagnosis codes for acute stroke for 96 of 98 sampled enrollee-years.¹⁴ Specifically:

- For 88 enrollee-years, the medical records did not support an acute stroke diagnosis.

- For 55 of the 88 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, the Coventry internal coding review noted for 1 enrollee-year that the individual was "presented to [the] provider office [on March 26, 2013] for neurological follow-up. Provider notes [individual] is post stroke [since] 2001."

- For the remaining 33 enrollee-years, the medical records did not contain sufficient information to support an acute stroke diagnosis. In some instances, the medical records indicated that the physicians performed an assessment for a stroke; however, the results did not justify an acute stroke diagnosis.

For example, the Coventry internal coding review noted for 1 enrollee-year that the individual was admitted to the emergency department for a cerebrovascular accident. An assessment for an acute stroke was performed and a CT of the head "revealed no acute intracranial bleed and no acute cerebrovascular accident [acute stroke]."

- For 8 of the enrollee-years, the medical records did not contain sufficient information to justify an acute stroke diagnosis in accordance with ICD Coding Guidelines. The Coventry internal coding review stated that the medical records technically did not support an acute stroke diagnosis code. However, the review indicated that the acute stroke HCCs were supported from a clinical perspective (which is separate from a coding review and not permissible under ICD Coding Guidelines). Because CMS requires that MA organizations submit diagnosis codes that comply with ICD Coding Guidelines, we classified these 8 enrollee-years as errors.

For example, the Coventry internal coding review for 1 enrollee-year noted that an individual was presented to the emergency department "with vertigo and a history of [stroke]." The coding review noted that the provider stated that there were "no focal findings of acute posterior cerebrovascular accident [(acute stroke)]." The Coventry internal coding review also stated: "[t]herefore, the diagnosis might not be viewed as supported from a pure coding perspective based solely on a review of this record.

¹⁴ Of the 96 enrollee-years that were not supported in the medical records, the Coventry internal coding review identified 90 enrollee-years and the independent medical review contractor identified 6 enrollee-years.

However, based on the clinical support in the record for the diagnosis originally reported by the treating provider, [Coventry] is reporting this record as supported.” Because Coventry acknowledged that the acute stroke diagnosis code did not comply with ICD Coding Guidelines, we classified this example as an error.

As a result of these errors, the HCCs for Ischemic or Unspecified Stroke were not validated, and Coventry received \$238,910 of overpayments for these 96 sampled enrollee-years.

Incorrectly Submitted Diagnosis Codes for Acute Heart Attack

Coventry incorrectly submitted diagnosis codes for acute heart attack for 69 of 71 sampled enrollee-years.¹⁵ Specifically:

- For 48 enrollee-years, the medical records did not support an acute myocardial infarction diagnosis. However, we identified support for a diagnosis of old myocardial infarction, which is a less severe manifestation:
 - For 31 of the 48 enrollee-years, which occurred in 2014 or 2015, an old myocardial infarction diagnosis mapped to an HCC for a less severe manifestation of the disease-related group. Accordingly, Coventry should not have received an increased payment for the acute myocardial infarction diagnoses but should have received a lesser increased payment for the old myocardial infarction diagnoses.
 - For the remaining 17 enrollee-years, which occurred in 2016, an old myocardial infarction diagnosis did not map to an HCC.¹⁶ Coventry should not have received an increased payment for acute myocardial infarction.

For example, the Coventry internal coding review for 1 enrollee-year noted that the individual was “presented to office for follow-up. Provider notes in assessment old myocardial infarction. Old myocardial infarction is also listed in the diagnoses. Plan includes return visit in 6 months.” The Coventry internal coding review made no mention of acute myocardial infarction in the medical records.

- For 18 enrollee-years, the medical records did not support either a diagnosis for an acute myocardial infarction or an old myocardial infarction.

¹⁵ Of the 69 enrollee-years that were not supported in the medical records, the Coventry internal coding review identified 67 enrollee-years and the independent medical review contractor identified 2 enrollee-years.

¹⁶ For 2016, CMS used only the Version 22 model, which did not include an Old Myocardial Infarction HCC, to calculate risk scores (footnote 7).

For example, the Coventry internal coding review for 1 enrollee-year noted that the individual was “presented to [e]mergency [d]epartment for nausea Acute myocardial infarction not mentioned in provider note.” Further, the coding review did not make any mention of old myocardial infarction diagnoses in the medical records.

- For 2 enrollee-years, the medical records did not contain sufficient information to justify an acute myocardial infarction diagnosis in accordance with ICD Coding Guidelines. The Coventry internal coding review stated that the medical records technically did not support an acute heart attack diagnosis code. However, the review indicated that the Acute Heart Attack HCCs were supported from a clinical perspective (which is separate from a coding review and not permissible under ICD Coding Guidelines). Because CMS requires MA organizations to submit diagnosis codes that comply with ICD Coding Guidelines, we classified these 2 enrollee-years as errors.

For example, the Coventry internal coding review for 1 enrollee-year noted that the individual came to the emergency department for general weakness and got a preliminary diagnosis of myocardial infarction. The internal coding review also noted that the discharge summary for the individual did not contain a myocardial infarction diagnosis. The internal coding review stated: “[t]herefore, the diagnosis might not be viewed as supported from a pure coding perspective based solely on a review of this record. However, based on the clinical support in the record for the diagnosis originally reported by the treating provider, [Coventry] is reporting this record as supported.”

- For the remaining 1 enrollee-year, Coventry did not submit the correct diagnosis code to CMS. In this instance, Coventry did not submit a diagnosis code for “subendocardial infarction, initial,” which mapped to the most severe manifestation in the disease-related group. Instead, Coventry submitted a diagnosis code for “acute myocardial infarction, unspecified,” which mapped to a less severe manifestation. If Coventry had submitted the correct diagnosis code, the more severe HCC would have replaced the less severe HCC in the risk score. This error caused an underpayment.

As a result of these errors, the Acute Heart Attack HCCs were not validated, and Coventry received \$122,081 of net overpayments for these 69 sampled enrollee-years.

Incorrectly Submitted Diagnosis Codes for Embolism

Coventry incorrectly submitted diagnosis codes for embolism for 28 of 34 sampled enrollee-years.¹⁷ Specifically, the medical records did not support an embolism diagnosis. In these instances, the medical records indicated that the individual had previously had an embolism, but the records did not justify an embolism diagnosis at the time of the service.

¹⁷ The Coventry internal coding review made the determination for all 34 enrollee-years.

For example, the Coventry internal coding review for 1 enrollee-year noted that the diagnosis code for “other pulmonary embolism without acute cor pulmonale [right heart failure]” (that was submitted to CMS) was not supported and stated that the individual was “seen for leg swelling. Provider states [that the individual] has personal history of pulmonary embolism with a follow-up in two weeks.”

As a result of these errors, the Embolism HCCs were not validated, and Coventry received \$74,987 of overpayments for these 28 sampled enrollee-years.

Incorrectly Submitted Diagnosis Codes for Vascular Claudication

Coventry incorrectly submitted diagnosis codes for vascular claudication for 6 of 30 sampled enrollee-years.¹⁸ Specifically, for 6 enrollee-years, the medical records did not contain any indication of a vascular claudication diagnosis.

For example, the Coventry internal coding review for 1 enrollee-year noted that the individual was “presented to provider office for follow-up on respiratory failure. Peripheral vascular disease [a diagnosis that maps to the Vascular Disease HCC] not addressed or noted for this visit.”

As a result of these errors, the HCCs for Vascular Disease were not validated, and Coventry received \$14,706 of overpayments for these 6 sampled enrollee-years.

Incorrectly Submitted Diagnosis Codes for Major Depressive Disorder

Coventry incorrectly submitted diagnosis codes for major depressive disorder for 3 of 12 sampled enrollee-years.¹⁹ The medical records did not support these diagnoses. The Coventry internal coding review classified a major depressive disorder as unsupported when the medical records either lacked statements that the individuals had a major depressive disorder or did not indicate any treatment plan for the major depressive disorder. Further, the Coventry internal coding review noted that the physicians should have documented a diagnosis code for a less severe form of depression (that does not map to an HCC), instead of one for a major depressive disorder, on the medical record.

For example, the Coventry internal coding review for 1 enrollee-year noted that the individual was “presented to office for follow-up. Provider noted . . . that [the individual] has depression, however the depression [was] not stated as [a] major depressive disorder.”

¹⁸ Of the 6 enrollee-years that were not supported in the medical records, the Coventry internal coding review identified 5 enrollee-years and the independent medical review contractor identified 1 enrollee-year.

¹⁹ The Coventry internal coding review made the determination for all 12 enrollee-years.

As a result of these errors, the HCCs for Major Depressive, Bipolar, and Paranoid Disorders were not validated, and Coventry received \$7,842 of overpayments for these 3 sampled enrollee-years.

Incorrectly Submitted Potentially Mis-keyed Diagnosis Codes

Coventry incorrectly submitted potentially mis-keyed diagnosis codes for 24 of 30 sampled enrollee-years. The medical records did not support these diagnoses.²⁰ For each of the 24 enrollee-years, an incorrect diagnosis code was mis-keyed into the electronic claim. Specifically, the numerical diagnosis codes had numbers that either were transposed or had other data entry errors. Because of these errors, Coventry inadvertently submitted unsupported diagnosis codes that mapped to unvalidated HCCs. Table 3 in Appendix C contains the mis-keyed diagnosis codes that we identified for the 24 enrollee-years.

- For 15 enrollee-years, the medical records did not support the reviewed diagnosis code. Because of the data entry errors, Coventry submitted unsupported diagnosis codes that mapped to unvalidated HCCs to CMS.

For example, Coventry incorrectly submitted diagnosis code 482.0 (pneumonia) to CMS instead of the correct diagnosis code 428.0 (congestive heart failure, unspecified) for 1 enrollee-year. As a result, Coventry incorrectly received increased payments for the Aspiration and Specified Bacterial Pneumonias HCCs.

- For 9 enrollee-years, the medical records did not support the diagnosis code submitted to CMS; however, we identified support for another diagnosis code that mapped to a different HCC.

For example, Coventry incorrectly submitted diagnosis code 441.01 (dissection of aorta, thoracic) to CMS instead of the correct diagnosis code 414.01 (coronary atherosclerosis of native coronary artery) for 1 enrollee-year. We identified support for diagnosis code 441.4 (abdominal aneurysm without mention of rupture), which results in the Vascular Disease HCCs. Accordingly, Coventry should not have received an increased payment for the Vascular Disease With Complications HCCs, but it should have received a lesser increased payment for the Vascular Disease HCCs.

Appendix C contains the 24 HCCs that were not validated (Table 3) and the additional HCCs that were supported for the 9 enrollee-years (Table 4).

As a result of these errors, the HCCs associated with the potentially mis-keyed diagnosis codes were not validated, and Coventry received \$90,326 of overpayments for these 24 sampled enrollee-years.

