Department of Health and Human Services
Office of Inspector General
Office of Audit Services

March 2026 | A-07-22-01207

Medicare Advantage Compliance Audit of Specific Diagnosis Codes That Blue Cross and Blue Shield of Alabama (Contract H0104) Submitted to CMS

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Why OIG Did This Audit

- Under the Medicare Advantage (MA) program, CMS makes monthly payments to MA organizations based in part on the health status of the enrollees being covered.
- 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.
- This audit of Blue Cross and Blue Shield of Alabama (BCBSAL) is part of a series of audits in which we are reviewing high-risk diagnosis codes that MA organizations submitted to CMS for use in its risk adjustment program.

What OIG Found

Most of the selected diagnosis codes that BCBSAL submitted to CMS for use in CMS's risk adjustment program did not comply with Federal requirements.

- For 247 of the 271 sampled enrollee-years, medical records did not support the diagnosis codes and resulted in $769,195 in overpayments.
- On the basis of our sample results, we estimated that BCBSAL received at least $7 million in overpayments for 2018 and 2019.

As demonstrated by the errors found in our sample, BCBSAL's policies and procedures to prevent, detect, and correct noncompliance with CMS's program requirements, as mandated by Federal regulations, could be improved.

What OIG Recommends

We recommend that BCBSAL:

1. refund to the Federal Government the $7 million of estimated overpayments;
2. identify, for the high-risk diagnoses included in this report, similar instances of noncompliance that occurred after our audit period and refund any resulting overpayments to the Federal Government; and
3. enhance its examination of its existing compliance procedures to identify areas where improvements can be made to ensure that diagnoses that are at high risk for being miscoded comply with Federal requirements (when submitted to CMS for use in CMS's risk adjustment program) and take the necessary steps to enhance those procedures.

BCBSAL did not concur with some of our findings and requested that we reconsider all of our recommendations.

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INTRODUCTION

WHY WE DID THIS AUDIT

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

This audit is part of a series of audits in which we are reviewing the accuracy of diagnosis codes that MA organizations submitted to CMS.[2] Using data mining techniques and considering discussions with medical professionals, we identified diagnoses that were at higher risk for being miscoded and consolidated those diagnoses into specific groups. (For example, we consolidated 54 breast cancer diagnoses into 1 group.) This audit covered Blue Cross and Blue Shield of Alabama (BCBSAL) for contract number H0104, and focused on nine groups of high-risk diagnosis codes for payment years 2018 and 2019.[3, 4]

OBJECTIVE

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

BACKGROUND

Medicare Advantage Program

The MA program offers people eligible for Medicare managed care options by allowing them to enroll in private health care plans rather than having their care covered through Medicare's

[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.

[2] MA compliance audit reports issued by the Office of Inspector General (OIG) are published on the OIG website.

[3] All subsequent references to "BCBSAL" in this report refer solely to contract number H0104.

[4] The 2018 and 2019 payment year data were the most recent data available at the start of the audit.

traditional fee-for-service (FFS) program.[5] Individuals who enroll in these plans are known as enrollees. To provide benefits to enrollees, CMS contracts with MA organizations, which in turn contract with providers (including hospitals) and physicians.

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

For 2024, CMS paid MA organizations $494 billion, which represented 44 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.[6]

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.[7] 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.[8]

- *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

[5] 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.

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

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

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

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).[9] Each HCC has a factor (which is a numerical value) assigned to it for use in each enrollee's risk score.

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

For enrollees who have certain combinations of HCCs, CMS assigns a separate factor that further increases the risk score. CMS refers to these combinations as disease interactions. For example, if MA organizations submit diagnosis codes for an enrollee that map to the HCCs for lung cancer and immune disorders, CMS assigns a separate factor for this disease interaction. By doing so, CMS increases the enrollee's risk score for each of the two HCC factors and by an additional factor for the disease interaction.

The risk adjustment program is prospective. Specifically, CMS uses the diagnosis codes that the enrollee received for one calendar year (known as the service year) to determine HCCs and calculate risk scores for the following calendar year (known as the payment year). Thus, an enrollee's risk score does not change for the year in which a diagnosis is made. Instead, the risk score changes for the entirety of the year after the diagnosis has been made. Further, the risk score calculation is an additive process: As HCC factors (and, when applicable, disease interaction factors) accumulate, an enrollee's risk score increases, and the monthly risk-adjusted payment to the MA organization also increases. In this way, the risk adjustment program compensates MA organizations for the additional risk of 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 sequestration reduction.[10] Thus, if the factors used to determine an enrollee's risk score are

[9] During our audit period, CMS calculated risk scores based on the Version 22 CMS-HCC model for payment year 2018 and the Version 23 CMS-HCC model for payment year 2019.

[10] 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.

incorrect, CMS will make an improper payment to an MA organization. Specifically, if medical records do not support the diagnosis codes that an MA organization submitted to CMS, the HCCs are not validated, which causes overstated enrollee risk scores and overpayments from CMS.[11] Conversely, if medical records support the diagnosis codes that an MA organization did not submit to CMS, validated HCCs may not have been included in enrollees' risk scores, which may cause those risk scores to be understated and may result in underpayments.

High-Risk Groups of Diagnoses

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

- *Acute stroke*: An enrollee received one acute stroke diagnosis (that mapped to the HCC for Ischemic or Unspecified Stroke) on only one physician claim during the service year but did not have an acute stroke diagnosis on a corresponding inpatient or outpatient hospital claim. In these instances, a diagnosis of history of stroke (which does not map to an HCC) typically should have been used.

- *Acute myocardial infarction*: An enrollee received one diagnosis (that mapped to the HCC for Acute Myocardial Infarction) on only one physician or outpatient claim during the service year but did not have an acute myocardial infarction diagnosis on a corresponding inpatient hospital claim (either within 60 days before or 60 days after the physician or outpatient claim). In these instances, a diagnosis indicating a history of a myocardial infarction (which does not map to an HCC) 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) on only one claim during the service year but did not have an anticoagulant medication dispensed on his or her behalf. An anticoagulant medication is typically used to treat an embolism. In these instances, a diagnosis of history of embolism (an indication that the provider is evaluating a prior acute embolism diagnosis, which does not map to an HCC) typically should have been used.

- *Lung cancer*: An enrollee received one lung cancer diagnosis (that mapped to the HCC for Lung and Other Severe Cancers) on only one claim during the service year but did not have surgical therapy, radiation treatments, or chemotherapy drug treatments administered within a 6-month period either before or after the diagnosis. In these

[11] 42 CFR § 422.310(e) requires MA organizations (when undergoing an audit conducted by the Secretary) to submit "medical records for the validation of risk adjustment data." For purposes of this report, we use the terms "supported" or "not supported" to denote whether or not the reviewed diagnoses were evidenced in the medical records. If our audit determines that the diagnoses are supported or not supported, we accordingly use the terms "validated" or "not validated" with respect to the associated HCC.

instances, a diagnosis of history of lung cancer (which does not map to an HCC) typically should have been used.

- *Breast cancer*: An enrollee received one breast cancer diagnosis (that mapped to the HCC for Breast, Prostate, and Other Cancers and Tumors) on only one claim during the service year but did not have surgical therapy, radiation treatments, or chemotherapy drug treatments administered within a 6-month period before or after the diagnosis. In these instances, a diagnosis of history of breast cancer (which does not map to an HCC) typically should have been used.

- *Colon cancer*: An enrollee received one colon cancer diagnosis (that mapped to the HCC for Colorectal, Bladder, and Other Cancers) on only one claim during the service year but did not have surgical therapy, radiation treatments, or chemotherapy drug treatments administered within a 6-month period before or after the diagnosis. In these instances, a diagnosis of history of colon cancer (which does not map to an HCC) typically should have been used.

- *Prostate cancer:* An enrollee 74 years old or younger received one prostate cancer diagnosis (that mapped to the HCC for Breast, Prostate, and Other Cancers and Tumors) on only one claim during the service year but did not have surgical therapy, radiation treatments, or chemotherapy drug treatments administered within a 6-month period before or after the diagnosis. In these instances, a diagnosis of history of prostate cancer (which does not map to an HCC) typically should have been used.

- *Sepsis:* An enrollee received one sepsis diagnosis (that mapped to the HCC for Septicemia, Sepsis, Systemic Inflammatory Response Syndrome/Shock) on only one physician or outpatient claim during the service year but did not have a sepsis diagnosis on a corresponding inpatient hospital claim. A sepsis diagnosis generally results in an inpatient hospital admission.

- *Pressure Ulcer:* An enrollee received one pressure ulcer diagnosis[12] that mapped to either the HCC for Pressure Ulcer of Skin With Full Thickness Skin Loss or the HCC for Pressure Ulcer of Skin With Necrosis Through to Muscle, Tendon, or Bone (Pressure Ulcer HCCs) on only one claim during the service year but did not have a pressure ulcer diagnosis on another inpatient, outpatient, or physician claim for either the calendar year before or the calendar year after the service year. Individuals diagnosed with the most severe types of pressure ulcers generally receive treatment on multiple occasions.

