1

Presented by:

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Population Health Coding Analyst
Saint Luke's Physician Group

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Agenda

Who are the players?
Medicare Advantage Plans
The OIG
Billing Providers

What's the focus?
Risk Adjustment Audits

What can we learn?
Supporting Diagnoses with Documentation

3

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The Players

U.S. Department of Health and Human Services
Office of Inspector General

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

BlueCross BlueShield MEDICARE

aetna medicare solutions

CarePlus HEALTH PLANS

VIDANT Medical Center

SELECTCARE of TEXAS, L.L.C.

Humana Medicare Advantage

Excellus

4

4

Who are the HHS-OIG?

5

5

Medicare Advantage

- Also known as Part C
- Offers beneficiaries an option enroll in private healthcare plans rather than having their care covered through Medicare's traditional fee-for-service program
- CMS contracts with these MA organizations, which in turn contract with providers (including hospitals) and physicians.

In 2022, CMS paid MA organizations $403 billion, which represented 45 percent of all Medicare payments for that year.

CMS estimates that 9.5 percent of payments to MA organizations are improper, mainly due to unsupported diagnoses ***submitted by MA organizations.***

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Risk Adjustment Basics

Risk Score

- CMS makes payments to MA organizations according to its risk adjustment program.
- CMS pays MA organizations the anticipated cost of providing benefits based on risk factors as the age, gender, and health status of that individual (risk score)
- Health status information comes from medical and prescription claims sent to the MA plans
- The risk adjustment program is prospective; CMS uses the diagnosis codes that the enrollee received during one calendar year (known as the *service year*) to determine HCCs and calculate risk scores for the next calendar year (known as the *payment year*).

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Risk Score Example

Summary	
Demographic Risk Factor	0.573
HCC Risk factor	1.231
Total Risk Score	1.804
Total Monthly Premium	$1,443

Dx Code	Dx Description	HCC	HCC Description	Trumped By	RAF	Monthly Premium
I509	Heart failure, unspecified	HCC85	Congestive Heart Failure	--	0.276	$221
J449	Chronic obstructive pulmonary disease, unspecified	HCC111	Chronic Obstructive Pulmonary Disease	--	0.280	$224
N1832	Chronic kidney disease, stage 3b	HCC138	Chronic Kidney Disease, Moderate (Stage 3)	--	0.058	$46
E1122	Type 2 diabetes mellitus with diabetic chronic kidney disease	HCC18	Diabetes with Chronic Complications	--	0.252	$202
		HCC85_gRenal_v24	Interaction Codes	--	0.130	$104
		CHF_gCopdCF	Interaction Codes	--	0.129	$103
		Diabetes_CHF	Interaction Codes	--	0.101	$81
		D4	Payment HCC counts	--	0.005	$4

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Risk Score Comparison

E11.9 Type II DM w/o complications
I25.10 CAD
J44.9 COPD

≠

E11.22 Type II DM ***with CKD***
I25.10 CAD ***with angina***
J44.9 COPD

Summary	
Demographic Risk Factor	0.329
HCC Risk factor	0.368
Total Risk Score	0.697
Total Monthly Premium	$558

Summary	
Demographic Risk Factor	0.329
HCC Risk factor	0.645
Total Risk Score	0.974
Total Monthly Premium	$779

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What's the Focus?

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CMS to MA Plans

CMS requires all submitted diagnosis codes to be documented on the medical record … as a result of a face-to-face encounter (the Manual, chap. 7, § 40).

The diagnosis must be coded according to the ICD-10-CM, Official Guidelines for Coding and Reporting (42 CFR § 422.310(d)(1) and 45 CFR §§ 162.1002(b)(1) and (c)(2)-(3)).

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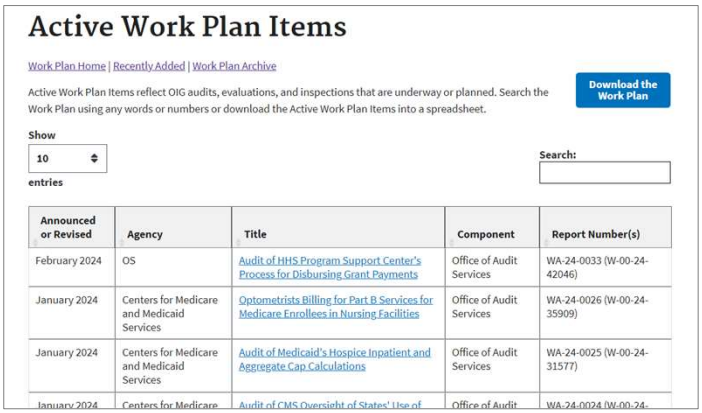
The OIG Work Plan

Work Plan Items reflect OIG audits, evaluations, and inspections that are underway or planned.