²⁰ The Coventry internal coding review made the determination for all 30 enrollee-years.

THE POLICIES AND PROCEDURES THAT COVENTRY USED TO DETECT AND CORRECT NONCOMPLIANCE WITH FEDERAL REQUIREMENTS WERE NOT ALWAYS EFFECTIVE

The errors we identified occurred because the policies and procedures that Coventry had to detect and correct noncompliance with CMS's program requirements, as mandated by Federal regulations (42 CFR § 422.503(b)(4)(vi) (Appendix B)), were not always effective.

Coventry had compliance procedures to determine whether the diagnosis codes that it submitted to CMS to calculate risk-adjusted payments were correct. These procedures included a provider education program that was designed to promote accurate diagnosis codes; however, providers were not always instructed on the proper coding of high-risk diagnoses. In addition, Coventry's compliance procedures included steps to identify and correct diagnosis codes that did not comply with Federal requirements, but these procedures did not focus on high-risk diagnosis codes. Thus, Coventry could not always determine whether high-risk diagnosis codes were at risk for noncompliance.

COVENTRY RECEIVED NET OVERPAYMENTS

As a result of the errors we identified, Coventry received \$548,852 of net overpayments for the 226 enrollee-years (Table 2).

Table 2: Net Overpayments for High-Risk Groups

High-Risk Group	Net Overpayments
Acute stroke	\$238,910
Acute heart attack	122,081
Embolism	74,987
Vascular claudication	14,706
Major depressive disorder	7,842
Potentially mis-keyed diagnosis codes	90,326
Total	\$548,852

RECOMMENDATIONS

We recommend that Coventry Health Care of Missouri, Inc.:

- refund to the Federal Government the \$548,852 of total net overpayments;
- identify, for the diagnoses included in this report, instances of noncompliance in the enrollee-years that occurred: (1) during our audit period but were not included in our judgmental sample and (2) before and after our audit period and refund any resulting overpayments to the Federal Government; and

- enhance its compliance procedures to focus on diagnosis codes that are at high risk for being miscoded by:
 - educating its providers about the proper use and documentation of these diagnoses and
 - determining whether these diagnosis codes (when submitted to CMS for use in CMS's risk adjustment program) comply with Federal requirements.

COVENTRY COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

In written comments on our draft report, Coventry disagreed with some of our findings and recommendations. Coventry agreed that the reviewed diagnosis codes were not supported by medical records for 218 of the 226 enrollee-years in error and said that it had identified \$542,541 to refund to the Federal Government.²¹ However, Coventry did not agree with the other findings associated with our first recommendation and submitted additional documentation for our consideration. As an extension of this disagreement and in the context of its disagreement with our second recommendation, Coventry said that our report reflected “a number of serious flaws that fundamentally undermine [our] audit methodology, findings, and recommendations.” With respect to our third recommendation, Coventry stated that it had made enhancements to its compliance processes since our audit period, including provider education.

We reviewed the entirety of Coventry's comments and the additional information that it provided in preparing our final report. In addition, we determined that in our draft report we did not consider the less severe manifestations of a disease in the related-disease groups for 9 of the mis-keyed enrollee-years. Including the less severe HCCs in the risk scores reduced the overpayments for these enrollee-years. Further, our draft report did not consider the effects of sequestration and therefore did not reduce the net overpayment by 2 percent. Accordingly, we revised some of our findings and the first recommendation to refund overpayments (from \$584,005 to \$548,852) for this final report.²² We also revised Appendix C to clarify some of our findings. We made no change to our second recommendation and slightly revised some of the language in our third recommendation.

²¹ In its comments on our draft report, Coventry disagreed with our findings for 10 enrollee-years; however, as discussed below in “Coventry Disagreed With Our Findings For 6 Enrollee-Years,” we reversed our determinations for 2 enrollee-years. Coventry also stated in its comments that it had refunded \$543,280; however, through later correspondence Coventry clarified that it had identified \$542,541 to refund.

²² After we issued our draft report, we discovered a minor error in the methodology we used to calculate the amounts that CMS paid to Coventry for the enrollee-years included in our audit and associated overpayment amounts. Accordingly, we adjusted our calculations, which resulted in a decrease in our net overpayment amount of \$845.

A summary of Coventry's comments and our responses follows. Coventry's comments appear as Appendix D. We excluded a document (which Coventry identified as Exhibit A in its comments) that contained personally identifiable information for some of the enrollee-years. We are separately providing Coventry's comments and the additional information that it provided in their entirety to CMS.

COVENTRY DISAGREED WITH HOW THE OFFICE OF INSPECTOR GENERAL INSTRUCTED ITS MEDICAL REVIEW CONTRACTOR TO REVIEW MEDICAL RECORDS FOR 4 ENROLLEE-YEARS

Coventry Comments

For 4 enrollee-years, Coventry did not agree with how we reviewed the medical records that it submitted or the results of our reviews. Each of these individuals had been admitted into an inpatient hospital through an emergency room. To support the acute stroke diagnoses (3 enrollee-years) and the acute myocardial infarction diagnosis (1 enrollee-year), Coventry initially provided us with inpatient hospital records (which incorporated information from emergency room visits and notes from physicians) for the 4 enrollee-years.

Coventry did not agree with how we reviewed these medical records because, according to Coventry, we "viewed these diagnosis codes as errors simply because the conditions were ruled out by the subsequent hospital admission, even though the documentation submitted by the ER [emergency room] physician or ER department met [ICD Coding Guidelines]." In this regard, Coventry contended that we should have performed separate reviews of the emergency room records and the inpatient records.

Coventry also disagreed with the results of our independent medical review contractor and said, "At the conclusion of the ER visit, the physician had a definitive diagnosis and treatment plan including admission to the inpatient setting, consistent with ICD coding requirements. The progress notes contained definitive diagnoses for the care provided by the ER attending physician." Coventry also provided further explanations in its Exhibit A as support for the HCCs for the 4 enrollee-years.

Office of Inspector General Response

We do not agree with Coventry that we performed the wrong reviews or reached the wrong conclusions for these 4 enrollee-years.

Coventry provided us with inpatient records to support the HCCs for these 4 enrollee-years. Accordingly, we instructed our independent medical review contractor to review these records according to the ICD Coding Guidelines for inpatient records. Coventry has contended that to validate the HCCs, we should have evaluated the initial diagnoses that were made at the time of the emergency visit. Coventry provided inpatient records that incorporated information from emergency room visits and notes from physicians. In this regard, CMS's *Medical Record Reviewer Guide* (Reviewer Guide) makes clear that the emergency department "record date of

service is considered part of the inpatient date range when followed by a direct admission.”²³ Thus, we correctly instructed our independent medical review contractor to review these records in their entirety as inpatient records according to the ICD Coding Guidelines for inpatient records. Our contractor also reviewed the additional explanations that Coventry provided in its comments on our report.

Because our contractor did not find support for the reviewed HCCs, we made no changes to our findings and recommendations for these 4 enrollee-years.

COVENTRY DISAGREED WITH OUR FINDINGS FOR 6 ENROLLEE-YEARS

Coventry Comments

Coventry did not agree with our findings for 6 enrollee-years and provided explanations as to why it believed the medical records that it had previously provided to us validated the HCCs for the high-risk diagnosis codes we reviewed.

- For 3 enrollee-years, Coventry initially told us (during our audit) that the medical records did not contain sufficient information to justify an acute stroke diagnosis (2 enrollee-years) or a vascular claudication diagnosis (1 enrollee-year). We relied on Coventry’s initial statement for our draft report. However, in its comments on our draft report, Coventry said that these same records would validate the HCCs.²⁴ Coventry requested that our independent medical review contractor review these medical records and the explanations that Coventry provided for all 3 of these enrollee-years as support for the HCCs.
- For the remaining 3 enrollee-years, Coventry said that our independent medical review contractor made the wrong determinations.
 - For 1 enrollee-year, Coventry provided an explanation as to why it believed an emergency room medical record would validate an Acute Heart Attack HCC.
 - For 1 enrollee-year, Coventry provided explanations as to why it believed medical records would validate the Vascular Disease HCCs.
 - For the 1 remaining enrollee-year, Coventry initially provided an inpatient hospital record and an emergency room record to support an Acute Heart Attack HCC. In response to our adverse decision in our draft report, Coventry provided

²³ CMS created the Medical Record Reviewer Guide to provide information on its risk adjustment data validation medical record process. Coders use these guidelines to evaluate the medical records that MA organizations submit to CMS for audit purposes to validate audited diagnoses.

²⁴ These 3 enrollee-years are also included in “Coventry Did Not Agree With the Substantive Standards That the Office of Inspector General Applied To Support Its Findings for 13 Enrollee-Years” later in this report.

additional explanations as to why the emergency room record supported this HCC.

Office of Inspector General Response

Our independent medical review contractor reviewed all of the medical records to which Coventry referred as well as the explanations that Coventry provided in its comments on our draft report.

- For the 3 enrollee-years for which Coventry initially told us that the medical records did not contain sufficient information to justify the HCCs, we disagree with Coventry that the medical records now validate the HCCs. Our independent medical review contractor reviewed both the medical records and the explanations that Coventry provided and did not find support for the HCCs. Specifically, the medical records did not support any of the diagnosis codes that mapped to the HCCs. Accordingly, we continue to classify these enrollee-years as errors, but we reclassified the errors for these enrollee-years from “the medical records did not contain sufficient information to justify the HCC” to “the medical records did not contain any indication of the HCC” within the high-risk groups in our “Findings” section.
- For the remaining 3 enrollee-years for which Coventry said that our independent medical review contractor made the wrong determinations, we continue to disagree with Coventry regarding 1 enrollee-year, but we agree with Coventry on the other 2 enrollee-years and have revised our findings accordingly for this final report.
 - We continue to disagree with Coventry regarding the enrollee-year for which Coventry provided an explanation as to why it believed an emergency room medical record would validate an Acute Heart Attack HCC. Specifically, our independent medical review contractor reviewed Coventry’s explanation as well as both the emergency room record (according to ICD Coding Guidelines applicable to non-inpatient medical records) and the discharge summary from an inpatient medical record (according to ICD Coding Guidelines applicable to inpatient medical records), and did not find support for any diagnosis that would validate the Acute Heart Attack HCC.
 - We agree with Coventry that the medical record that it provided contained support for the Vascular Disease HCCs for 1 enrollee-year. Accordingly, we revised our finding for the vascular claudication high-risk group.
 - For the remaining enrollee-year (with an Acute Heart Attack HCC), Coventry separately submitted an inpatient hospital record and a document that recorded a portion of the emergency room visit (emergency room document). For our draft report, our independent medical review contractor reviewed only the inpatient hospital record and did not find support for the HCC. For this final

report, our contractor re-reviewed the inpatient record and also reviewed: (1) Coventry's explanations as to why it believed the emergency room document supported the HCCs and (2) the emergency room document itself. Our contractor found support on the emergency room record that validated the HCCs and, accordingly, we revised our finding for the acute heart attack high-risk group.