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

[12] Pressure ulcer diagnoses are categorized into five groups according to severity: stages 1, 2, 3, 4, and unstageable. For this audit, we audited only the most severe types of pressure ulcers: stages 3, 4, and unstageable.

Blue Cross and Blue Shield of Alabama

BCBSAL is an MA organization based in Birmingham, Alabama. As of December 2019, BCBSAL provided coverage under contract number H0104 to 101,417 enrollees. For the 2018 and 2019 payment years (audit period), CMS paid BCBSAL approximately $1.8 billion to provide coverage to its enrollees.[13]

HOW WE CONDUCTED THIS AUDIT

Our audit included enrollees on whose behalf providers documented diagnosis codes that mapped to one of the nine high-risk groups during the 2017 and 2018 service years, for which BCBSAL received increased risk-adjusted payments for payment years 2018 and 2019, respectively. Because enrollees could be classified into more than one high-risk group or could have high-risk diagnosis codes documented in more than 1 year, we classified these individuals according to the condition and the payment year, which we refer to as "enrollee-years."

We identified 3,706 unique enrollee-years and limited our review to the portions of the payments that were associated with these high-risk diagnosis codes ($7,973,663). We selected for audit a stratified random sample of 271 enrollee-years as shown in Table 1.

Table 1: Sampled Enrollee-Years

High-Risk Group	Number of Sampled Enrollee-Years
(1) Acute stroke	30
(2) Acute myocardial infarction	30
(3) Embolism	30
(4) Lung cancer	30
(5) Breast cancer	30
(6) Colon cancer	30
(7) Prostate cancer	30
(8) Sepsis	30
(9) Pressure ulcer	31
Total for All High-Risk Groups	**271**

[13] All of the payment amounts that CMS made to BCBSAL and the overpayment amounts that we identified in this report reflect the budget sequestration reduction.

BCBSAL provided medical records as support for the selected diagnosis codes associated with 267 of the 271 sampled enrollee-years.[14] We used an independent medical review contractor to review the medical records to determine whether the HCCs associated with the sampled enrollee-years were validated. For the HCCs that were not validated, if the contractor identified a diagnosis code that should have been submitted to CMS instead of the selected diagnosis code, or if we identified another diagnosis code (on CMS's systems) that mapped to an HCC in the related-disease group, we included the financial impact of the resulting HCC (if any) in our calculation of overpayments.

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

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

FINDINGS

With respect to the nine high-risk groups covered by our audit, most of the selected diagnosis codes that BCBSAL submitted to CMS for use in CMS's risk adjustment program did not comply with Federal requirements. For 24 of the 271 sampled enrollee-years, the medical records validated the reviewed HCCs. For the remaining 247 enrollee-years, however, either the medical records that BCBSAL provided did not support the diagnosis codes or BCBSAL could not locate the medical records to support the diagnosis codes; therefore, the associated HCCs were not validated and resulted in $769,195 in overpayments.

As demonstrated by the errors found in our sample, BCBSAL's policies and procedures to prevent, detect, and correct noncompliance with CMS's program requirements, as mandated by Federal regulations, could be improved. On the basis of our sample results, we estimated that BCBSAL received at least $7 million in overpayments for 2018 and 2019.[15]

[14] Our draft report stated that BCBSAL could not locate medical records for 45 sampled enrollee-years. Along with its written comments on our draft report, BCBSAL provided medical records for 41 of these 45 sampled enrollee-years, which we submitted to the independent medical review contractor for review. BCBSAL could not locate medical records, either during our audit or in response to our draft report, for the remaining 4 sampled enrollee-years.

[15] To be conservative, we estimate overpayments at the lower limit of a two-sided 90-percent confidence interval. Lower limits calculated in this manner are designed to be less than the actual overpayment total 95 percent of the time.

FEDERAL REQUIREMENTS

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

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

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

CMS has provided instructions to MA organizations regarding the submission of data for risk scoring purposes (the Manual, chap. 7 (last rev. Sept. 19, 2014)). Specifically, CMS requires all submitted diagnosis codes to be documented in the medical record and to be documented as a result of a face-to-face encounter (the Manual, chap. 7, § 40). The diagnosis must be coded according to the International Classification of Diseases, Clinical Modification, *Official Guidelines for Coding and Reporting* (42 CFR § 422.310(d)(1) and 45 CFR §§ 162.1002(c)(2)-(3)). Further, 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).

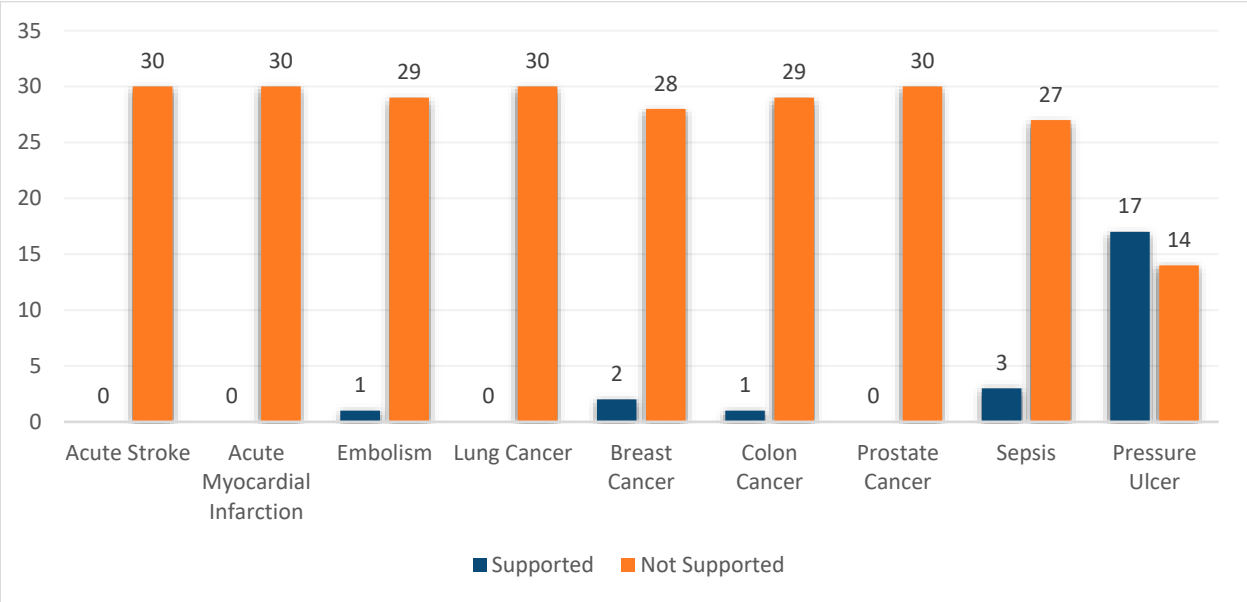
Federal regulations state that MA organizations must monitor the data that they receive from providers and submit to CMS. Federal regulations also state that MA organizations must "adopt and implement an effective compliance program, which must include measures that prevent, detect, and correct non-compliance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

MOST OF THE SELECTED HIGH-RISK DIAGNOSIS CODES THAT BLUE CROSS AND BLUE SHIELD OF ALABAMA SUBMITTED TO CMS DID NOT COMPLY WITH FEDERAL REQUIREMENTS

Most of the selected high-risk diagnosis codes that BCBSAL submitted to CMS for use in CMS's risk adjustment program did not comply with Federal requirements. Specifically, as shown in the figure on the following page, for 247 of the 271 sampled enrollee-years either the medical records that BCBSAL provided did not support the diagnosis codes or BCBSAL could not locate

the medical records to support the diagnosis codes. In these instances, BCBSAL should not have submitted the diagnosis codes to CMS and received the resulting overpayments.

Figure: Analysis of High-Risk Groups



Incorrectly Submitted Diagnosis Codes for Acute Stroke

BCBSAL incorrectly submitted diagnosis codes for acute stroke for all 30 sampled enrollee-years. Specifically:

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

  For example, for 1 enrollee-year, the independent medical review contractor stated that "there is no documentation of an acute cerebrovascular accident (CVA) that results in the assignment of the HCC under review. There is documentation of a past medical history of . . . [a] CVA [diagnosis] which does not result in an HCC."[16]

- For 7 enrollee-years, the medical records in each case did not support an acute stroke diagnosis.

  For example, for 1 enrollee-year, the independent medical review contractor stated that "there is no documentation of any condition that results in the assignment of the HCC under review."

[16] CVA is the medical term for a stroke. A stroke occurs when blood flow to a part of the brain is stopped by either a blockage or the rupture of a blood vessel.

As a result of these errors, the HCC for Ischemic or Unspecified Stroke was not validated, and BCBSAL received $63,293 in overpayments for these 30 sampled enrollee-years.

Incorrectly Submitted Diagnosis Codes for Acute Myocardial Infarction

BCBSAL incorrectly submitted diagnosis codes for acute myocardial infarction for all 30 sampled enrollee-years. Specifically:

- For 16 enrollee-years, the medical records indicated in each case that the individual had previously had an acute myocardial infarction, but the records did not justify an acute myocardial infarction diagnosis at the time of the physician's service.