Active Work Plan Items

Work Plan Home | Recently Added | Work Plan Archive

Active Work Plan Items reflect OIG audits, evaluations, and inspections that are underway or planned. Search the Work Plan using any words or numbers or download the Active Work Plan Items into a spreadsheet.

Download the Work Plan

Show 10 entries

Search:

Announced or Revised	Agency	Title	Component	Report Number(s)
February 2024	OS	Audit of HHS Program Support Center's Process for Disbursing Grant Payments	Office of Audit Services	WA-24-0033 (W-00-24-42046)
January 2024	Centers for Medicare and Medicaid Services	Optometrists Billing for Part B Services for Medicare Enrollees in Nursing Facilities	Office of Audit Services	WA-24-0026 (W-00-24-35909)
January 2024	Centers for Medicare and Medicaid Services	Audit of Medicaid's Hospice Inpatient and Aggregate Cap Calculations	Office of Audit Services	WA-24-0025 (W-00-24-31577)
January 2024	Centers for Medicare	Audit of CMS Oversight of States' Use of	Office of Audit	WA-24-0024 (W-00-24-

https://oig.hhs.gov/reports-and-publications/workplan/index.asp

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Nationwide Audits of Medicare Part C High-Risk Diagnosis Codes

Payments to Medicare Advantage (MA) organizations are risk-adjusted on the basis of the health status of each enrollee. MA organizations are required to submit risk-adjustment data to CMS according to CMS instructions (42 CFR § 422.310(b)). Miscoded diagnoses may cause CMS to pay MA organizations improper amounts (The Act §§ 1853(a)). For these audits, we will focus on enrollees who received diagnoses that are at high risk for being miscoded and resulted in increased risk-adjusted payments from CMS to MA organizations. We will determine whether these diagnosis codes, as submitted by MA organizations to CMS for use in CMS's risk-adjustment program, complied with Federal requirements.

Announced or Revised	Agency	Title	Component	Report Number(s)	Expected Issue Date (FY)
June 2023	Centers for Medicare and Medicaid Services	Nationwide Audits of Medicare Part C High-Risk Diagnosis Codes	Office of Audit Services	WA-23-0019 (W-00-23-35896)	2024

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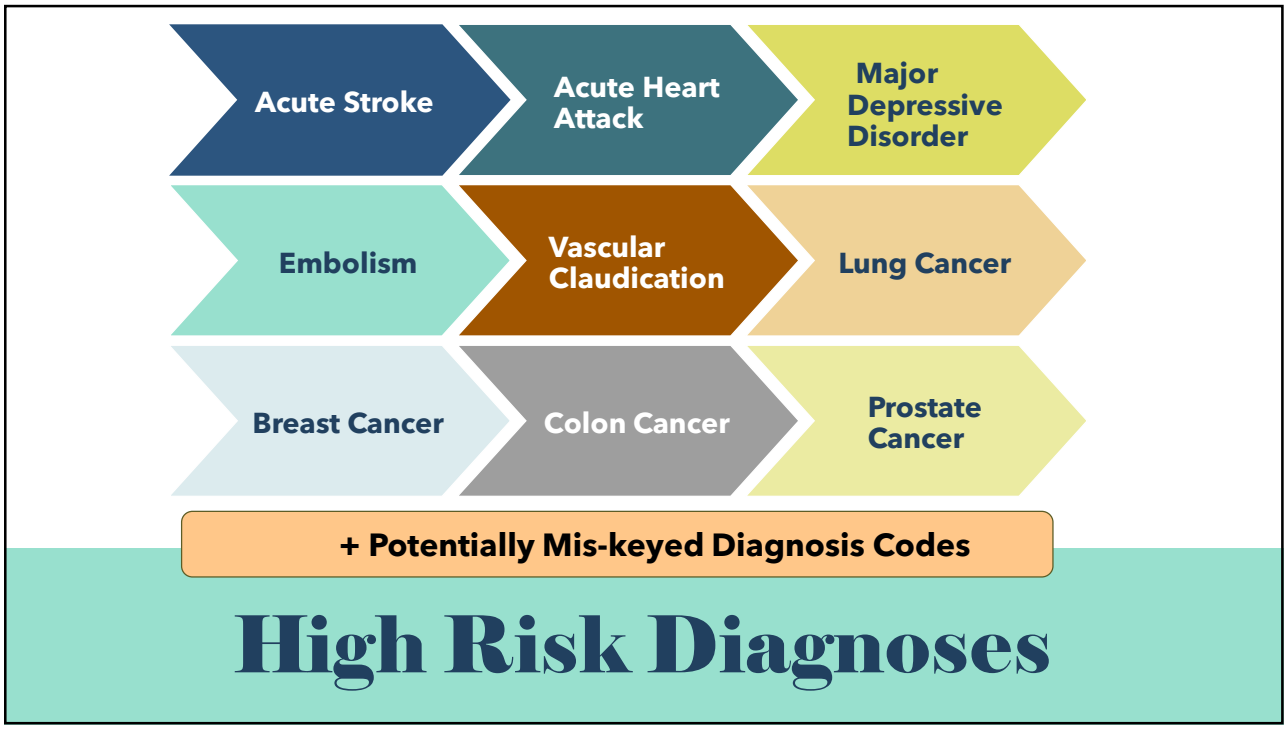
Medicare Part C Audits of Documentation Supporting Specific Diagnosis Codes