COVENTRY DID NOT AGREE WITH THE SUBSTANTIVE STANDARDS THAT THE OFFICE OF INSPECTOR GENERAL APPLIED TO SUPPORT ITS FINDINGS FOR 13 ENROLLEE-YEARS

Coventry Comments

Coventry disagreed with our findings for 13 enrollee-years because, it said, we applied a flawed audit methodology to review diagnosis codes.²⁵ Specifically, Coventry said that our reliance on the Manual and the *Risk Adjustment Training Manual* as criteria was an application of "substantive standards that did not comply with notice-and-comment requirements set forth in *Azar v. Allina Health Services*."²⁶ Coventry said that "substantive standards governing payments under Medicare must be promulgated pursuant to notice-and-comment rulemaking under 42 U.S.C. Section 1395hh(b), regardless of whether such standards are framed as rules, policies or otherwise."

Coventry stated that the "standards set forth in the Managed Care Manual created substantive payment standards that have not been properly promulgated, and therefore, may not be applied in any audit." These standards include requirements that risk adjustment diagnoses be "based on a face to face encounter" and originate "from a hospital inpatient, outpatient, or physician provider type with only a particular specified physician specialty." Coventry also said that "[r]isk adjustment is designed to look holistically at a patient's health condition." Coventry questioned our decision not to "review or consider as evidence of a health condition because of the absence of certain words in the medical record."

Coventry requested that we reconsider our position for these enrollee-years because, according to Coventry, the HCCs were supported from a clinical perspective.

Office of Inspector General Response

We disagree with Coventry's assertion that our methodology for evaluating the validity of certain codes Coventry submitted was flawed because our methodology applied substantive

²⁵ We identified 13 enrollee-years (10 for acute stroke, 2 for acute heart attack, and 1 for vascular claudication) as findings because Coventry's self-review identified that the diagnoses were supported from a clinical perspective, which is separate from a coding review and not permissible under ICD Coding Guidelines. These 13 enrollee-years are separate from the enrollee-years for which Coventry disagreed with our draft report and stated that the medical records supported the diagnosis codes (footnote 21).

²⁶ *Azar v. Allina Health Services*, 139 S. Ct. 1804 (2019).

standards that did not comply with notice-and comment requirements set forth in *Azar v. Allina Health*. The Manual is legally binding on an MA organization based not only on regulation, but also on the organization's 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.²⁷ In addition, MA organizations that contract with CMS must agree to follow CMS's instructions, including the provisions of the Manual.²⁸ Coventry has agreed to operate in compliance 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.²⁹

With regard to Coventry's statement that we declined to review the support (the medical records) that Coventry submitted for the 13 enrollee-years, we note that Coventry told us, during our fieldwork, that this support did not comply with ICD Coding Guidelines. MA organizations are required to adhere to ICD Coding Guidelines as required by Federal regulations at 42 CFR § 422.310(d)(1) and 45 CFR §§ 162.1002(b)(2)-(3) and (c)(2)-(3). Because Coventry identified the support for these 13 enrollee-years as noncompliant, we did not have our independent medical review contractor review these medical records.

We believe that MA organizations, such as Coventry, should expect that the diagnosis codes that it submits to CMS for risk adjustment purposes will be audited. Federal regulations at 42 CFR § 422.310(e) make clear that these diagnosis codes may be audited against the enrollees' medical records and that MA organizations are required to return payments due to diagnoses identified as unsupported.

Accordingly, Coventry's comments on our draft report did not cause us to make any revisions to our audit findings or recommendations for these 13 enrollee-years. We note that the net amounts that Coventry told us that it had already refunded to the Federal Government included refunds for 10 of these 13 enrollee-years.³⁰

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

²⁸ 42 CFR § 422.504(a).

²⁹ HHS [Department of Health and Human Services] *Good Guidance Final Rule* at 45 CFR part 1 (85 Fed. Reg. 78770 (Dec. 7, 2020)).

³⁰ The 3 enrollee-years for which Coventry did not refund net overpayments are those that we discussed in footnote 21.

COVENTRY DID NOT AGREE WITH THE OFFICE OF INSPECTOR GENERAL'S APPLICATION OF CMS REQUIREMENTS FOR CALCULATIONS OF OVERPAYMENTS

Coventry Comments

Coventry stated that our audit methodology failed to address critical aspects unique to MA and, as a result, our report contained “a flawed description of the [MA] program, unsupported findings, and problematic recommendations.” Specifically, Coventry stated that we did not address the statutorily required payment principle known as “actuarial equivalence.”

Coventry cited the provision of the Act that “requires CMS to pay MAOs [MA organizations] at rates that ensure ‘actuarial equivalence’ with what Medicare pays directly for similar health services for participants in traditional Medicare.” To this point, Coventry stated that the actuarial equivalence principle “is a legal mandate that must be considered in any context where an MAO’s payment for covering its Medicare Advantage enrollees is at issue.” Coventry also stated that “without accounting for the difference” between the unaudited data that CMS used to set the rates and the audited data, a data inconsistency problem would arise that could undermine the purpose of the risk adjustment program and result in payment inequities.

Coventry stated that to address this data inconsistency problem, CMS announced in calendar year 2012 that when calculating payment errors, it must apply a Fee-for-Service Adjuster (FFSA) amount as an offset to the preliminary recovery amount.³¹ In this regard, Coventry cited CMS’s statement (in the 2012 announcement) that the FFSA accounts for the fact that the documentation standard used in Risk Adjustment Data Validation (RADV) audits to determine a contract’s payment error (medical records) is different from the documentation standard used to develop the Part C risk adjustment model (FFS claims). To support its position, Coventry cited a Federal district court decision stating that actuarial equivalence requires that overpayment determinations based on reviews of medical records must account for the data inconsistency issue.³²

Coventry also stated that we exceeded our stated audit objective when we determined that unsupported diagnosis codes gave rise to overpayments. Thus, Coventry requested that we revise our findings and recommendations and address how our revised findings and recommendations are consistent with the statutory requirement of actuarial equivalence.

Office of Inspector General Response

Our audit objective and methodology correctly addressed certain aspects unique to the MA program, including actuarial equivalence.

³¹ *Notice of Final Payment Error Calculation Methodology for Part C Medicare Advantage Risk Adjustment Data Validation Contract-Level Audits* (Feb. 24, 2012).

³² *UnitedHealthcare Ins. Co. v. Azar*, 330 F.Supp.3d 173, 184 (D.D.C. 2018), *rev’d sub nom. UnitedHealthcare Ins. Co. v. Becerra*, No. 18-5326, 2021 WL 3573766 (D.C. Cir. Aug. 13, 2021).

We used the results of Coventry's internal coding review and our independent medical review to determine which of the high-risk HCCs were not substantiated and, in some instances, to identify HCCs that should have been used but were not used in the sampled enrollees' risk score calculations. We followed the requirements of CMS's risk adjustment program to determine the payment that CMS should have made for each enrollee. In this regard, unsupported diagnosis codes correlated to overpayments. We used the overpayments and underpayments identified for each enrollee to determine net overpayments.

Coventry commented that we did not consider actuarial equivalence in our overpayment calculations. CMS, not the Office of Inspector General (OIG), is responsible for making operational and program payment determinations for the MA program, including the application of any FFSA. Moreover, CMS has not issued any requirements that compel us to reduce our net overpayment calculations.³³ If CMS deems it appropriate to apply an FFSA, it will adjust our overpayment finding by whatever amount it determines necessary. Thus, we believe that the steps that we followed in this audit provide a reasonable basis for our findings and conclusions, including our calculation of net overpayments.³⁴

COVENTRY DISAGREED WITH THE OFFICE OF INSPECTOR GENERAL'S ASSESSMENTS OF ITS POLICIES AND PROCEDURES

Coventry Comments

Coventry said that our assessment of its policies and procedures as not always effective was "premised on a flawed expectation for MAOs that go well beyond what is required of MAOs." In this regard, Coventry stated that our audit methodology "may suggest an expectation that MAOs are required to ensure 100% accuracy of coding." To this point, Coventry stated that there is no "requirement that MAOs ensure 100% medical record support for the voluminous diagnosis data that healthcare providers submit to them" and that verifying all of the submitted risk adjustment data would be "prohibitive for MAOs."

Focusing on the actuarial equivalent requirement, Coventry said that "an expectation to ensure 100% accuracy of codes would disregard the known presence of unsubstantiated codes in the Original Medicare data and would render the risk adjustment system actuarially inequivalent." Coventry added that "MAOs do not have an obligation to identify and delete every erroneous diagnosis, or even a large fraction of them."

³³ We note that in 2018, CMS proposed "not to include an FFS adjuster in any final RADV payment error methodology." (Proposed Rule at 83 Fed. Reg. 54982, 55041.)

³⁴ 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 the 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.

Office of Inspector General Response

Coventry's comments implied that we opined on its responsibilities to ensure 100-percent accuracy on 100 percent of the data submitted to CMS. That was not our intention or our focus for this audit. As stated in our objective, we limited our review to selected diagnoses that we had determined to be at higher risk of being miscoded. Our audit revealed a significant error rate for some of these high-risk groups. In contrast to Coventry's statement regarding its obligation to identify and delete every erroneous diagnosis code, we believe that the Federal regulations compel Coventry to correct the errors identified in this report and to take steps to correct similar errors outside of those specifically identified in this audit.

These Federal regulations state that MA organizations are responsible for the accuracy, completeness, and truthfulness of the data submitted to CMS for payment purposes (42 CFR § 422.504(l)). MA organizations are also required to implement compliance programs that "must, at a minimum, include [certain] core requirements," which include steps to establish and implement "an effective system for routine monitoring and identification of compliance risks." These steps "should include internal monitoring and audits and, as appropriate, external audits," to evaluate the MA organizations "compliance with CMS requirements and the overall effectiveness of the compliance program" (42 CFR § 422.503(b)(4)(vi)(F)). Relatedly, MA organizations must exercise due diligence and good faith in ensuring data accuracy (42 CFR § 422.504(l)) and a duty to detect and correct noncompliance with CMS's program requirements (42 CFR § 422.503(b)(4)(vi)). Therefore, MA organizations, including Coventry, must implement a robust compliance program to identify problematic areas and should then delete diagnosis codes not supported by medical records.

We followed the requirements of CMS's risk adjustment program to determine the payment that CMS should have made for each enrollee. In this regard, unsupported diagnosis codes often correlate with overpayments. We used the overpayments and underpayments identified for each enrollee to determine net overpayments. Thus, Coventry's comments did not cause us to make any revisions to our audit findings and recommendations.