  For example, for 1 enrollee-year, the independent medical review contractor stated that "there is no documentation of any condition that results in the assignment of the HCC under review. There is documentation of a past medical history of myocardial infarction [diagnosis] which does not result in an HCC."

- For 8 enrollee-years, the medical records in each case did not support an acute myocardial infarction diagnosis. However, for each of these enrollee-years, we identified support for another diagnosis on CMS's systems that mapped to an HCC for a less severe manifestation of the related-disease group. Accordingly, BCBSAL should not have received an increased payment for the acute myocardial infarction diagnosis, but it should have received a lesser increased payment for the other diagnosis identified.

- For 5 enrollee-years, the medical records in each case did not support an acute myocardial infarction diagnosis.

  For example, for 1 enrollee-year, the independent medical review contractor stated that "there is no documentation of any condition that results in the assignment of the HCC under review."

- For the remaining 1 enrollee-year, BCBSAL could not locate any medical records to support the acute myocardial infarction diagnosis; therefore, the HCC for Acute Myocardial Infarction was not validated.[17]

As a result of these errors, the HCC for Acute Myocardial Infarction was not validated, and BCBSAL received $49,297 in overpayments for these 30 sampled enrollee-years.

[17] For this enrollee-year, we identified support for another diagnosis on CMS's systems that mapped to an HCC for a less severe manifestation of the related-disease group. Accordingly, BCBSAL should not have received an increased payment for the acute myocardial infarction diagnosis, but it should have received a lesser increased payment for the other diagnosis identified.

Incorrectly Submitted Diagnosis Codes for Embolism

BCBSAL incorrectly submitted diagnosis codes for embolism for 29 of 30 sampled enrollee-years. Specifically:

- For 15 enrollee-years, the medical records indicated in each case that the individual had previously had an embolism, but the records did not justify a diagnosis that mapped to an Embolism HCC at the time of the physician's service.

  For example, for 1 enrollee-year, the independent medical review contractor stated that "there is no documentation of any condition that results in the assignment of the HCC under review. There is documentation of a past medical history of deep vein thrombosis [diagnosis] which does not result in an HCC."[18]

- For 13 enrollee-years, the medical records in each case did not support a diagnosis that mapped to an Embolism HCC.

  For example, for 1 enrollee-year, the independent medical review contractor stated that "there is no documentation of any condition that results in the assignment of the HCC under review."

- For the remaining 1 enrollee-year, the medical record did not support an embolism diagnosis. However, for this enrollee-year, we identified support for another diagnosis on CMS's systems that mapped to an HCC for a less severe manifestation of the related-disease group. Accordingly, BCBSAL should not have received an increased payment for the submitted embolism diagnosis, but it should have received a lesser increased payment for the other diagnosis identified.

As a result of these errors, the Embolism HCCs were not validated, and BCBSAL received $79,428 in overpayments for these 29 sampled enrollee-years.

Incorrectly Submitted Diagnosis Codes for Lung Cancer

BCBSAL incorrectly submitted diagnosis codes for lung cancer for all 30 sampled enrollee-years. Specifically:

- For 13 enrollee-years, the medical records indicated in each case that the individual had previously had lung cancer, but the records did not justify a lung cancer diagnosis at the time of the physician's service.

[18] Deep vein thrombosis occurs when a blood clot forms in one or more of the deep veins of the body, usually in the legs.

For example, for 1 enrollee-year, the independent medical review contractor stated that "there is no documentation of any condition that results in the assignment of the HCC under review. There is documentation of a past medical history of lung cancer [diagnosis] which does not result in an HCC."

- For 9 enrollee-years, the medical records in each case did not support a lung cancer diagnosis. However, for each of these enrollee-years, we identified support for another diagnosis on CMS's systems that mapped to an HCC for a less severe manifestation of the related-disease group. Accordingly, BCBSAL should not have received an increased payment for the lung cancer diagnosis, but it should have received a lesser increased payment for the other diagnosis identified.

- For 7 enrollee-years, the medical records in each case did not support a lung cancer diagnosis.

  For example, for 1 enrollee-year, the independent medical review contractor stated that "there is no documentation of any condition that results in the assignment of the HCC under review."

- For the remaining 1 enrollee-year, BCBSAL could not locate any medical records to support the lung cancer diagnosis; therefore, the HCC for Lung and Other Severe Cancers was not validated.

As a result of these errors, the HCC for Lung and Other Severe Cancers was not validated, and BCBSAL received $198,842 in overpayments for these 30 sampled enrollee-years.

Incorrectly Submitted Diagnosis Codes for Breast Cancer

BCBSAL incorrectly submitted diagnosis codes for breast cancer for 28 of 30 sampled enrollee-years. Specifically:

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

  For example, for 1 enrollee-year, the independent medical review contractor stated that "there is no documentation of any condition that results in the assignment of the HCC under review. There is documentation of a past medical history of breast cancer [diagnosis] which does not result in an HCC."

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

For example, for 1 enrollee year, the independent medical review contractor stated that "there is no documentation of any condition that results in the assignment of the HCC under review."

- For the remaining 1 enrollee-year, BCBSAL could not locate any medical records to support the breast cancer diagnosis; therefore, the HCC for Breast, Prostate, and Other Cancers and Tumors was not validated.

As a result of these errors, the HCC for Breast, Prostate, and Other Cancers and Tumors was not validated, and BCBSAL received $34,508 in overpayments for these 28 sampled enrollee-years.

Incorrectly Submitted Diagnosis Codes for Colon Cancer

BCBSAL incorrectly submitted diagnosis codes for colon cancer for 29 of 30 sampled enrollee-years. Specifically:

- For 22 enrollee-years, the medical records indicated in each case that the individual had previously had colon cancer, but the records did not justify a colon cancer diagnosis at the time of the physician's service.

  For example, for 1 enrollee-year, the independent medical review contractor stated that "there is no documentation of any condition that results in the assignment of the HCC under review. There is documentation of a past medical history of colon cancer [diagnosis] which does not result in an HCC."

- For 4 enrollee-years, the medical records in each case did not support a colon cancer diagnosis.

  For example, for 1 enrollee-year, the independent medical review contractor stated that "there is no documentation of any condition that results in the assignment of the HCC under review."

- For the remaining 3 enrollee-years, the medical records in each case did not support the submitted colon cancer diagnosis. However, for each of these enrollee-years, we identified support for another diagnosis on CMS's systems that mapped to an HCC for a less severe manifestation of the related-disease group. Accordingly, BCBSAL should not have received an increased payment for the submitted colon cancer diagnosis, but it should have received a lesser increased payment for the other diagnosis identified.

As a result of these errors, the HCC for Colorectal, Bladder, and Other Cancers was not validated, and BCBSAL received $65,284 in overpayments for these 29 sampled enrollee-years.

Incorrectly Submitted Diagnosis Codes for Prostate Cancer

BCBSAL incorrectly submitted diagnosis codes for prostate cancer for all 30 sampled enrollee-years. Specifically:

- For 26 enrollee-years, the medical records indicated in each case that the individual had previously had prostate cancer, but the records did not justify a prostate cancer diagnosis at the time of the physician's service.

  For example, for 1 enrollee-year, the independent medical review contractor stated that "there is no documentation of any condition that results in the assignment of the HCC under review. There is documentation of a past medical history of prostate cancer [diagnosis] which does not result in an HCC."

- For the remaining 4 enrollee-years, the medical records in each case did not support a prostate cancer diagnosis.

  For example, for 1 enrollee-year, the independent medical review contractor stated that "there is no documentation of any condition that results in the assignment of the HCC under review."

As a result of these errors, the HCC for Breast, Prostate, and Other Cancers and Tumors was not validated, and BCBSAL received $37,877 in overpayments for these 30 sampled enrollee-years.

Incorrectly Submitted Diagnosis Codes for Sepsis

BCBSAL incorrectly submitted diagnosis codes for sepsis for 27 of 30 sampled enrollee-years. Specifically:

- For 21 enrollee-years, the medical records in each case did not support a sepsis diagnosis.[19]

  For example, for 1 enrollee-year, the independent medical review contractor stated that "there is no documentation of any condition that results in the assignment of the HCC

[19] For risk adjustment purposes, CMS uses only diagnoses that enrollees receive from acceptable data sources (a face-to-face encounter with a provider, physician, or other practitioner) (42 CFR § 422.310(d)(3)); the Manual, chap. 7, §§ 40 and 120.1). For 2 of these enrollee-years, the documentation that BCBSAL submitted did not reflect a face-to-face visit. BCBSAL submitted documentation of diagnostic radiology services, the results of which did not include a physician's interpretation, and which did not reflect a face-to-face visit. Because this documentation did not meet CMS's requirements for acceptable data sources, the reviewed HCCs were not validated.

under review. The enrollee was noted to have cellulitis of the right lower leg [diagnosis] that does not result in an HCC."[20]

- For 5 enrollee-years, the medical records indicated in each case that the individual had previously had sepsis, but the records did not justify a sepsis diagnosis at the time of the physician's service.