Payments to Medicare Advantage (MA) organizations are risk-adjusted based on each enrollee's health status (SSA § 1853(a)). MA organizations are required to submit risk-adjustment data to CMS in accordance with CMS instructions (42 CFR § 422.310(b)), and inaccurate diagnoses may cause CMS to pay MA organizations improper amounts. In general, MA organizations receive higher payments for enrollees with more complex diagnoses. CMS estimates that 9.5 percent of payments to MA organizations are improper, mainly due to unsupported diagnoses submitted by MA organizations. Prior OIG reviews have shown that some diagnoses are more at risk than others to be unsupported by medical record documentation. We will perform a targeted review of these diagnoses and will review the medical record documentation to ensure that it supports the diagnoses that MA organizations submitted to CMS for use in CMS's risk score calculations and to determine whether the diagnoses submitted complied with Federal requirements.

Announced or Revised	Agency	Title	Component	Report Number(s)	Expected Issue Date (FY)
November 2023	Centers for Medicare and Medicaid Services	Medicare Part C Audits of Documentation Supporting Specific Diagnosis Codes	Office of Audit Services	WA-24-0004 (W-00-24-35906)	2026

14



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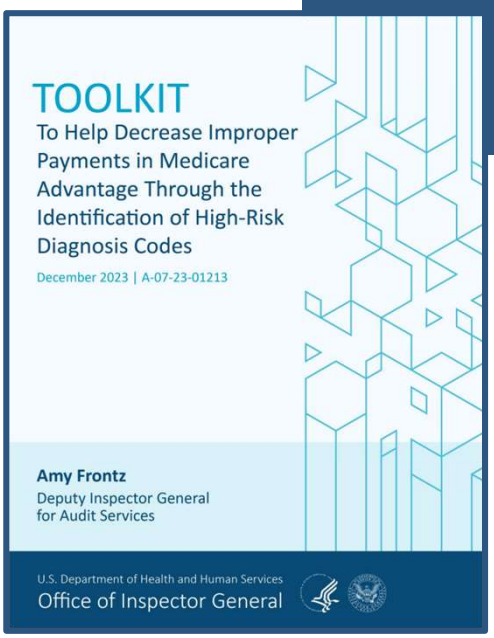

The Toolkit

"We have performed several audits for which our objectives were to determine whether MA organizations submitted certain diagnosis codes—ones that when coupled with other data indicated that the codes were at **high risk for being miscoded**—to CMS for use in CMS's risk adjustment program... Thus far, we have found that overall, **approximately 70 percent of those diagnosis codes were not supported in the associated medical records**"

Other MA organizations—including ones that we have not audited—have asked us to share with them how we decided which diagnosis codes were at high risk for being miscoded.

https://oig.hhs.gov/oas/reports/region7/72301213.pdf

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The Toolkit

High-Risk Group	Total	Errors	Error %
Acute stroke	945	908	96%
Acute heart attack	791	751	95%
Embolism	754	593	79%
Lung cancer	391	345	88%
Breast cancer	390	373	96%
Colon cancer	390	368	94%
Prostate cancer	360	322	89%
Potentially mis-keyed diagnosis codes	522	421	81%
Totals	**4,543**	**4,081**	**90%**

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Toolkit: Lung Cancer

4. Lung Cancer High-Risk Group

For the lung cancer high-risk group, we focused on enrollees who received one lung cancer diagnosis (that mapped to the HCC for Lung and Other Severe Cancers (HCC 9)) 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 (Table 4.1). In these instances, a diagnosis of history of lung cancer (which does not map to an HCC) typically should have been used.