COVENTRY DID NOT ALWAYS AGREE WITH THE OFFICE OF INSPECTOR GENERAL'S RELIANCE ON CMS'S REVIEWER GUIDE TO EVALUATE MEDICAL RECORDS

Coventry Comments

Coventry stated that our instructions to our independent medical review contractor that it rely on CMS's Reviewer Guide ignored data submission requirements that CMS has placed upon MA organizations. Specifically, Coventry said the portion of the Reviewer Guide that directs reviewers to consider an emergency department record date of service as part of the inpatient range (when followed by a direct admission) ignores CMS risk adjustment submission requirements. According to Coventry, CMS's encounter submission guidance requires MA organizations to separately submit encounter data for both emergency room physician and outpatient services as well as for inpatient services.

To this point, Coventry said, “OIG’s recommendations could impose different requirements on Coventry than the industry, resulting in varying submission requirements. If the government wishes to change encounter data submission requirements to account for the ER and other issues discussed above, the more appropriate avenue is to address these changes through industry wide regulatory guidance that causes all MAOs to change submission processes—not just MAOs subject to audits.”

Office of Inspector General Response

We do not agree with Coventry that this portion of the Reviewer Guide ignores the requirement in the CMS *Encounter Data Submission Guide* that MA organizations must submit all risk adjustment data, including emergency room physician, emergency room outpatient, and inpatient stays. These guides serve different purposes.

CMS’s *Encounter Data Submission Guide* is a technical guide that instructs MA organizations on how to populate and submit encounter data records to CMS and that provides information on how CMS processes these records. According to Chapter 1.1, CMS requires MA organizations “to submit risk adjustment data that characterize the context and purpose of each item and service provided to a Medicare enrollee, as described in regulation at 42 CFR § 422.310.”

The Reviewer Guide provides instructions to coders on how to evaluate the medical records submitted by plans to validate audited diagnoses (footnote 23). This guidance does not mandate which records an MA organization may provide for an audit; instead, it requires the coders to evaluate the medical records that the MA organizations submit in accordance with the ICD Coding Guidelines.

For our audit, Coventry had the option to provide us up to 5 medical records that were associated with encounters that Coventry submitted to CMS, presumably in accordance with the *Encounter Data Submission Guide*. Our independent medical review contractor then reviewed each of those records according to the ICD Coding Guidelines for inpatient records or ICD Coding Guidelines for non-inpatient records, respectively.

In summary, this comment did not cause us to change our report.

COVENTRY DISAGREED WITH THE OFFICE OF INSPECTOR GENERAL’S AUDIT METHODOLOGY

Coventry Comments

Coventry stated that our audit methodology and the execution of that audit methodology contained flaws and, accordingly, contributed to skewed results. Specifically, Coventry stated that we designed our audit methodology with a bias “towards finding unsupported [diagnosis] codes.” Coventry also requested that we note that our “judgmentally selected audit is not representative of anything beyond the samples selected.” In this regard, Coventry made several points:

- Coventry stated that we “initially directed” it “to perform a self-review of 300 submitted diagnosis codes to determine if the samples were properly coded.”
- Coventry stated that we took an “unusual” step a year after we received its self-review results in that we “reduced the sample size by removing 25 samples.” Coventry noted that its “review results indicated that 19 of those 25 samples were validated” (emphasis removed).

Coventry also said that we may have deviated from generally accepted government auditing standards (GAGAS) when we did not disclose in our draft report that we had discarded “samples that were selected for testing—specifically samples that had a higher pass rate.” Coventry stated that we may have deviated from the GAGAS requirement to “explain how the completed audit work supports the audit objectives” and “identify significant assumptions made in conducting the audit.”

- Coventry stated that we used “targeting mechanisms” that undermined the usefulness of our report and that raised “questions as to whether . . . conclusions could be drawn” from our audit results. Specifically, Coventry stated that our report was not indicative of its overall adherence to Federal requirements because we targeted a “sub-cohort” of diagnoses that were at higher risk for being miscoded. In this context, Coventry took issue with our audit methodology because we selected for review only enrollees who:
 - received only one selected diagnosis during a calendar year,
 - did not receive a certain medication, and
 - had a claim with a certain place-of-service identifier.

Coventry contended that the sub-cohort of diagnosis codes represented codes that could only be in error (thus, a “one direction” audit). Coventry said that we neglected to audit “other codes [that were] susceptible to inaccuracies in the other direction [that is, diagnosis codes that Coventry did not submit to CMS].” In addition, Coventry stated that we should have performed our audit on “a statistically valid and randomly selected sample of (at a minimum) an entire Medicare Advantage contract.”³⁵

- Coventry stated that we failed to adequately explain “why some complex coding samples were sent” to our independent medical review contractor “while other equally complex samples were not” sent. Coventry also stated: “The samples that were sent . . . included only those samples for which Coventry had found support in the medical record” and that under this approach, validated samples “appeared to be subjected to a more rigorous review,” which further skewed our results.

³⁵ Coventry also stated that we should have applied an appropriate contract-level FFSA to ensure actuarial equivalence (this payment principle is discussed above in “Coventry Did Not Agree With the Office of Inspector General’s Application of CMS Requirements for Calculations of Overpayments”).

In summary, Coventry stated that we should address these flaws and revise our report.

Office of Inspector General Response

We disagree with Coventry's comments on our audit methodology and execution. Our objective and our explanation of the audit methodology and the scope of our review (Appendix A) make it clear that our audit considered only selected diagnoses that Coventry, under contract number H2663, submitted to CMS. We correctly conveyed our findings and recommendations (i.e., our audit results) within the framework of these limitations, as explained below:

- We did not *direct* Coventry to perform a "self-review" of the high-risk diagnosis codes for the enrollee-years; we do not have that authority and at no point did we imply that we did. Rather, we *asked* Coventry if it would perform this review. Coventry agreed to do so. If Coventry had not agreed to perform a self-review, we would have arranged for our independent medical review contractor to conduct medical reviews for all sampled items.
- Initially, we selected 300 enrollee-years for review. However, after we notified Coventry that we had selected these enrollee-years, we identified information that demonstrated that the 25 enrollee-years were no longer at high risk for being miscoded. Specifically, for 18 of the 25 enrollee-years, we identified anti-depressant medication dispensed on behalf of the individuals. For the remaining 7 enrollee-years, we identified information on CMS's systems that, because of timing differences in when CMS's systems were updated, no longer classified these enrollee-years into one of the high-risk groups as shown in Appendix A. Thus, we removed those 25 enrollee-years from our judgmental sample and on October 10, 2019, communicated the details of this decision to Coventry. In this regard, we believe that it was appropriate to reduce the scope of our audit to the remaining 275 sampled enrollee-years.

Furthermore, we disagree with Coventry's implication that our audit may have deviated from GAGAS. We adequately notified Coventry during our audit about the changes that we made to our audit scope. This report correctly conveys the results of the audit that we performed on the remaining 275 enrollee-years. Specifically, this report demonstrates that our completed audit work was consistent with the audit objectives and identifies the significant assumptions that we made when we conducted the audit. Thus, we did not deviate from GAGAS.

- We disagree that the usefulness of our report is undermined because of what Coventry described as our "targeting mechanisms." We neither designed nor executed our audit to evaluate Coventry's overall adherence to Federal requirements. In fact, our audit is useful precisely because we focused on what Coventry referred to as a "sub-cohort" of high-risk diagnosis codes for which we identified a significant number of errors and made appropriate recommendations.

Moreover, review of a statistically valid random sample associated with Coventry's entire contract or the inclusion of diagnosis codes that Coventry did not, but could have, submitted to CMS was beyond the scope of our audit.

- We disagree with Coventry's statement that we did not adequately address why we sent certain sampled enrollee-years to our independent medical review contractor. As explained to Coventry on multiple occasions during our audit and then again in this report, we decided to have certain sampled enrollee-years reviewed by our independent medical review contractor when we could not determine whether Coventry's internal coding review adhered to ICD Coding Guidelines. The results of Coventry's self-review for these enrollee-years had no bearing on our decision to refer them to our medical review contractor.

Thus, we did not make any revisions to language in our report in response to Coventry's comments on our audit methodology, execution, and scope.

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

CMS paid Coventry \$1,545,612,133 to provide coverage to its enrollees from 2014 through 2016. Our audit covered 2,650 unique enrollee-years on whose behalf providers documented high-risk diagnosis codes for the 2013 through 2015 service years, for which CMS paid Coventry a total of \$43,120,293. Of these unique enrollee-years, we judgmentally selected 275 enrollee-years with payments totaling \$4,597,079.

The 275 enrollee-years included 98 acute stroke diagnoses, 71 acute heart attack diagnoses, 34 embolism diagnoses, 30 vascular claudication diagnoses, 12 major depressive disorder diagnoses, and 30 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 \$701,593.

Our audit objective did not require an understanding or assessment of Coventry'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 December 2017 through May 2021.

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 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,
 - 58 diagnosis codes for embolism,
 - 4 diagnosis codes for vascular claudication, and
 - 27 diagnosis codes for major depressive disorder.

- We developed an analytical tool that identified 413 scenarios for the 2013 and 2014 service years in which ICD-9 diagnosis codes that, 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 413 occurrences, the tool identified a potentially mis-keyed diagnosis code and the likely correct diagnosis code. Accordingly, we considered the potentially 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)³⁶ to identify enrollees who received high-risk diagnosis codes from a physician during the service years,
 - Risk Adjustment System (RAS)³⁷ to identify enrollees who received an HCC for the high-risk diagnosis codes,
 - Medicare Advantage Prescription Drug (MARx)³⁸ to identify the total Medicare payments that CMS calculated, before applying the budget sequestration reduction, for Coventry for the payment years, and
 - Prescription Drug Event (PDE) to identify enrollees who had Medicare claims with certain medications dispensed on their behalf.
- We interviewed Coventry officials to gain an understanding of: (1) the policies and procedures that Coventry followed to submit diagnosis codes to CMS for use in the risk adjustment program and (2) Coventry's monitoring of those diagnosis codes to identify and detect noncompliance with Federal requirements.
- We judgmentally selected 275 enrollee-years that had either:
 - an acute stroke diagnosis (which maps to the HCC for Ischemic or Unspecified Stroke) on 1 physician claim during the service year but did not have that diagnosis on a corresponding inpatient hospital claim (98 enrollee-years),
 - a diagnosis that mapped to an Acute Heart Attack HCC on only 1 physician claim but did not have that diagnosis on a corresponding inpatient hospital claim either 60 days before or 60 days after the physician claim (71 enrollee-years),

³⁶ MA organizations use the RAPS to submit diagnosis codes to CMS.

³⁷ The RAS identifies the HCCs that CMS factors into each enrollee's risk score calculation.

³⁸ The MARx identifies the payments made to MA organizations.