  For example, for 1 enrollee-year, the independent medical review contractor stated that "there is no documentation of any condition that results in the assignment of the HCC under review. There is documentation of a past medical history of sepsis [diagnosis] which does not result in an HCC."

- For the remaining 1 enrollee-year, BCBSAL could not locate any medical records to support the sepsis diagnosis; therefore, the HCC for Septicemia, Sepsis, Systemic Inflammatory Response Syndrome/Shock was not validated.

As a result of these errors, the HCC for Septicemia, Sepsis, Systemic Inflammatory Response Syndrome/Shock was not validated, and BCBSAL received $92,647 in overpayments for these 27 sampled enrollee-years.

Incorrectly Submitted Diagnosis Codes for Pressure Ulcer

BCBSAL incorrectly submitted diagnosis codes for pressure ulcer for 14 of 31 sampled enrollee-years. Specifically:

- For 12 enrollee-years, the medical records in each case did not support a pressure ulcer diagnosis.[21]

  For example, for 1 enrollee-year, the independent medical review contractor stated that "there is no documentation of any condition that results in the assignment of the HCC under review. There is documentation of a stage 2 pressure ulcer of other site [diagnosis] which does not result in an HCC."[22]

[20] Cellulitis is a common bacterial skin infection that causes redness, swelling, and pain in the infected area of the skin. If untreated, it can spread and cause serious health problems.

[21] For 1 of these enrollee-years, BCBSAL submitted documentation of a diagnostic radiology service, the results of which did not include a physician's interpretation, and which did not reflect a face-to-face visit. Because this documentation did not meet CMS's requirements for acceptable data sources, the reviewed HCC was not validated (footnote 19).

[22] Stage 2 pressure ulcers occur when the sore has broken through the top layer of the skin and part of the layer below, which results in a shallow open wound.

- For the remaining 2 enrollee-years, the medical records in each case did not support the submitted pressure ulcer diagnosis. However, for each of these enrollee-years, we identified support for another diagnosis on CMS's systems that mapped to an HCC for a less severe manifestation of the related-disease group. Accordingly, BCBSAL should not have received an increased payment for the submitted pressure ulcer diagnosis, but it should have received a lesser increased payment for the other diagnosis identified.

As a result of these errors, the Pressure Ulcer HCCs were not validated, and BCBSAL received $148,019 in overpayments for these 14 sampled enrollee-years.

Summary of Incorrectly Submitted Diagnosis Codes

In summary and with respect to the nine high-risk groups covered by our audit, BCBSAL received $769,195 in overpayments for 247 of the 271 sampled enrollee-years.

THE POLICIES AND PROCEDURES THAT BLUE CROSS AND BLUE SHIELD OF ALABAMA HAD TO PREVENT, DETECT, AND CORRECT NONCOMPLIANCE WITH FEDERAL REQUIREMENTS COULD BE IMPROVED

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

As part of its preventative measures, BCBSAL had compliance procedures in place that consisted of a variety of provider-specific outreach efforts to train and educate its providers on coding and medical record documentation. These efforts included the distribution of coding educational materials and short coding videos to assist providers with the proper coding of diagnoses and the creation of accurate medical record documentation. BCBSAL also held conferences with its providers and vendors that focused on coding guideline updates and other best practices.

BCBSAL's compliance procedures also included detection and correction measures designed to determine whether the diagnosis codes that it submitted to CMS to calculate risk-adjusted payments were correct. For example, BCBSAL routinely conducted retrospective reviews of claims to verify that submitted diagnosis codes were supported by medical record documentation. If the reviews identified any coding errors, BCBSAL provided guidance to providers and vendors on how to submit the corrections to CMS.

Additionally, BCBSAL required its coders to meet certain efficiency standards. Specifically, BCBSAL required its coders to undergo monthly coding reviews to verify that they were identifying codes with at least 95-percent accuracy. Furthermore, if a coder was unable to maintain a 95-percent accuracy rate for 2 consecutive months, BCBSAL increased the number of that coder's claims that it reviewed by 50 percent. BCBSAL used the results of these reviews to identify additional areas for training or coaching.

We acknowledge that BCBSAL has compliance procedures in place that include measures designed to ensure that diagnosis codes comply with Federal requirements. However, because we found that 247 of the 271 sampled enrollee-years were not supported by medical records, we believe that these procedures, as they relate to diagnoses that are at high risk for being miscoded, could be improved.

BLUE CROSS AND BLUE SHIELD OF ALABAMA RECEIVED OVERPAYMENTS

As a result of the errors we identified, the HCCs for these high-risk diagnosis codes were not validated. On the basis of our sample results, we estimated that BCBSAL received $7,058,246 in overpayments for our audit period.

RECOMMENDATIONS

We recommend that Blue Cross and Blue Shield of Alabama:

- refund to the Federal Government the $7,058,246 of estimated overpayments;[23]

- identify, for the high-risk diagnoses included in this report, similar instances of noncompliance that occurred after our audit period and refund any resulting overpayments to the Federal Government; and

- enhance its examination of its existing compliance procedures to identify areas where improvements can be made to ensure that diagnoses that are at high risk for being miscoded comply with Federal requirements (when submitted to CMS for use in CMS's risk adjustment program) and take the necessary steps to enhance those procedures.

BLUE CROSS AND BLUE SHIELD OF ALABAMA COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

In written comments on our draft report, BCBSAL did not concur with some of our findings and requested that we reconsider all of our recommendations. BCBSAL did not concur with our findings for 64 of the 252 enrollee-years that we had identified as errors in our draft report and provided additional information for our consideration.[24] BCBSAL did not agree or disagree with

[23] OIG audit recommendations do not represent final determinations. Action officials at CMS will determine whether an overpayment exists and will recoup any overpayments consistent with CMS's policies and procedures. In accordance with 42 CFR § 422.311, which addresses audits conducted by the Secretary (including those conducted by OIG), if a disallowance is taken, MA organizations have the right to appeal the determination that an overpayment occurred through the Secretary's Risk Adjustment Data Validation (RADV) appeals process.

[24] In its comments on our draft report, BCBSAL provided additional information for 11 enrollee-years about which it did not concur with our findings. After BCBSAL had submitted its written comments, it gave us additional information for 12 more enrollee-years for our consideration. BCBSAL also submitted medical records for 41 of the enrollee-years for which it had not previously been able to locate a medical record (footnote 14). In total, then, BCBSAL gave us, after issuance of our draft report, additional information for 64 enrollee-years.

our findings for the remaining 188 enrollee-years, but stated that it did concur, in part, with errors that we identified.

BCBSAL stated that our overall audit approach "raises concerns" because we targeted only overpayments and did not use established risk adjustment data validation (RADV) audit processes. Accordingly, and with reference to our second recommendation, BCBSAL stated that because it found "issues and bias" in our audit, "applying these same procedures to a subsequent inquiry of high-risk diagnoses would be improper." BCBSAL also stated that it would continue to evaluate its compliance procedures but did not concur with our third recommendation's "implication" that BCBSAL's compliance program "requires enhancement."

After reviewing BCBSAL's comments and the additional information that it provided, we reduced the number of enrollee-years in error from 252 (in our draft report) to 247 and adjusted our calculation of overpayments for this final report. Accordingly, we reduced our first recommendation from $7,174,865 to $7,058,246 for this final report. We maintain that our second and third recommendations remain valid.

A summary of BCBSAL's comments and our responses follows. BCBSAL's comments appear as Appendix E. We excluded an attachment because it contained personally identifiable information. We are separately providing BCBSAL's comments and the attachment in their entirety to CMS.

BLUE CROSS AND BLUE SHIELD OF ALABAMA DID NOT CONCUR WITH THE OIG'S FINDINGS FOR 64 SAMPLED ENROLLEE-YEARS

Blue Cross and Blue Shield of Alabama Comments

BCBSAL did not concur with our findings for 64 sampled enrollee-years (as shown in Table 2 on the following page) and provided either explanations or medical records supporting its belief that the HCCs in question were validated.

Table 2: Summary of Enrollee-Years for Which Blue Cross and Blue Shield of Alabama Disagreed With Our Findings

High-Risk Group	Number of Sampled Enrollee-Years
Acute stroke	8
Acute myocardial infarction	4
Embolism	6
Lung cancer	6
Breast cancer	7
Colon cancer	5
Prostate cancer	7
Sepsis	14
Pressure ulcer	7
Total	**64**

BCBSAL's comments elaborated on its disagreement with some of our findings. BCBSAL referred to the International Classification of Diseases (ICD), Clinical Modification (CM), *Official Guidelines for Coding and Reporting* (ICD Coding Guidelines) instructions for coding cancer diagnoses, specifically guidance for coding "[c]urrent malignancy versus personal history of malignancy." BCBSAL stated that our findings for some enrollee-years "did not align" with ICD Coding Guidelines in this regard. BCBSAL cited a specific example for a sampled enrollee-year from the prostate cancer high-risk group and explained why it believed that the medical records that it previously gave us validated the reviewed HCC.