Codes Used in Our Analysis

Table 4.1 includes the 17 lung cancer diagnosis codes used in our analysis:

Table 4.1: Lung Cancer Diagnosis Codes

Diagnosis Code	Description
C33	Malignant neoplasm of trachea
C3400	Malignant neoplasm of unspecified main bronchus
C3401	Malignant neoplasm of right main bronchus
C3402	Malignant neoplasm of left main bronchus
C3410	Malignant neoplasm of upper lobe, unspecified bronchus or lung

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Toolkit: Lung Cancer

We used various Current Procedural Terminology (CPT) codes to further refine our analysis.[7] We identified and removed enrollees who received at least one of the following:

1. Table 4.2 includes 19 chemotherapy drug treatment CPT codes that we identified as common procedure codes associated with an enrollee who received a chemotherapy drug treatment for an active cancer diagnosis.

Table 4.2: Chemotherapy Drug Treatment CPT Codes

CPT Code	Description
96420	Injection of chemotherapy using push technique into an artery
96402	Hormonal anti-neoplastic chemotherapy administration beneath the skin or into muscle
96405	Administration of chemotherapy into growth, 1 – 7
96406	Chemotherapy into a lesion, more than 7 lesions
96409	Infusion of chemotherapy into a vein using push technique
96411	Infusion of different chemotherapy drug or substance into a vein
96413	Infusion of chemotherapy into a vein up to 1 hour
96415	Infusion of chemotherapy into a vein
96401	Administration of non-hormonal anti-neoplastic chemotherapy under skin or into muscle
96417	Infusion of different chemotherapy drug or substance into a vein up to 1 hour
96549	Other chemotherapy procedure
96422	Infusion of chemotherapy into an artery up to 1 hour

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The Toolkit – Data Analytics

"We have included explanations that demonstrate why these specific diagnosis codes, when coupled with other are at high risk for being miscoded.

For example, one high-risk group included individuals who received one **lung cancer diagnosis** during a service year, but the encounters did not indicate that the individuals received certain types of care and medication."

"Based on discussions with medical professionals, we have also provided in each case the diagnosis code that **typically** should have been submitted to CMS instead of the incorrect diagnosis code that actually was submitted. **Continuing with the lung cancer diagnosis example, a history of lung cancer diagnosis is generally what was supported in the medical records."**

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MA RADV Final Rule

- RADV: To recover improper risk adjustment payments made to Medicare Advantage (MA) plans
- Final Rule: CMS will **extrapolate** RADV audit findings beginning with payment year (PY) 2018

"It is also expected that the use of extrapolation will incentivize MAOs to take meaningful steps to reduce improper risk adjusted payments in the future."

https://www.cms.gov/newsroom/fact-sheets/medicare-advantage-risk-adjustment-data-validation-final-rule-cms-4185-f2-fact-sheet

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"Studies and **audits** done separately by CMS and the HHS Office of Inspector General (HHS-OIG) have shown that **medical records do not always support the diagnoses reported** by MAOs, which leads to **billions** of dollars in overpayments and increased costs to the Medicare program...

Through RADV audits, a **sample** of beneficiary medical records are provided by MAOs, and CMS reviews those records to verify that diagnoses reported for risk adjusted payments are accurate and supported in the medical record. Risk adjustment **discrepancies can be aggregated** to determine an overall level of payment error, which can then be **extrapolated**."

https://www.cms.gov/newsroom/fact-sheets/medicare-advantage-risk-adjustment-data-validation-final-rule-cms-4185-f2-fact-sheet

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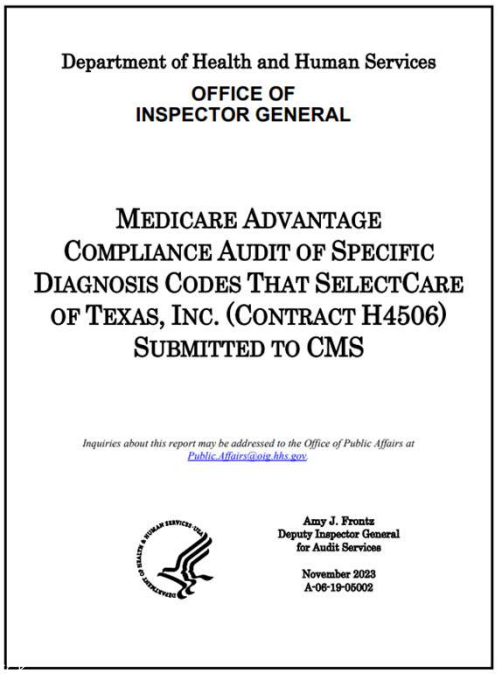
Post Audit Report – SelectCare of Texas, Inc.