- a diagnosis that mapped to an Embolism HCC but for which an anti-coagulant medication was not dispensed (34 enrollee-years),
 - a vascular claudication diagnosis (which maps to the HCC for Vascular Disease) but for which medication was dispensed for neurogenic claudication (30 enrollee-years),
 - a major depressive disorder diagnosis (which maps to the HCC entitled Major Depressive, Bipolar, and Paranoid Disorders) on 1 claim during the service year and for which an anti-depressant medication was not dispensed (12 enrollee-years), or
 - one of the 413 potentially mis-keyed diagnosis codes and multiple instances of diagnosis codes that were likely keyed correctly (30 enrollee-years).
- We requested that Coventry obtain and perform internal coding reviews of the medical records for the 275 enrollee-years to determine whether the high-risk diagnosis codes submitted to CMS complied with Federal requirements:
 - For 274 of the 275 enrollee-years, Coventry reviewed the medical record for the claim that contained the diagnosis code that it had originally submitted to CMS. However, for the remaining enrollee-year, Coventry could not obtain the medical record for the claim that contained the diagnosis code that it had originally submitted but located another medical record to review.
 - For some of the 275 enrollee-years, Coventry also reviewed other medical records of face-to-face encounters for the applicable enrollee-year.
 - We evaluated each of the steps that Coventry used to perform its internal coding reviews and then relied on the results of those reviews for 240 of the 275 enrollee-years for this report.

For Coventry's internal coding reviews for the remaining 35 enrollee-years, we could not determine whether Coventry's internal coding review adhered to ICD Coding Guidelines. For that reason, we used an independent medical review contractor to perform a coding review for these 35 enrollee-years to determine whether the medical records supported the diagnosis codes.

- The independent medical review contractor's coding review of the 35 enrollee-years 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 and then:
 - If the second senior coder also did not find support, the HCC was considered to be not 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 Coventry internal coding review and the independent medical review to calculate overpayments or underpayments for each enrollee. 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.
- We discussed the results of our audit with Coventry officials on February 5, 2020, and provided updated results on September 22, 2021.

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 B: 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 C: BREAKOUT OF MIS-KEYED DIAGNOSIS CODES

Table 3: 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	
7	441.01	Dissection of Aorta, Thoracic	Vascular Disease With Complications	414.01	Coronary Atherosclerosis of Native Coronary Artery	\$10,137
2	205.00	Leukemia	Metastatic Cancer and Acute Leukemia	250.00	Type 2 Diabetes Mellitus Without Complications	33,321
2	200.00	Reticulosarcoma, Unspecified Site	Lymphoma and Other Cancers	250.00	Type 2 Diabetes Mellitus Without Complications	10,928
2	250.10	Diabetes With Ketoacidosis	Diabetes Without Complications	205.10	Chronic Myeloid Leukemia	7,821
2	714.9	Unspecified Inflammatory Polyarthropathy	Rheumatoid Arthritis and Inflammatory Connective Tissue Disease	174.9	Malignant Neoplasm of Female Breast	5,447
1	200.60	Anaplastic Large Cell Lymphoma, NOS*	Lymphoma and Other Cancers	250.60	Diabetes With Neurological Manifestations, Type II or NOS	5,185
1	482.0	Pneumonia	Aspiration and Specified Bacterial Pneumonias	428.0	Congestive Heart Failure, Unspecified	4,424
1	249.10	Diabetes With Ketoacidosis, Type II or NOS	Diabetes With Acute Complications	294.10	Dementia Without Behavior Disturbance	2,846

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	446.7	Takayasu's Disease	Rheumatoid Arthritis and Inflammatory Connective Tissue Disease	447.6	Arteritis NOS	\$2,778
1	433.01	Cerebral Infarction	Ischemic or Unspecified Stroke	433.10	Occlusion and Stenosis of Carotid Artery	2,153
1	402.01	Hypertensive Heart Disease With Heart Failure	Congestive Heart Failure	402.10	Hypertensive Heart Disease Without Heart Failure	1,814
1	441.00	Dissection of Aorta, Unspecified Site	Vascular Disease With Complications	414.00	Coronary Atherosclerosis of Unspecified Type of Vessel	1,759
1	174.0	Malignant Neoplasm of Female Breast	Breast, Prostate, and Other Cancers and Tumors	714.0	Rheumatoid Arthritis	1,330
1	250.00	Type 2 Diabetes Mellitus Without Complications	Diabetes Without Complications	205.00	Leukemia	383
24						\$90,326

* NOS: Not otherwise specified.

**Table 4: Hierarchical Condition Categories (HCCs) That Were Not Validated;
However, Support Was Found for a Different HCC**

Count of Sampled Enrollee- Years*	Hierarchical Condition Category That Was Not Validated	Hierarchical Condition Category That Was Supported
8	Vascular Disease With Complications	Vascular Disease
1	Metastatic Cancer and Acute Leukemia	Breast, Prostate, Colorectal and Other Cancers and Tumors (Version 12 model) and Breast, Prostate, and Other Cancers and Tumors (Version 22 model)

* The 9 enrollee-years identified in Table 4 are a subset of the enrollee-years in Table 3.



August 20, 2020

Patrick Cogley
Regional Inspector General for Audit Services
Office of Audit Services, Region VII
Office of Inspector General
601 East 12th Street, Room 0429
Kansas City, MO 64106

Dear Mr. Cogley,

This letter is submitted on behalf of Coventry Health Care of Missouri, Inc. (“Coventry”)¹ in response to the Office of Inspector General (“OIG”)’s Draft Report entitled “Medicare Advantage Compliance Audit of Specific Diagnosis Codes That Coventry Health Care of Missouri, Inc. (Contract H2663) Submitted to CMS,” Report No. A-07-17-01173 (the “Draft Report”).²

Coventry understands it was subject to one of two pilot audits related to the Medicare Advantage risk adjustment program implemented by the OIG and appreciates the opportunity to provide comments for OIG’s consideration. Coventry is committed to an effective and insightful compliance program and stands ready to work with OIG in a collaborative fashion to address these issues. Coventry previously has offered to meet with the Office of Counsel to work with OIG to revise its approach to reflect the Medicare Advantage environment and continues to be ready to do so.

In Coventry’s view, the Draft Report reflects a number of serious flaws that fundamentally undermine OIG’s audit methodology, findings, and recommendations. An overarching concern is that OIG has not tailored its typical audit approaches to reflect the unique legal and actuarial framework, as well as the operational environment, of Medicare Advantage risk adjustment. Assumptions and approaches derived from Original Medicare cannot be directly applied to Medicare Advantage without careful evaluation. Coventry details its specific concerns with the Draft Report below and respectfully requests that OIG address these issues prior to finalizing the Report.

¹ Coventry Health Care Inc., the parent entity of Coventry Health Care of Missouri, Inc. was acquired by Aetna Inc. on May 7, 2013. Aetna Inc. was acquired by CVS Health on November 28, 2018. Throughout this response, we use the term Coventry to refer to the entity subject to this audit.

² References to “CMS” in these comments refers to the Centers for Medicare & Medicaid Services.

First, the Draft Report indicates that OIG did not appropriately address the requirement of actuarial equivalence with traditional Medicare reimbursement. Any determination of “overpayments” in Medicare Advantage must account for the need for payments to be actuarially equivalent to the Original Medicare program. See *UnitedHealthcare Ins. Co. v. Azar*, 330 F.Supp.3d 173, 185 (D.D.C. 2018) (“[P]ayments for care under traditional Medicare and Medicare Advantage are both set annually based on costs from unaudited traditional Medicare records, but the 2014 Overpayment Rule systemically devalues payments to Medicare Advantage insurers by measuring ‘overpayments’ based on audited patient records. This distinction makes an actuarial difference.”). But the Draft Report could imply that Medicare Advantage Organizations (“MAOs”) must assure that *all* codes—the vast majority of which are submitted by providers—are accurate and supported by medical record documentation. This expectation is reflected in OIG’s description of program requirements, its discussion of internal controls, and its recommendations. However, this expectation fails to consider MAOs’ role in the Medicare Advantage risk adjustment program, as well as that MAOs’ actions in monitoring provider-submitted codes must be appropriately calibrated to maintain a payment structure that is actuarially equivalent to Original Medicare. In fact, the Draft Report goes beyond the level of review the Department of Justice (“DOJ”) articulated in its recent defense of CMS’s 2014 Overpayment Rule. *UnitedHealthcare Ins. Co. v. Azar*, No. 18-5326, Brief for Appellants, at 2-3 (D.C. Cir. April 23, 2020).

The Draft Report’s failure to address actuarial equivalence while making its “overpayment” findings is a critical and fundamental issue affecting the validity of the OIG’s findings and recommendations. Coventry requests that OIG revise its findings and recommendations and address in its Final Report how its revised findings and recommendations are consistent with the statutory requirement of actuarial equivalence and an MAO’s oversight obligations.

Second, OIG applied substantive review standards in this audit that have not been subject to notice-and-comment procedures as required under *Allina*. *Azar v. Allina Health Services*, 139 S. Ct. 1804 (2019).

Third, OIG’s audit methodology focused only on a sub-cohort of codes—leading inevitably to results that were not representative of Coventry’s overall adherence to federal requirements. Moreover, audit findings associated with targeted audits are unreliable barometers of overpayment liability, and overpayment refund findings resulting from these targeted audits directly contravene the actuarial equivalence requirement.

Fourth, the findings with respect to certain individual conditions are incorrect. As an example, the Draft Report fails to acknowledge that Coventry is obligated under CMS rules to submit certain codes to CMS. OIG focuses on diagnosis codes submitted by Emergency Room (“ER”) physicians or departments that were later ruled out by a hospital inpatient stay. OIG suggests that—somehow among the millions of claims submitted—MAOs should compare ER claims with later hospital inpatient stays to reconcile conditions reported. Not only does this ignore

accepted coding standards, it ignores CMS's requirement that Coventry submit **both** the ER and inpatient stay claims.

We thank you for the opportunity to respond to your Draft Report and ask that you take our comments into consideration when preparing your Final Report. We ask that you include in your Final Report a copy of this letter and Attachment A, in its entirety.

Respectfully,

A handwritten signature in black ink, appearing to read "Patrick J. Jeswald, Jr.", written in a cursive style.

Patrick J. Jeswald, Jr.
Vice President, Chief Compliance Officer, Medicare

Attachment A

I. The Audit Methodology and the Draft Report Fail to Address Critical Aspects Unique to Medicare Advantage, including the Statutory Requirement of Actuarial Equivalence.

Medicare Advantage risk adjustment is a unique, actuarially based program that relies upon a vast quantity of data, principally generated by healthcare providers. As discussed below, these unique features of the Medicare Advantage risk adjustment program are not addressed in the design of the audit, nor the Draft Report. Such deficiencies led OIG to include in the Draft Report a flawed description of the program, unsupported findings, and problematic recommendations.