Furthermore, BCBSAL stated that the criteria we used for identifying certain diagnoses that were at higher risk of being miscoded, such as those in the prostate cancer related high-risk group, (i.e., no surgical therapy, radiation treatments, or chemotherapy drug treatments administered within a 6-month period either before or after the diagnosis) were not included in the ICD Coding Guidelines.

OIG Response

The independent medical review contractor reviewed the additional information that BCBSAL provided for the 64 sampled enrollee-years.

- For 59 of the 64 enrollee-years, the independent medical review contractor did not find support in the additional information to validate the reviewed HCCs.

  For example, for 1 enrollee-year from the lung cancer high-risk group, the contractor upheld its original decision upon reconsideration and stated that "There is documentation of a past history of [a] lung cancer [diagnosis] which does not result in

any HCC. There is no documentation of active treatment or recurrence, and the progress specifically notes the lung cancer to be 'resolved'."

- For the remaining 5 enrollee-years, the contractor found support for the reviewed HCCs and therefore validated the HCCs.[25]

Accordingly, we reduced the number of enrollee-years in error from 252 (as reported in our draft report) to 247. We also revised our findings and reduced the associated monetary recommendation. Further, the independent medical review contractor confirmed that its review of the explanations that BCBSAL gave to us did not have an impact on the decisions that the contractor had made for the sampled enrollee-years with which BCBSAL neither agreed nor disagreed.

Notwithstanding these revisions, we disagree with BCBSAL's statement that our medical review coding determinations "did not align" with ICD Coding Guidelines. Our independent medical review contractor used the following coding and documentation standards: (1) ICD-10-CM *Official Guidelines for Coding and Reporting*, (2) the AHA Coding Clinic for ICD-10-CM and ICD-10-PCS, and (3) the CMS-published *Contract-Level Risk Adjustment Data Validation Medical Record Reviewer Guidance.* The medical reviews were performed by professional coders who were credentialed by the American Health Information Management Association (AHIMA), the American Academy of Professional Coders (AAPC), or both. (See footnote 32 in Appendix A.) These coders are experienced in coding ICD-10-CM diagnosis codes for hospital inpatient, outpatient, and physician medical records.

Diagnoses documented on the medical records that are submitted to CMS for risk adjustment purposes must be coded in accordance with the ICD Coding Guidelines. Thus, the senior coders that the independent medical review contractor used did in fact apply the ICD Coding Guidelines and relevant CMS guidance to review medical records and make their coding determinations.

Furthermore, BCBSAL is correct that the criteria we used to identify diagnoses at higher risk of being miscoded is not included in the ICD Coding Guidelines, nor does it have to be. In this respect, we designed our audit methodology to accomplish our audit objective. Our approach involved data mining techniques and discussions with medical professionals to identify indicators that an enrollee could have had an incorrect diagnosis. We believe that our approach was reasonable, which is also reflected in the high number of errors that we identified for this audit. Our sampling methodology had no correlation to coding and documentation standards that the independent medical review contractor used to determine whether or not the diagnoses were supported in the medical records.

[25] The five enrollee-years were in the following high-risk groups: breast cancer (2), pressure ulcer (2), and colon cancer (1).

BLUE CROSS AND BLUE SHIELD OF ALABAMA STATED THAT THE OIG'S AUDIT TARGETED ONLY OVERPAYMENTS AND DID NOT USE ESTABLISHED RISK ADJUSTMENT DATA VALIDATION PROCESSES

Blue Cross and Blue Shield of Alabama Comments

BCBSAL stated that our overall audit approach "raises concerns" because we targeted only overpayments and did not use established RADV audit processes.

Specifically, BCBSAL stated that it did not concur with our draft report's "primary finding" that it received $7.1 million of estimated overpayments because, it said, our audit was "designed to find overpayments" instead of ensuring that BCBSAL, overall, made accurate payments. BCBSAL also said that because our audit identified only those diagnoses that were at higher risk for being miscoded, "[e]nrollees without any diagnoses or suspected missing diagnoses were not included in the scope of the audit."

In addition, BCBSAL stated that "[i]nherently, within claims data, there exists some misclassification of diagnosis codes" and added that this misclassification also occurs in Medicare FFS, "which is the basis for the [MA] payment rates." Therefore, according to BCBSAL, our sample was not "representative of the population" and instead was "presented in a way that is biased to overemphasize overpayments." To support its statement, BCBSAL pointed to language in our draft report (in Appendix A) in which we state that we limited our review of internal controls to those directly related to our objective.

Furthermore, BCBSAL stated that "many" of the audited MA organizations under this series of OIG audits have taken "issue with the approach of the audit because it does not follow established [CMS] processes for validation of risk adjustment data. . . ." BCBSAL said that if we had used "a more comprehensive model, which would include evaluation of both overpayments and underpayments, the bias towards findings overpayments to the detriment of the [MA organizations] would be lessened." BCBSAL supported this conclusion by citing the results of its most recent CMS Improper Payment Measure (IPM) audit, in which CMS found that BCBSAL "validated 100 [percent] of [HCCs] requested."

Moreover, BCBSAL stated that "there is no mechanism to pay" our first recommendation's extrapolated overpayment amount to CMS "for an audit which is not performed under the CMS RADV audit process." According to BCBSAL, "[MA] payments are determined and paid at an individual member level" and because our extrapolated overpayment amount is not "member specific," BCBSAL would need additional guidance to return the funds to CMS, "if it is indeed proper under the parameters of this audit and regulatory guidance."

OIG Response

We disagree with BCBSAL's assertion that our audit focused only on finding overpayments. Our objective was to determine whether selected high-risk diagnosis codes that BCBSAL submitted

to CMS for use in CMS's risk adjustment program complied with Federal requirements. We identified diagnoses that were at higher risk for being miscoded and consolidated those diagnoses into nine specific high-risk groups. This process involved a carefully designed audit methodology (Appendix A). Our objective did not extend to diagnosis codes not previously submitted by BCBSAL or to HCCs that were beyond the scope of our audit.

For the HCCs that were not validated, if the independent medical review contractor identified a diagnosis code that should have been submitted to CMS instead of the selected diagnosis code, or if we identified another diagnosis code (on CMS's systems) that mapped to an HCC in the related-disease group, we included the financial impact of the resulting HCC (if any) in our calculation of overpayments.

A valid estimate of overpayments, given the objective of our audit, does not need to take into consideration all potential HCCs or underpayments within the audit period. We based our estimate of overpayments on the results of the independent medical review contractor's review; this estimate addressed only the accuracy of the portion of payments related to the reviewed HCCs and did not extend to HCCs that were beyond the scope of this audit. We followed CMS's risk adjustment program requirements to determine the payment that CMS should have made for each enrollee and to estimate overpayments. For these reasons, we believe that a recommended refund of estimated overpayments based on our findings is appropriate.

We agree with BCBSAL that our audit methodology is different from that of the CMS RADV audit methodology. Although our approach was generally consistent with the methodology used by CMS in its RADV audits, it did not mirror CMS's approach in all aspects, nor did it have to. Furthermore, the IPM audit coding accuracy results that BCBSAL cited are not relevant to our audit and therefore have no impact on our methodology or findings. All of our audits are intended to provide an independent assessment of Department of Health and Human Services programs and operations in accordance with the Inspector General Act of 1978, 5 U.S.C. Ch. 4. We believe that our audit methodology provides a reasonable basis for our findings and recommendations.

Additionally, we recognize that OIG audit findings and recommendations do not represent final determinations by CMS. Accordingly, we will provide CMS with our independent medical review contractor's results for its consideration as part of the audit resolution process. CMS will determine whether an overpayment exists and will work with BCBSAL to recoup any overpayments consistent with its policies and procedures (footnote 23).

BLUE CROSS AND BLUE SHIELD OF ALABAMA DID NOT CONCUR WITH THE OIG'S RECOMMENDATION TO IDENTIFY SIMILAR INSTANCES OF NONCOMPLIANCE THAT OCCURRED AFTER OUR AUDIT PERIOD AND REFUND ANY RESULTING OVERPAYMENTS TO THE FEDERAL GOVERNMENT

Blue Cross and Blue Shield of Alabama Comments

BCBSAL did not concur with our second recommendation to identify similar instances of noncompliance that occurred after our audit period and refund any resulting overpayments to the Federal Government. According to BCBSAL, in light of what it described as "issues and bias" in our audit, the task of "applying these same procedures" to identify similar issues of noncompliance after our audit period would be "improper." BCBSAL did, however, state that it would "continue evaluating and enhancing existing policies and procedures related to high-risk diagnosis codes."

OIG Response

We do not agree with BCBSAL that its implementation of our second recommendation would be "improper." We recognize that MA organizations have the latitude to design their own federally mandated compliance programs. We believe, though, that this recommendation conforms to the requirements specified in Federal regulations (42 CFR § 422.503(b)(4)(vi) (Appendix D)).

These Federal regulations state that MA organizations must "implement an effective compliance program, which must include measures that prevent, detect, and correct noncompliance with CMS' program requirements." These regulations also require MA organizations to implement procedures as well as a system to investigate "potential compliance problems as identified in the course of self-evaluations and audits, correcting such problems promptly and thoroughly to reduce the potential for recurrence" (42 CFR § 422.503(b)(4)(vi)(G)). Thus, CMS has, through the issuance of these Federal regulations, assigned the responsibility for dealing with potential compliance issues to the MA organizations.

We believe that—as we discuss further in the next section of this final report—the error rate identified in our audit (247 of 271 enrollee-years (Appendix C)) demonstrates that BCBSAL has compliance issues that need to be addressed. These issues may extend to periods of time beyond the scope of our audit. Accordingly, we maintain that our second recommendation remains valid.

BLUE CROSS AND BLUE SHIELD OF ALABAMA DID NOT CONCUR WITH THE OIG'S RECOMMENDATION THAT ITS COMPLIANCE PROGRAM REQUIRES ENHANCEMENT

Blue Cross and Blue Shield of Alabama Comments

BCBSAL did not concur with our third recommendation to enhance its examination of its existing compliance procedures for diagnoses that are at high risk for being miscoded. Specifically, BCBSAL stated that it "has a strong and comprehensive compliance program" and supported this statement by citing language in our report that describes features of that program. BCBSAL also stated that we had recommended "'improvement' without outlining specific recommendations."

Furthermore, BCBSAL stated that "the audit appears to require 100 [percent] accuracy in order to avoid overpayments and does not allow for any mitigation measures to be considered." BCBSAL also stated that it would "ensure [that] corrective action is implemented for identified errors and will continue to evaluate and enhance its policies and procedures with the goal of improving accuracy and efficiency but cannot realistically expect 100 [percent] accuracy at any point."

OIG Response

We acknowledge (as we stated in our draft report) that BCBSAL had compliance procedures in place during our audit period to promote the accuracy of diagnosis codes submitted to CMS to calculate risk-adjusted payments. However, we continue to believe that the continued improvement of BCBSAL's existing procedures (based on the results of this audit) will assist BCBSAL in attaining better assurance with regard to the "accuracy, completeness and truthfulness" of the risk adjustment data that it submits to CMS in the future.

BCBSAL's comments on our third recommendation implied that we are opining on the effectiveness of its entire compliance program and on its responsibilities to ensure 100-percent accuracy on 100 percent of the data it submitted to CMS. That was not our intention or our focus for this audit. Rather, we limited our audit to selected diagnoses that we determined to be at high risk for being miscoded. Our audit revealed a substantial error rate for all of these high-risk groups. Accordingly, we note that Federal regulations require MA organizations to implement procedures for "promptly responding to compliance issues as they are raised" and to "[correct] such problems promptly and thoroughly to reduce the potential for recurrence" (42 CFR § 422.503(b)(4)(vi)(G)).

Accordingly, we maintain that our third recommendation remains valid.

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

CMS paid BCBSAL approximately $1.7 billion to provide coverage to its enrollees for 2018 and 2019. We identified a sampling frame of 3,706 unique enrollee-years on whose behalf providers documented high-risk diagnosis codes during the 2017 and 2018 service years. BCBSAL received $51,744,037 in payments from CMS for these enrollee-years for 2018 and 2019. We selected for audit 271 enrollee-years with payments totaling $5,007,431.

The 271 enrollee-years included 30 acute stroke diagnoses, 30 acute myocardial infarction diagnoses, 30 embolism diagnoses, 30 lung cancer diagnoses, 30 breast cancer diagnoses, 30 colon cancer diagnoses, 30 prostate cancer diagnoses, 30 sepsis diagnoses, and 31 pressure ulcer diagnoses. We limited our review to the portions of the payments that were associated with these high-risk diagnosis codes, which totaled $1,003,272 for our sample.

Our audit objective did not require an understanding or assessment of BCBSAL'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 April 2022 through August 2025.

METHODOLOGY

To accomplish our objective, we performed the following steps:

- We reviewed applicable Federal laws, regulations, and guidance.

- We discussed with CMS program officials the Federal requirements that MA organizations should follow when submitting diagnosis codes to CMS.

- We identified, through data mining and discussions with medical professionals at a Medicare administrative contractor, diagnosis codes and HCCs that were at high risk for noncompliance. We also identified the diagnosis codes that potentially should have been used for cases in which the high-risk diagnoses were miscoded.

- We consolidated the high-risk diagnosis codes into specific groups, which included:

    - 94 diagnosis codes for acute stroke,
    - 17 diagnosis codes for acute myocardial infarction,
    - 63 diagnosis codes for embolism,
    - 17 diagnosis codes for lung cancer,
    - 54 diagnosis codes for breast cancer,
    - 10 diagnosis codes for colon cancer,

- 1 diagnosis code for prostate cancer,
- 30 diagnosis codes for sepsis, and
- 50 diagnosis codes for pressure ulcer.

- 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)[26] and Encounter Data System (EDS)[27] to identify enrollees who received high-risk diagnosis codes from a physician during the service years,

  - Risk Adjustment System (RAS)[28] to identify enrollees who received an HCC for the high-risk diagnosis codes,

  - Medicare Advantage Prescription Drug System (MARx)[29] to identify enrollees for whom CMS made monthly Medicare payments to BCBSAL, before applying the budget sequestration reduction, for the relevant portions of the service and payment years (Appendix B),

  - EDS[30] to identify enrollees who received specific procedures, and

  - Prescription Drug Event (PDE) file[31] to identify enrollees who had Medicare claims with certain medications dispensed on their behalf.

- We communicated with BCBSAL officials to gain an understanding of: (1) the policies and procedures that BCBSAL followed to submit diagnosis codes to CMS for use in the risk adjustment program and (2) BCBSAL's monitoring of those diagnosis codes to detect and correct noncompliance with Federal requirements.

- We selected for audit a stratified random sample of 271 enrollee-years (Appendix B).

[26] MA organizations use the RAPS to submit diagnosis codes to CMS.

[27] CMS uses the EDS to collect encounter data, including diagnosis codes, from MA organizations.

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

[29] The MARx identifies the payments made to MA organizations.

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

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

- We used an independent medical review contractor to perform a coding review for 267 enrollee-years (footnote 14) to determine whether the high-risk diagnosis codes submitted to CMS complied with Federal requirements.[32]

- The independent medical review contractor's coding review followed a specific process to determine whether there was support for a diagnosis code and the associated HCC:

    - If the first senior coder found support for the diagnosis code on the medical record(s), the HCC was considered validated.

    - If the first senior coder did not find support on the medical record(s), a second senior coder performed a separate review of the same medical record(s):

        - 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 the coding supervisor independently reviewed the medical record(s) to make the final determination.

    - If either the first or second senior coder asked the coding supervisor for assistance, the coding supervisor's decision became the final determination. Additionally, at any point in the review process, a senior coder or coding supervisor may have consulted a physician reviewer for additional clarification.

- We used the results of the independent medical review contractor, and CMS's systems, to calculate overpayments or underpayments (if any) for each enrollee-year. Specifically, we calculated:

    - a revised risk score in accordance with CMS's risk adjustment program and

    - the payment that CMS should have made for each enrollee-year.

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

- We estimated the total overpayment made to BCBSAL for the high-risk groups included in the sampling frame for the audit period in accordance with CMS's regulations for the use of extrapolation in RADV audits for recovery purposes.[33]

- We discussed the results of our audit with BCBSAL officials.

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

[33] Federal regulations at 42 CFR § 422.311(a) state: "[T]he Secretary annually conducts RADV audits to ensure risk-adjusted payment integrity and accuracy." (1) Recovery of improper payments from MA organizations will be conducted in accordance with the Secretary's payment error extrapolation and recovery methodologies. (2) CMS may apply extrapolation to audits for payment year 2018 and subsequent payment years (88 Fed. Reg. 6643, 6655 (Feb. 1, 2023)).

APPENDIX B: STATISTICAL SAMPLING METHODOLOGY

SAMPLING FRAME

We identified BCBSAL enrollees who: (1) were continuously enrolled in BCBSAL throughout all of the 2017 or 2018 service year and January of the following year, (2) were not classified as being enrolled in hospice or as having end-stage renal disease status at any time during 2017 or 2018 or in January of the following year, and (3) received a high-risk diagnosis during 2017 or 2018 that caused an increased payment to BCBSAL for 2018 or 2019, respectively.

We presented the data for these enrollees to BCBSAL for verification and performed an analysis of the data included on CMS's systems to ensure that the high-risk diagnosis codes increased CMS's payments to BCBSAL. After we performed these steps, our finalized sampling frame consisted of 3,706 enrollee-years.

SAMPLE UNIT

The sample unit was an enrollee-year, which covered either payment year 2018 or 2019.