A. Critical Features of the Medicare Advantage Risk Adjustment Program.

i. Actuarial Equivalence

Medicare Advantage is an alternative to Original Medicare. Under Original Medicare,³ CMS pays healthcare providers directly for services provided to Medicare beneficiaries. Under Medicare Advantage, private insurers like Coventry contract with CMS to provide Medicare benefits to individuals who choose to enroll in Medicare Advantage plans. CMS pays MAOs a pre-determined differentiated per-member, per-month premium for each enrollee. Under the Medicare Advantage model, MAOs bear the risk for their enrollees' health costs, but must provide at least the same level of benefits to their enrollees as Original Medicare. If the cost of an enrollee's care exceeds the monthly payment the MAO receives, the MAO generally will bear the cost of the difference. To compensate insurers fairly for this risk, Congress established a risk-adjustment payment system.

As a critical feature of the Medicare Advantage risk adjustment program, the Social Security Act requires CMS to pay MAOs at rates that ensure "actuarial equivalence" with what Medicare pays directly for similar health care services for participants in traditional Medicare. 42 U.S.C. § 1395w-23(a)(1)(C)(i). Not only does this principle apply in CMS's implementation of the payment model, this principle is a legal mandate that must be considered in any context where an MAO's payment for covering its Medicare Advantage enrollees is at issue. In fact, the principle of actuarial equivalence has been recognized in a variety of contexts and organizations, including by a federal court. *UnitedHealthcare Ins. Co.*, 330 F.Supp.3d at 185.

The American Academy of Actuaries (the "Academy"), and CMS, recognized the need to account for actuarial equivalence in the context of risk adjustment data validation ("RADV") audits.

³ On occasion, this response, and references cited in this response, utilize the term "traditional Medicare" in lieu of "Original Medicare".

In 2011, in connection with a CMS proposal related to Medicare Advantage RADV payment error calculation methodology, the Academy submitted comments expressing concern that the proposed audit methodology created an “inconsistency between how the risk-adjustment factors were developed and how they now would be applied.” *American Academy of Actuaries Comment on RADV Sampling and Error Calculation Methodology* (Jan. 21, 2011). That is, CMS had utilized unaudited data in developing risk adjustment factors, but now sought to utilize audited data to calculate payment error without accounting for the difference. The Academy went on to note that “[t]his type of data inconsistency” could create “systematic underpayment, undermining the purpose of the risk-adjustment system and potentially resulting in payment inequities.” *Id.*

In acknowledging this actuarial equivalence problem, CMS adopted a “Final Payment Error Calculation Methodology” for RADV audits in which CMS concluded that it must “apply a Fee-for-Service Adjuster (FFS Adjuster) amount as an offset to the preliminary recovery amount.” CMS, *Notice of Final Payment Error Calculation Methodology for Part C Medicare Advantage Risk Adjustment Data Validation Contract-Level Audits* (Feb. 24, 2012). In that final methodology, CMS stated “[t]he FFS Adjuster accounts for the fact that the documentation standard used in RADV audits to determine a contract’s payment error (medical records) is different from the documentation standard used to develop the Part C risk-adjustment model (FFS claims).”

And, in *UnitedHealthcare Ins. Co. v. Azar*, the court explained that “the FFS Adjuster reflects CMS’s own estimate of the error rate in risk factors and diagnosis codes submitted by healthcare providers and paid by CMS for its traditional Medicare participants; applied to the results of a RADV audit of a Medicare Advantage insurer, it is designed to achieve actuarial equivalence between the two.” 330 F. Supp. 3d at 180.

Actuarial equivalence requires that any overpayment determination based on reviews of medical records must similarly account for the data inconsistency issue. *See UnitedHealthcare Ins. Co. v. Azar*, 330 F.Supp.3d 184 (“[P]ayments for care under traditional Medicare and Medicare Advantage are both set annually based on costs from unaudited traditional Medicare records, but the 2014 Overpayment Rule systemically devalues payments to Medicare Advantage insurers by measuring ‘overpayments’ based on audited patient records. This distinction makes an actuarial difference.”). Failure to do so will lead to underpayments to MAOs: “while CMS pays for all diagnostic codes, erroneous or not, submitted to traditional Medicare, it will pay less for Medicare Advantage coverage because essentially no errors would be reimbursed.” *Id.* at 187 (citation omitted). The court rejected the very approach OIG takes in this audit:

CMS cannot subject the diagnosis codes underlying Medicare Advantage payments to a different level of scrutiny than it applies to its own payments under traditional Medicare without impermissibly skewing the calculus. By doing so, it ensures that there will not be actuarial equivalence between traditional Medicare payments and Medicare Advantage payments for comparable patients.

Id. at 186.⁴

Finally, OIG previously acknowledged that error rates inherent in Original Medicare could affect audits of MAOs. See Department of Health and Human Services, Office of Inspector General, *Risk Adjustment Data Validation of Payments Made to PacifiCare of Texas for Calendar Year 2007 (Contract Number H4590)*, dated May 2012 (“while an analysis to determine the potential impact of error rates inherent in FFS data on MA payments was beyond the scope of our audit, we acknowledge that CMS is studying this issue and its potential impact on audits of MA organizations.”).

ii. *MAOs’ Role in Risk Adjustment*

MAOs must obtain and submit to CMS risk adjustment data as well as data necessary to characterize the context and purposes of each item and service provided by healthcare providers and suppliers to MA enrollees. 42 CFR 422.310(b) and 42 CFR 422.310(d)(3). The provision of care to an MAO’s enrollees generate tens of millions of claims from the providers rendering care, typically reflecting multiple diagnoses assigned by the providers, resulting in vast quantities of data for MAOs to receive and process. CMS’s risk adjustment model uses claims data in accordance with its goal of promoting practicality and administrative simplicity. See CMS, Advance Notice of Methodological Changes for Calendar Year (CY) 2004 Medicare+Choice (M+C) Payment Rates at 5 (Mar. 28, 2003) (CMS selected a risk adjustment model intended to “improve payment accuracy while minimizing the administrative data burden on” MAOs); see also Am. Acad. of Actuaries, Risk Adjustor Work Group, Actuarial Review of the Health Status Risk Adjustor Methodology at 30-31 (Jan. 14, 1999), available at <http://www.actuary.org/pdf/medicare/hcfa-riskadj.pdf> (model should be based on “data gained from administrative sources (typically from claim records or encounter files)” rather than clinical records because “clinical information from sources such as medical records and patient charts is nearly impossible to gather, except in the most manpower intensive manner.” MAOs rely upon healthcare facilities and providers (“providers”) to generate the majority of its risk adjustment data through the assessment and reporting of health conditions of an MAO’s enrollees.

The regulatory framework of Medicare Advantage risk adjustment does not include an expectation or requirement that MAOs ensure 100% medical record support for the voluminous diagnosis data that healthcare providers submit to them. Verifying 100% of submitted risk adjustment data would be prohibitive for MAOs. It also would be impractical, financially

⁴ The court also held that, by including in the Medicare Overpayment Rule supposed overpayments that should have been identified through reasonable diligence, the rule unlawfully imposed a more stringent knowledge standard on MAOs than existing federal law required. *UnitedHealthcare Ins. Co.*, 330 F. Supp. 3d at 190-191. The DOJ did not appeal this ruling. *UnitedHealthcare Ins. Co. v. Azar*, No. 18-5326, Brief for Appellants, at 22 (D.C. Cir. April 23, 2020).

unsustainable for MAOs, and inconsistent with the goal of administrative simplicity that underlies the actuarial hierarchical condition category (HCC) model. In recognition of these facts, CMS long has recognized 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.” 65 Fed. Reg. 40170, 40268 (June 29, 2000). Federal regulations require that MAOs submit all risk adjustment data from providers and also requires an attestation in respect 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.

Moreover, an expectation to ensure 100% accuracy of codes would disregard the known presence of unsubstantiated codes in the Original Medicare data and would render the risk adjustment system actuarially inequivalent. In its appeal of the district court’s ruling in *UnitedHealthcare*, the DOJ recognized that broad monitoring obligations would implicate actuarial equivalence. DOJ 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.***” *UnitedHealthcare Ins. Co. v. Azar*, No. 18-5326, Brief for Appellants, at 2-3 (D.C. Cir. April 23, 2020) (emphasis added). MAOs do not have an obligation to identify and delete every erroneous diagnosis, or even a large fraction of them. See *UnitedHealthcare Ins. Co. v. Azar*, No. 18-5326, Brief for Appellants, at 39-40 (D.C. Cir. April 23, 2020).

Although Coventry disagrees with DOJ’s position on the Overpayment Rule, its defense of that position confirms that a broad expectation to monitor and delete codes would violate actuarial equivalence.

B. Impact of Critical Features.

The failure to account for these critical aspects of Medicare Advantage, as described in Section A above, undermines the validity of the Draft Report’s overpayment findings (Draft Report at pp. 6-7), the description of plan obligations (Draft Report at p. 7), the evaluation of internal controls (Draft Report at p. 14), and the recommendations (Draft Report at pp. 14-15). Coventry requests that the OIG address these critical issues in the Final Report.

i. Overpayment Determinations

As discussed in Section I(A)(i), the statutory framework of the Medicare Advantage risk adjustment program requires that any determination of “overpayments” based on review of medical records must account for errors inherent in Original Medicare data that was used to construct the Medicare Advantage payment model. The Draft Report does not take account of this requirement. In addition, a determination of whether there has been any overpayment requires consideration of the legal requirements around actuarial equivalence as well as the

statutory and regulatory provisions governing overpayments, which the Draft Report does not address. Despite the fact that Coventry has raised, and courts have addressed, the core question of what constitutes an “overpayment,” the Draft Report fails to mention or discuss that question or the core issue of actuarial equivalence. The Draft Report’s findings of “overpayments” therefore are unsupported and inconsistent with statutory requirements.

In addition to being inconsistent with actuarial equivalence, we note that the “overpayment” determinations go beyond OIG’s stated objective for the audit – “to determine whether selected diagnosis codes that Coventry submitted to CMS for use in CMS’s risk adjustment program complied with Federal requirements.” But whether an unsupported code gives rise to an “overpayment” is a different question that is beyond the audit’s stated objective.

ii. Description of Monitoring Requirements and Assessment of Internal Controls

Actuarial equivalence also affects MAOs’ monitoring and compliance responsibilities and activities. While the Draft Report does not address the impact of actuarial equivalence on monitoring obligations of MAOs, it does state that “Federal regulations state that MA organizations must monitor the data that they receive from providers and submit to CMS.” (Draft Report at p. 8). The Draft Report does not quote or cite any rule directly stating this, and the scope of any such obligation is unsettled and implicates actuarial equivalence.

The OIG’s audit methodology itself may suggest an expectation that MAOs are required to ensure 100% accuracy of coding. (Draft Report at p. 7). As discussed in Section I(A) above, that is neither required nor feasible and would be inconsistent with actuarial equivalence.