SAMPLE DESIGN AND SAMPLE SIZE

The design for our statistical sample comprised nine strata of enrollee-years. For the enrollee-years in each respective stratum, each individual received:

- an acute stroke diagnosis (that mapped to the HCC for Ischemic or Unspecified Stroke) on only one physician claim during the service year but did not have an acute stroke diagnosis on a corresponding inpatient or outpatient hospital claim (1,223 enrollee-years);

- an acute myocardial infarction diagnosis (that mapped to the HCC for Acute Myocardial Infarction) on only one physician or outpatient claim during the service year but did not have an acute myocardial infarction diagnosis on a corresponding inpatient hospital claim either 60 days before or 60 days after the physician or outpatient claim (375 enrollee-years);

- an embolism diagnosis (that mapped to an Embolism HCC) on only one claim during the service year but did not have an anticoagulant medication dispensed on his or her behalf (310 enrollee-years);

- a lung cancer diagnosis (that mapped to the HCC for Lung and Other Severe Cancers) on only one claim during the service year but did not have surgical therapy, radiation treatments, or chemotherapy drug treatments related to the lung cancer diagnosis administered within a 6-month period before or after the diagnosis (89 enrollee-years);

- a breast cancer diagnosis (that mapped to the HCC for Breast, Prostate, and Other Cancers and Tumors) on only one claim during the service year but did not have surgical therapy, radiation treatments, or chemotherapy drug treatments related to the breast cancer diagnosis administered within a 6-month period before or after the diagnosis (675 enrollee-years);

- a colon cancer diagnosis (that mapped to the HCC for Colorectal, Bladder, and Other Cancers) on only one claim during the service year but did not have surgical therapy, radiation treatments, or chemotherapy drug treatments administered within a 6-month period before or after the diagnosis (245 enrollee-years);

- a prostate cancer diagnosis (that mapped to the HCC for Breast, Prostate, and Other Cancers and Tumors), for an individual 74 years old or younger, on only one claim during the service year but did not have surgical therapy, radiation treatments, or chemotherapy drug treatments administered within a 6-month period before or after the diagnosis (600 enrollee-years);

- a sepsis diagnosis (that mapped to the HCC for Septicemia, Sepsis, Systemic Inflammatory Response Syndrome/Shock) on only one physician or outpatient claim during the service year but did not have a sepsis diagnosis on a corresponding inpatient hospital claim (158 enrollee-years); or

- a pressure ulcer diagnosis (that mapped to a Pressure Ulcer HCC) on only one claim during the service year but did not have a pressure ulcer diagnosis on another inpatient, outpatient, or physician claim for either the calendar year before or the calendar year after the service year (31 enrollee-years).

The specific strata are shown in Table 3 on the following page.

Table 3: Sample Design for Audited High-Risk Groups

Stratum (High-Risk Groups)	Frame Count of Enrollee-Years	CMS Payment for HCCs in Audited High-Risk Groups	Sample Size
1 – Acute stroke	1,223	$2,484,502	30
2 – Acute myocardial infarction	375	721,247	30
3 – Embolism	310	856,087	30
4 – Lung cancer	89	696,579	30
5 – Breast cancer	675	940,162	30
6 – Colon cancer	245	618,787	30
7 – Prostate cancer	600	758,557	30
8 – Sepsis	158	578,581	30
9 – Pressure ulcer	31	319,161	31
Total	3,706	**$7,973,663**	**271**

SOURCE OF RANDOM NUMBERS

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

METHOD FOR SELECTING SAMPLE ITEMS

We sorted the items in each stratum by the enrollee-year (a combination of the enrollee identifier and the payment year being reviewed), then consecutively numbered the items in each stratum in the stratified sampling frame. After generating random numbers according to our sample design, we selected the corresponding frame items for review.

ESTIMATION METHODOLOGY

We used the OIG, OAS, statistical software to estimate the total amount of overpayments in the sampling frame made to BCBSAL at the lower limit of the two-sided 90-percent confidence interval (Appendix C). Lower limits calculated in this manner are designed to be less than the actual overpayment total 95 percent of the time.

APPENDIX C: SAMPLE RESULTS AND ESTIMATES

Table 4: Sample Details and Results

Audited High-Risk Groups	Frame Size	CMS Payments for HCCs in Audited High-Risk Groups (for Enrollee-Years in Frame)	Sample Size	CMS Payments for HCCs in Audited High-Risk Groups (for Sampled Enrollee-Years)	Number of Sampled Enrollee-Years With HCCs That Were Not Validated	Overpayments for HCCs That Were Not Validated (for Sampled Enrollee-Years)
1 – Acute stroke	1,223	$2,484,502	30	$63,293	30	$63,293
2 – Acute myocardial infarction	375	721,247	30	58,128	30	49,297
3 – Embolism	310	856,087	30	82,711	29	79,428
4 – Lung cancer	89	696,579	30	230,690	30	198,842
5 – Breast cancer	675	940,162	30	37,534	28	34,508
6 – Colon cancer	245	618,787	30	70,939	29	65,284
7 – Prostate cancer	600	758,557	30	37,877	30	37,877
8 – Sepsis	158	578,581	30	102,939	27	92,647
9 – Pressure ulcer	31	319,161	31	319,161	14	148,019
Total	**3,706**	**$7,973,663**	**271**	**$1,003,272**	**247**	**$769,195**

Table 5: Estimated Overpayments in the Sampling Frame
(Limits Calculated at the 90-Percent Confidence Level)

Point estimate	$7,310,196
Lower limit	$7,058,246
Upper limit	$7,562,146

APPENDIX D: 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.

BlueCross BlueShield
of Alabama

April 11, 2025

James I. Korn
Regional Inspector General for Audit Services
US Department of Health and Human Services
Office of Inspector General
1201 Walnut Street, Suite 1338
Kansas City, MO 64106

RE: Report A-07-22-10207: Medicare Advantage Compliance Audit of Specific Diagnosis Codes That Blue Cross and Blue Shield of Alabama (Contract H0104) Submitted to CMS, dated February 2025

Dear Mr. Korn,

Blue Cross and Blue Shield of Alabama ("BCBSAL") writes in response to the draft report issued by the United States Department of Health and Human Services, Office of Inspector General, dated February 27, 2025, entitled *Medicare Advantage Compliance Audit of Specific Diagnosis Codes that Blue Cross and Blue Shield of Alabama (Contract H0104) Submitted to CMS* ("Draft Report").

BCBSAL is a not-for-profit licensee of the Blue Cross and Blue Shield Association which offers PPO Medicare Advantage products to individuals in Alabama. In the most recent Medicare Star Ratings, our Blue Advantage Medicare Advantage product scored 4 out of a possible 5 stars and has held this level of performance for a number of years. It is evident based upon these achievements that BCBSAL is committed to serving our members through access to high quality healthcare, robust benefits, and excellent customer service.

In light of the audit's findings, OIG recommends BCBSAL do the following:

(1) Refund to the Federal Government the $7,174,865 of estimated overpayments;
(2) Identify, for the high-risk diagnoses included in this report, similar instances of noncompliance that occurred after our audit period and refund any resulting overpayments to the Federal Government; and
(3) Enhance its examination of its existing compliance procedures to identify areas where improvements can be made to ensure that diagnoses that are at high risk for being miscoded comply with Federal requirements (when submitted to CMS for use in CMS's risk adjustment program) and take the necessary steps to enhance those procedures.[1]

BCBSAL does not concur, in the aggregate, with the finding that it received $7.1 million in estimated overpayments from CMS for the population we serve. BCBSAL respectfully agrees in

[1] Draft Report, page 18

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part with the findings of the Draft Report, but also requests the OIG reconsider certain recommendations for the reasons stated herein.

I. The overall approach of the audit raises concerns, as it targets overpayments and does not use established risk adjustment data validation audit processes.

BCBSAL does not concur with the primary finding that it received $7.1 million of estimated overpayments in the 2018-2019 payment years examined given that the audit process itself is designed to find overpayments rather than ensure accurate payments are being made by the plan. The objective for the audit was "to determine whether selected diagnosis codes BCBSAL submitted to CMS for use in CMS's risk adjustment program complied with Federal requirements."[2] The audit identified diagnoses that were at a higher risk for being miscoded, mapping to one of nine high-risk diagnosis groups. Enrollees without any diagnoses or suspected missing diagnoses were not included in the scope of the audit. Inherently, within claims data, there exists some misclassification of diagnosis codes. This occurs in Medicare fee-for-service as well, which is the basis for the Medicare Advantage payment rates. At the outset, the BCBSAL sample design is not representative of the population, but rather, is presented in a way that is biased to overemphasize overpayments. The report says as much, in that the audit objective "did not require an understanding or assessment of BCBSAL's complete internal control structure, and we limited our review of internal controls to those directly related to our objective."[3]

A. The audit did not utilize an established process for risk adjustment and therefore did not consider all factors applicable to a Medicare Advantage program's payment accuracy and integrity.