Further, the Draft Report states that the purported errors OIG identified occurred because Coventry’s policies and procedures were not always effective and that “Coventry could not always determine whether high-risk diagnosis codes were at risk for noncompliance.” (Draft Report at p. 14). As described in Section I(A), these conclusions are premised on a flawed expectation for MAOs that go well beyond what is required of MAOs.

iii. Audit Methodology

OIG’s auditing of only a sub-cohort of codes compounds the actuarial equivalence issues. In this audit, OIG used unspecified data mining techniques to identify diagnoses that were at “higher risk for being miscoded” in one direction. (Draft Report at p. 4). But while certain codes may be susceptible to inaccuracies in one direction, other codes are susceptible to inaccuracies in the other direction. As CMS itself has stated, coding inaccuracies “mitigate each other due to offsetting effects.” CMS, Fee for Service Adjuster and Payment Recovery for Contract Level Risk Adjustment Data Validation Audits (Executive Summary) at p. 6 (Oct. 26, 2018).

In addition to selecting only a sub-cohort of codes, OIG applied additional analytics to identify claims for these codes that had a higher risk for error. Yet, the “high-risk” conditions that OIG identified may have been similarly at “high-risk” for being incorrectly coded in Original Medicare. Any audit/deletion process that focuses on diagnosis codes with a “higher risk for being miscoded” would systematically ignore the offsetting effects of errors in both Original Medicare and Medicare Advantage, and thereby render MAOs’ risk adjustment and payments actuarially inequivalent. In order to ensure actuarial equivalence, audits must be performed on a statistically valid and randomly selected sample of (at a minimum) an entire Medicare Advantage contract, with an appropriate contract-level FFS Adjuster.

Coventry requests that OIG revise its findings and recommendations and address in its Final Report how its revised findings and recommendations (i) are consistent with the statutory requirement of actuarial equivalence and (ii) properly reflect an MAO’s obligations.

II. This Audit Applied Review Standards that Are Not Consistent with Legal Requirements.

The audit’s methodology for evaluating the validity of certain codes submitted by Coventry is also flawed because it applied substantive standards that did not comply with notice-and-comment requirements set forth in *Azar v. Allina Health Services* and the related memo from the Department of Health and Human Services Office of the General Counsel.

In *Azar v. Allina Health Services*, 139 S. Ct. 1804 (2019), 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. Section 1395hh(b), regardless of whether such standards are framed as rules, policies or otherwise. The Department of Health and Human Services Office of the General Counsel recently has advised CMS that it may not apply in audits substantive standards that have not been properly promulgated.⁵ OIG’s audits, of course, must similarly apply only properly promulgated and binding legal standards.

In performing this audit, OIG utilized a variety of 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. Section 1395hh(b) and notice-and-comment requirements. These include requirements that risk adjustment diagnoses must be:

- based on a face to face encounter
- from a hospital inpatient, outpatient, or physician provider type with only a particular specified physician specialty

The samples at issue met the above requirements as well as other risk adjustment criteria. These and other standards set forth in the Managed Care Manual created substantive payment

⁵ Impact of *Allina* on Medicare Payment Rules at pp. 1-3 (available at https://d1198w4twoqz7i.cloudfront.net/wp-content/uploads/2019/12/05141151/CMS-Memo_Impact-of-Allina-on-Medicare-Payment-Rules.pdf).

standards that have not been properly promulgated, and therefore, may not be applied in any audit.

In addition, OIG did not allow the review of additional evidence relevant to evaluating enrollees' true health status. Coventry, through its affiliates, long has challenged the premise applied by CMS that an enrollee's health status can be evidenced only by the presence of certain words in a medical chart, without any further consideration of the enrollee's actual health condition as determined by the treating physician. Risk adjustment is designed to look holistically at a patient's health condition and is not focused on one point in time or a set date as this audit was designed. Coventry disagrees that the presence of certain words in a medical record can, or should, form the basis for a legally sufficient determination of an enrollee's health status. Coventry submitted clinical support for certain samples in this audit, which OIG declined to review or consider as evidence of a health condition because of the absence of certain words in the medical record. The Medicare Advantage risk adjustment program is intended to compensate MAOs for the health status of its membership; ignoring clinical evidence of health status and myopically focusing on key words in medical records undermines this objective.

III. OIG's Audit Approach and Execution Contributes to Skewed Results; Coventry Disagrees with the Application of Certain CMS Guidance and Particular Findings in the Audit.

A. Audit Findings of Unsupported Codes Is Not Reflective of Any Other Population.

The audit's objective was to determine whether the codes selected were supported. (Draft Report at p. 1). As noted above, Coventry disagrees with this audit's overpayment findings and the application of substantive standards that were not promulgated in accordance with notice and comment rules. Additionally, as set forth below, the manner in which codes were selected (and at times dropped) manifests that this audit was biased towards finding unsupported codes. Coventry recognizes that the judgmental sample in this audit does not implicate the same concerns as if OIG extrapolated the results across the entire Coventry contract. However, Coventry respectfully requests that the OIG note that this judgmentally selected audit is not representative of anything beyond the samples selected.

B. OIG Should Revise its Draft Report To Recognize that Flaws in the Scope of the Audit and Audit Execution Leads To Limited Applicability Beyond the Audit Sample.

OIG's narrow sample inevitably leads to conclusions that are not indicative of contract H2663 generally or Coventry's overall adherence to federal requirements. And as discussed in Section I, targeting a sub-cohort of codes that are "questionable" for being inaccurate presents an actuarial equivalence issue by subjecting MAOs' claims to far stricter scrutiny than Original Medicare.

Coventry was subject to one of two pilot audits OIG began in 2017. OIG describes this audit as a “performance audit” that targeted “six groups of high-risk diagnosis codes.” (Draft Report at p. 1). Using data mining techniques and discussions with medical professionals, OIG implemented a judgmental sample selection process that identified a limited set of diagnoses OIG viewed as being at higher risk for miscoding. (Draft Report at p. 1, 5-6). Starting with a judgmental sample focusing only on “high-risk” codes skews Coventry’s accuracy, especially where the risk adjustment model was calibrated to calculate reimbursement *across an entire population*—not for individual claims.

Coventry believes that the execution of the audit limits the applicability of its findings and recommendations. Three areas warrant consideration.

First, OIG initially directed Coventry to perform a self-review of 300 submitted diagnosis codes to determine if the samples were properly coded based on a review of the medical records over a three-year period.⁶ OIG then took the unusual step of reducing the sample size by removing certain samples *after* the samples had been reviewed. A year after receiving Coventry’s self-review results and two years after OIG began the audit, OIG reduced the sample size by removing 25 samples. Notably, Coventry’s review results indicated that **19 of those 25 samples were validated**.⁷ This is not addressed in the Draft Report. Indeed, if Coventry had been credited for those samples, the Draft Report would have reflected that Coventry correctly submitted diagnosis codes for 26 of the 30 enrollee years related to major depressive disorder, rather than 9 of 12 as indicated in the Draft Report. Coventry respectfully requests that OIG include and reflect these supported codes in the audit sample in the Final Report, or, in the alternative, address this reduction in sample size and potential change in audit methodology that occurred following Coventry’s submission of self-review results. Coventry believes that the OIG’s approach may deviate from traditional Generally Accepted Government Audit Standards.⁸

⁶ The audit focused on service years 2013 to 2015 for Coventry’s CMS Contract H2663 (these service years correspond to payment years of 2014-2016). Originally, the OIG announced the audit would be for payment years 2013-2015.

⁷ Of the 19 validated samples that were removed, 17 validated samples related to major depressive disorder and two validated samples related to acute myocardial infarction.

⁸ Discarding samples that were selected for testing—specifically samples that had a higher pass rate—suggests that OIG changed the audit methodology during the course of the audit. The Draft Report’s failure to address this issue appears inconsistent with Section 9.14 of the Generally Accepted Government Auditing Standards. Section 9.14 requires that in reporting audit methodology, auditors should explain how the completed audit work supports the audit objectives, including the evidence-gathering and evidence-analysis techniques, in sufficient detail to allow knowledgeable users of their reports to understand how the auditors addressed the audit objectives. Auditors also should (i) identify significant assumptions made in conducting the audit; (ii) describe comparative techniques applied; (iii) describe the criteria used; and, (iv) when the results of sample testing significantly support the auditors’ findings, conclusions, or recommendations, describe the sample design and state why the design was chosen, including whether the results can be projected to the intended population.

Second, on top of utilizing data mining and discussions with medical professionals to identify high-risk groups, the audit layered in additional targeting mechanisms that further undermine the Draft Report's applicability. These additional targeting mechanisms included: (i) choosing enrollee and diagnosis code combinations where a diagnosis code was submitted only once in the entire calendar year for such enrollee; (ii) selecting enrollees who had a certain condition but did not have a medication that is frequently dispensed in the treatment of such condition; and (iii) selecting a condition with a certain place of service. (Draft Report at p. 4). These additional screens raise questions as to whether even with respect to the sub-cohort of codes in this audit, conclusions could be drawn from the results.

Third, OIG used a third-party Independent Reviewer but failed to adequately address Coventry's questions as to why some complex coding samples were sent while other equally complex samples were not. The samples that were sent to the Independent Reviewer included only those samples for which Coventry had found support in the medical record.⁹ None of the samples that Coventry indicated as "discrepant" in its self-review results were sent to the Independent Reviewer for validation. Under this approach, "validated" samples appeared to be subjected to a more rigorous review than "discrepant" samples, further skewing results.

C. Emergency Medicine Physician Submissions, Clinically Supported Samples, Mis-Keyed Diagnoses and Other Findings with which Coventry Disagrees.

i. OIG Should Revise its Report To Recognize that ER Records May Be Accurately Coded Even if Later Inpatient Stays Rule Out Conditions.

Coventry disagrees with OIG's findings with respect to seven samples that a condition coded by an ER physician, other ER professional, or the Emergency Department—even if it is accurately coded at the time the patient was seen—is not supported because a later inpatient stay rules out the condition. (See Exhibit A for additional detail). OIG viewed these diagnosis codes as errors simply because the conditions were ruled out by the subsequent hospital admission, even though the documentation submitted by the ER physician or ER department met ICD-9 or ICD-10 coding guidelines. That approach imposes an unreasonable duty on MAOs and ignores CMS requirements and the practicalities of ER coding.

In accordance with CMS regulations, MAOs must submit to CMS data necessary to characterize the context and purposes of each item and service by a provider and must obtain risk adjustment data required by CMS from the provider that furnished the item or service.¹⁰ An ER

⁹ Originally, OIG sent 33 of the 300 samples to an Independent Reviewer. However, one of these samples was "removed" during the audit as described above.

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

physician is an acceptable physician specialty type for risk adjustment data submissions,¹¹ and therefore risk adjustment data from services provided by ER physicians must be reported to CMS. The same applies to outpatient claims from the ER department setting.

For these samples, the ER physician and other professionals in the ER department properly documented pertinent facts, findings, and observations. The medical records include testing, evaluation of symptoms, history of the enrollee, the chief complaint at the time, review of systems, and other medical details that occurred. At the conclusion of the ER visit, the physician had a definitive diagnosis and treatment plan including admission to the inpatient setting, consistent with ICD coding requirements. The progress notes contained definitive diagnoses for the care provided by the ER attending physician.