As stated in the Draft Report, the audit of BCBSAL is "part of a series of audits in which we are reviewing high-risk diagnosis codes that MA organizations submitted to CMS for use in its risk adjustment program."[4] In reviewing responses from other MAOs that have undergone audits within this series, many take issue with the approach of the audit because it does not follow established processes for validation of risk adjustment data or consider all necessary factors for plan administration.[5] Had the OIG chosen to operate this audit under a more comprehensive

[2] Draft Report, page 1
[3] Draft Report, page 19
[4] Draft Report, Highlights
[5] *See* OIG Audit Report A-07-20-01197, *Medicare Advantage Audit of Specific Diagnosis Codes that Presbyterian Health Plan, Inc. (contract H3204) Submitted to CMS,* dated August 2023, at 40 ("The methodology used by OIG to arrive at the Alleged Overpayment is flawed and overstates any potential overpayments because it did not take into account potential underpayments which would likely reduce the Alleged Overpayment amount."); OIG Audit Report A-07-22-01209, *Medicare Advantage Compliance Audit of Specific Diagnosis Codes that UCare Minnesota (Contract H2459) Submitted to CMS,* dated December 2024, at 44 ("OIG's audit targeted only potential *overpayments, rather than both overpayments and underpayments,* by focusing only on a limited set of very narrowly defined situations that it refers to as "high-risk" dia

model, which would include evaluation of both overpayments and underpayments, the bias towards finding overpayments to the detriment of the MAOs would be lessened.

The audit approach implies BCBSAL was, in the aggregate, overpaid. Other audit means utilized by CMS, such as the Improper Payment Measure (IPM)[6], look at both overpayments *and* underpayments by CMS to the plans. In the most recent IPM audit, BCBSAL validated 100% of Hierarchical Condition Categories (HCC) requested. This OIG audit did not take such a balanced approach, and as a result, there is no adjustment made for potential underpayments which would result in a more positive and accurate outcome.

B. BCBSAL requests OIG reconsider its draft recommendation that BCBSAL return an extrapolated overpayment of $7.1 million for plan years 2018 and 2019 as well as any subsequent overpayments found after the subject audit period.

Given the overall approach of this audit to focus on overpayments while failing to account for underpayments, as well as eschewing the possibility of errors from fee-for-service data, the finding that BCBSAL was overpaid in the amount of $7.1 million is based on one-sided audit methodology. Additionally, while the OIG recommends BCBSAL pay back CMS for the extrapolated amount of $7.1 million, there is no mechanism to pay such an amount to CMS for an audit which is not performed under the CMS RADV audit process.[7] Medicare Advantage payments are determined and paid at an individual member level. The extrapolated amount calculated by OIG is not member specific, but rather an estimate. Payers will need additional guidance to reconcile the estimates and instructions for returning funds to CMS, if it is indeed proper under the parameters of this audit and regulatory guidance.

II. BCBSAL concurs, in part, with errors found in the targeted sample.

While BCBSAL takes issue with the overall approach of the audit and its failure to allow for less than 100% accuracy in coding, there are elements within the findings of the target sample with which BCBSAL concurs. BCBSAL follows the International Classification of Diseases (ICD), Clinical Modification, Official Guidelines for Coding and Reporting.[8] During BCBSAL's evaluation of the medical record findings provided by the OIG's third-party auditor, BCBSAL disagrees with certain findings, as documentation was provided that aligns with the ICD Guidelines.

[6] The Improper Payment Measure, an annual measurement of projected payment errors for Medicare Advantage programs, is part of the Payment Integrity Information Act of 2019.
[7] See 42 CFR 422.310(e) ("*Validation of risk adjustment data.* MA organizations and their providers and practitioners are required to submit a sample of medical records for the validation of risk adjustment data, as required by CMS. There may be penalties for submission of false data. MA organizations must remit improper payments based on RADV audits, in a manner specified by CMS. For RADV audits, CMS may extrapolate RADV Contract-Level audit findings for payment year 2019 and subsequent payment years").
[8] ICD-10-CM Official Guidelines for Coding and Reporting, as provided by CMS and the National Center for Health Statis

Notably, Chapter 2 of the ICD Guidelines, which focuses on Neoplasms, outlines detailed instructions for coding cancer diagnoses. These include:

- Current malignancy versus personal history of malignancy:
    - If a primary malignancy has been excised, but further treatment—such as additional surgery, radiation therapy, or chemotherapy—is directed to the site, the primary malignancy code should continue to be used until treatment is completed.
    - When a primary malignancy has been excised or eradicated from its site, and no further treatment is directed to that site, nor is there any evidence of an existing primary malignancy, the code from category Z85 (Personal History of Malignant Neoplasm) should be applied to indicate the former site of the malignancy.

However, the OIG's findings, in some instances, did not align with the ICD guidelines above. For example, in sample 243, BCBSAL submitted ICD-10 code C61 (Malignant Neoplasm of the Prostate), mapping to V23 HCC 12, as supported by the medical record. The record indicated that the patient had completed radiation therapy, was actively receiving Lupron injections for the treatment of prostate cancer, and had an active prostate diagnosis, which had been assessed. As the patient was actively receiving treatment, according to the ICD guidelines, this is an active diagnosis. However, the OIG included this as an error.

Additionally, the OIG's criteria for identifying outliers included specific guidance, such as in the case of prostate cancer, which stated that if an enrollee did not undergo surgical therapy, radiation treatment, or chemotherapy drugs within six months before or after the diagnosis, a diagnosis of history of prostate cancer (which does not map to a Hierarchical Condition Category [HCC]) should typically be applied. However, upon reviewing the ICD Guidelines, BCBSAL found no mention of the six-month timeframe for treatment criteria.

Based on these findings, BCBSAL is rebutting a total of 11 samples due to appropriate documentation according to ICD guidelines being found within the medical record:

HCC Category	Enrollee
Breast Cancer HCC 12	2
Embolism HCC 108	3
Lung Cancer HCC 9	1
Pressure Ulcer HCC 158	2
Prostate Cancer HCC 12	3
Total	**11**

While BCBSAL agrees with certain errors found in the targeted sample, we request that the OIG reconsider its findings regarding the medical record support for diagnosis codes in 11 of the sampled enrollee-years. We have attached a table that identifies the 11 samples, OIG's findings, and our responses.

III. BCBSAL does not concur with the OIG's directive to identify similar instances of non-compliance occurring after the audit period, and refund overpayments accordingly.

OIG's second recommendation is that BCBSAL "identify, for the high-risk diagnoses in this report, similar instances of noncompliance that occurred after our audit period and refund any resulting overpayments to the Federal Government." BCBSAL does not concur in this recommendation. Given the issues and bias we have found in the initial audit, applying these same procedures to a subsequent inquiry of high-risk diagnoses would be improper. However, BCBSAL will continue evaluating and enhancing existing policies and procedures related to high-risk diagnosis codes.

IV. BCBSAL will continue to evaluate its compliance procedures based upon recommendations made but does not concur with OIG's implication that the compliance program requires enhancement.

OIG's final recommendation to BCBSAL centers upon examining existing compliance procedures to "ensure that diagnoses that are at high risk for being miscoded comply with Federal requirements (when submitted to CMS for use in CMS's risk adjustment program."[9] BCBSAL has a strong and comprehensive compliance program, which is described by the OIG as follows:

> As part of its preventative measures, BCBSAL had compliance procedures in place that consisted of a variety of provider-specific outreach efforts to train and educate its providers on coding and medical record documentation. These efforts included the distribution of coding educational materials and short coding videos to assist providers with the proper coding of diagnoses and the creation of accurate medical record documentation. BCBSAL also held conferences with its providers and vendors that focused on coding guideline updates and other best practices.
>
> BCBSAL's compliance procedures also included detection and correction measures designed to determine whether the diagnosis codes that it submitted to CMS calculate risk-adjusted payments were correct. For example, BCBSAL routinely conducted retrospective reviews of claims to verify that submitted diagnosis codes were supported by medical record documentation. If the reviews identified any coding errors, BCBSAL provided guidance to providers and vendors on how to submit the corrections to CMS.

[9] Draft Report, page 18

BlueCross BlueShield of Alabama

> Additionally, BCBSAL required its coders to meet certain efficiency standards. Specifically, BCBSAL required its coders to undergo monthly coding reviews to verify that they were identifying codes with at least 95-percent accuracy. Further, if a coder was unable to maintain a 95-percent accuracy rate for 2 consecutive months, BCBSAL increased the number of that coders claims that it reviewed by 50 percent. BCBSAL used the results of these reviews to identify additional areas for training or coaching.[10]

Even with acknowledging the measures BCBSAL takes to ensure accurate data relative to claims and documentation, OIG recommends "improvement" without outlining specific recommendations. As noted, the audit appears to require 100% accuracy in order to avoid overpayments and does not allow for any mitigation measures to be considered. BCBSAL compliance measures include evaluation of coders' efficiency and accuracy. BCBSAL will ensure corrective action is implemented for identified errors and will continue to evaluate and enhance its policies and procedures with the goal of improving accuracy and efficiency but cannot realistically expect 100% accuracy at any point.

In sum, BCBSAL provides quality healthcare and customer service to its Medicare Advantage population, and appreciates the opportunity to work alongside HHS, CMS, and the OIG in doing so. We remain committed to working with the agency to improve our processes, remedy findings, and enhance future audits.

Sincerely,

/Stacey Walters/

Stacey Walters
Vice President, Quality & Value Based Care

[10] Draft Report, pages 17-18

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