It appears that the Independent Reviewer and OIG relied upon guidance that CMS issued to its RADV contractors when finding these codes were unsupported.¹² This guidance is directed at medical record reviewers performing audits on CMS's behalf, and not MAOs. And as stated above, the guidance ignores the requirement that MAOs must submit this data under the CMS Encounter Data Submission requirements from both ER physician/outpatient services and inpatient stays. See Section III(D) below.

OIG's approach also is inconsistent with how emergency room care is provided. ER physicians and other physician specialists treat their patients (and submit their claims) based solely on how the patient is presenting at the ER. Obviously, while some conditions may be ruled out later, ER physicians and other physician specialists still may treat the patient for conditions they suspect at the time. They do not have the benefit of information from the subsequent inpatient stay or subsequent diagnostics.¹³ Still, OIG's approach would consider an ER code unsupported if it is later ruled out in a subsequent inpatient hospital stay even if the code is accurate at the time

¹¹ CMS's table for Acceptable Physician Specialty Type for Risk Adjustment Data Submissions for the audit period can be found at https://www.tpadministrator.com/internet/archive/cssc3_archive.nsf/docsCat/CSSC%20Operations~Risk%20Adjustment%20Processing%20System~References and [https://csscoperations.com/internet/csscw3_files.nsf/F/CSSCAcceptable%20Physician%20Specialty%20Types%20PY%202016_20140116.pdf/\\$FILE/Acceptable%20Physician%20Specialty%20Types%20PY%202016_20140116.pdf](https://csscoperations.com/internet/csscw3_files.nsf/F/CSSCAcceptable%20Physician%20Specialty%20Types%20PY%202016_20140116.pdf/$FILE/Acceptable%20Physician%20Specialty%20Types%20PY%202016_20140116.pdf)

¹² Contract-Level Risk Adjustment Data Validation Medical Record Reviewer Guidance at p. 40 (available at <https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-Risk-Adjustment-Data-Validation-Program/Other-Content-Types/RADV-Docs/Medical-Record-Reviewer-Guidance.pdf>).

¹³ In fact, Coventry examined the American College of Emergency Physicians organization's direction for graduating residents for coding and documentation. Physicians are directed as follows: "when physicians generate a chart for a patient encounter, the documentation is used by professional coders to assign specific patient care and procedural codes that reflect the extent of the evaluation and management of the care, as well as any procedures that may have been performed by the physician." This guidance indicates "it is important to note that the medical decision making of the chart that will determine the highest possible code and communicate to coders the complexity of the patient encounter and this is determined by three elements: 1) the differential diagnoses and management options that must be considered; 2) the data and the testing reviewed such as labs, EKGs, or x-rays; and 3) the risk of significant complications, morbidity, and or mortality to the patient."

of the ER visit, and even if the ER doctor provided care based on that initial diagnosis. Not only is OIG's approach illogical, it also raises an actuarial equivalence concern because this same pattern of coding occurs in Original Medicare claims.

Moreover, OIG's approach may violate *Allina* notice and comment requirements set forth in Section II(B)(i). If OIG and CMS intend to suggest that codes submitted by ER physicians are unsupported where they are ruled out by later stays, this guidance violates the agency's obligation to provide notice and comment procedures for substantive standards governing payment under Medicare.

Coventry asks OIG to reverse its findings with respect to these samples and recognize in its Final Report that Coventry is required to submit the ER claims to CMS and that, in many instances, ER physicians or ER departments accurately code conditions that may later be ruled out by subsequent care.

ii. OIG Should Revise Its Draft Report To Consider Samples that Were Clinically Supported.

As the Draft Report notes, Coventry found that certain samples were supported by clinical evidence during its self-review of medical records. (Draft Report at pp. 9, 10, 12).¹⁴ Coventry requests that OIG consider the health status of the enrollees as set forth in Section II and reverse its findings with respect to these samples in its Final Report. Specifically, Coventry found an enrollee's health status was clinically consistent with the diagnosis code Coventry had submitted to CMS during the audit period. Coventry submitted such samples to OIG as "supported," noting the basis for that support. The Draft Report notes that "[b]ecause CMS requires MAOs submit diagnosis codes that comply with ICD Coding Guidelines," OIG classified these clinically supported samples as errors. (Draft Report at pp. 9, 10, 12). Coventry asks that OIG consider samples that were clinically supported and reconsider its findings.

iii. OIG's Audit of Mis-Keyed Diagnoses Did Not Reliably Identify Errors and Cannot Be Applied To Claims Under Current ICD-10 Coding.

OIG also focused on "numerical diagnosis codes [that] had numbers that either were transposed or had other data entry errors"—described in the Draft Report as mis-keyed diagnoses. Coventry notes that the risk of continued inadvertent mis-keyed diagnoses for the codes OIG

¹⁴ In Coventry's self-review results, Coventry indicated 16 of the 300 samples were supported by clinical evidence. Later, Coventry submitted to OIG coding support for one of these samples, which OIG accepted. In addition, two of these samples were "removed" when OIG reduced the sample size of the audit. The Draft Report describes the remaining 13 samples as errors.

identified has been minimized by the transition to ICD-10 coding.¹⁵ Under ICD-9 coding guidelines, numerical diagnosis codes were used to designate a patient's health condition. With the transition to ICD-10 in 2015, changes were made to the numerical diagnosis code including the addition of letters and the update of numbers for each diagnosis code. These changes applied to the codes OIG identified as having a high risk for mis-keying in this audit. For example, OIG focused on 205.00 (Leukemia), which under ICD-9 could have been mis-keyed as 250.00 (Type 2 Diabetes Mellitus without Complications). Under ICD-10, the codes for Leukemia changed from 205.00 to C95.90, and the code for Type 2 Diabetes Mellitus without complications changed from 250.00 to E11.9. There is little chance Leukemia will be mis-keyed as Type 2 Diabetes Mellitus without complications.¹⁶

iv. Findings with which Coventry Disagrees.

During the exit conference and in subsequent discussions with OIG, Coventry requested additional information on determinations made by OIG and its Independent Reviewer as well as an opportunity to discuss the findings with which Coventry disagreed. In each case, OIG indicated that Coventry's opportunity to contest those findings was in this Response. In the attached Exhibit A, Coventry submits additional rationales for 10 samples with respect to which Coventry disagreed with findings set forth in the Draft Report. Coventry requests an opportunity to discuss these samples with OIG and the Independent Reviewer prior to the issuance of the Final Report.

D. OIG's Approach is Inconsistent With Encounter Data Requirements and Creates an Unlevel Playing Field When Applied Through Audits.

CMS requires submission of risk adjustment data even if an MAO has pended or denied a claim from the provider. Pursuant to Encounter Data Submission guidance issued by CMS, "CMS expects that MAOS and other entities will submit [encounter data records] for each service or item covered by the plan and provided to an enrollee, regardless of the payment status of the claim (for example, accepted, pending or denied for payment by MAO). Because an EDR is a record of a service or item covered by the plan and provided to an enrollee while enrolled in that plan, the MAO's final adjudication status of a claim from a provider is not relevant to the MAO's submission of an EDR report to CMS." CMS, *Encounter Data Submission and Processing Guide, Version 3.0, Medicare Advantage Program*, March 2019, at 2.1. OIG's recommendations could impose different requirements on Coventry than the industry, resulting in varying submission requirements. If the government wishes to change encounter data submission requirements

¹⁵ Appendix C of the Draft Report, "Mis-keyed Diagnosis Codes and Associated Overpayments" contains a technical error. The last row of Appendix C indicates that the correct code in this sample was 714.0 "Chronic hepatitis NOS." 714.0 is the diagnostic code for Rheumatoid Arthritis, and not Chronic Hepatitis NOS. In this particular case, the medical records showed support for both history of Malignant Neoplasm of the Female Breast and Rheumatoid Arthritis. Therefore, when taking this corrected information into account, it is unclear whether this was an example of mis-keyed data or simply improper coding by the provider.

¹⁶ Under ICD-10, the only medical conditions from the H2663 audit mis-keyed samples that continue to have similar diagnostic codes are Hypertensive Heart Disease with Heart Failure and Hypertensive Heart Disease without Heart Failure. These codes are similar because they are in the same ICD-10 category, reflecting the fact that they are in the same disease family.

to account for the ER and other issues discussed above, the more appropriate avenue is to address these changes through industry wide regulatory guidance that causes all MAOs to change submission processes—not just MAOs subject to audits.

IV. Recommendations.

A. OIG Recommends that Coventry Refund the \$584,005 in Overpayments.

Coventry submitted deletions through appropriate CMS processes for those diagnosis codes where Coventry concurred with OIG that the particular diagnosis code subject to audit was not supported by a medical record. This results in a total of \$543,279.73 in refunds to CMS—less than .05% of Contract H2663. For the reasons explained in Section I(A), above, Coventry does not agree with OIG’s characterization of such amounts as “overpayments” in the Draft Report. The legal framework does not support automatically equating unsupported risk adjustment data with an “overpayment,” as OIG’s recommendation does. For those diagnosis codes subject to the audit where Coventry found medical record support, Coventry did not submit deletions and does not concur with OIG’s findings or refund recommendations.

B. OIG Recommends that Coventry “identify, for the diagnoses included in this report, instances of noncompliance in the enrollee-years that occurred (1) during [OIG’s] audit period but were not included in [OIG’s] judgmental sample and (2) before and after [OIG’s] audit period and refund any resulting overpayments to the Federal Government.”

Coventry believes this recommendation reflects a number of flaws. To the extent it is based on the findings in the judgmental sample, as discussed in this response, the audit does not support the recommendation. The sample selected was not representative of the contract nor even a population of enrollees with these same diagnoses. In addition, the recommendation is inconsistent with the statutory actuarial equivalence requirement and legal provisions regarding identifying and refunding “overpayments,” along with other important issues.

C. OIG Recommends that Coventry Enhance its Compliance Procedures to Focus on Diagnosis Codes that are at High Risk for Being Miscoded.

With respect to the final recommendation to make certain enhancements to its compliance procedures, Coventry notes that enhancements have been made to compliance processes since the audit period, including, without limitation, enhancements to those processes focused on education of providers. Coventry is considering the appropriate course of action with respect to those remaining recommendations within the context of Coventry’s legal obligations. Coventry is committed to an effective compliance program and efforts to improve provider documentation and coding, but we ask that OIG’s Final Report take into account the unique statutory and regulatory environment for Medicare Advantage.

V. Conclusion.

Coventry recognizes that the audit at issue was a pilot audit and OIG may not have previously encountered some of the issues raised in this response. Coventry appreciates the opportunity to provide these comments on the Draft Report, and we look forward to OIG's careful consideration of the issues we have raised.