November 2023

23



Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

MEDICARE ADVANTAGE COMPLIANCE AUDIT OF SPECIFIC DIAGNOSIS CODES THAT SELECTCARE OF TEXAS, INC. (CONTRACT H4506) SUBMITTED TO CMS

Inquiries about this report may be addressed to the Office of Public Affairs at Public.Affairs@oig.hhs.gov

Amy J. Frontz
Deputy Inspector General
for Audit Services

November 2023
A-06-19-06002

23

SelectCare of Texas

"For the 2015 and 2016 payment years (audit period), CMS paid SelectCare approximately $1.5 billion to provide coverage to its enrollees

(we) limited our review to the portions of the payments that were associated with these high-risk diagnosis codes ($8,331,060)

MA organizations are responsible for the accuracy, completeness, and truthfulness of the data submitted to CMS for payment purposes"

High Risk Group	Number of Sampled Enrollee Years
1. Acute stroke	30
2. Acute heart attack	30
3. Major depressive disorder	30
4. Embolism	30
5. Vascular claudication	30
6. Lung cancer	30
7. Breast cancer	30
8. Colon cancer	30
9. Prostate cancer	30
Total for Stratified Random Sample	**270**
10. Potentially mis-keyed diagnosis codes	15
Total for All High-Risk Groups	**285**

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SelectCare of Texas

285 Records reviewed

65 Supported

220 Unsupported

$482,601 Overpayments identified

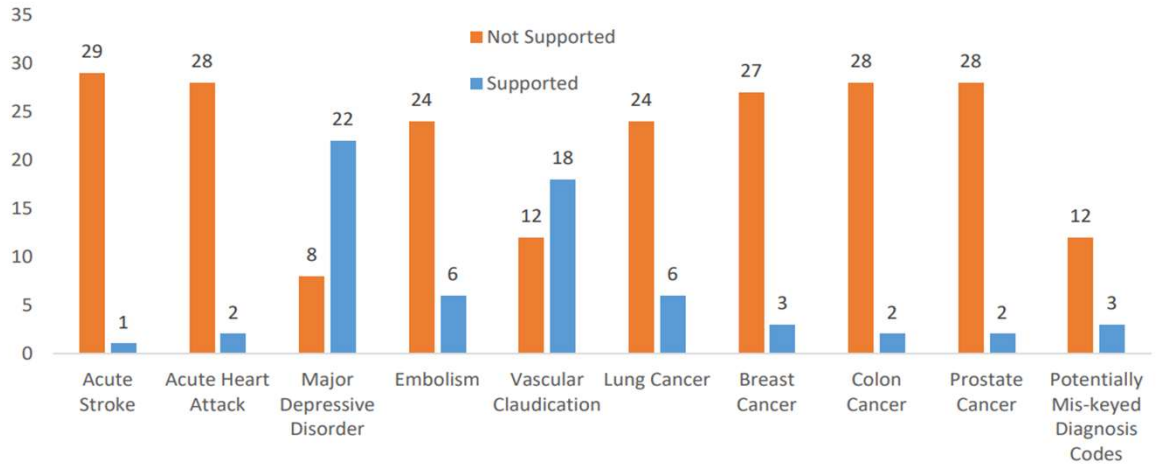
$5.1 million ***estimated*** Overpayments

"On the basis of our sample results, we ***estimated*** that SelectCare received at least $5.1 million in net overpayments for 2015 and 2016.

Because of Federal regulations that limit the use of extrapolation in Risk Adjustment Data Validation (RADV) audits for recovery purposes to payment year 2018 and forward, we are reporting the overall estimated overpayment amount but are recommending a refund of $482,601"

25

SelectCare of Texas



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What can we Learn?

Acute Stroke

An enrollee received one acute stroke diagnosis on only one physician claim during the service year but did not have that diagnosis on a corresponding inpatient or outpatient hospital claim.

For most patients "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"

"there is ***no evidence*** of an acute stroke or any related condition that result[s] in an assignment of the submitted HCC [for Ischemic or Unspecified Stroke] or a related HCC.

There is mention of [a] ***history of*** cerebrovascular accident but no description of residuals or sequelae that should be coded."

The history of stroke diagnosis code does not map to an HCC.

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High Risk Diagnosis: Acute Stroke

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CVA

Acute CVA codes should be used for inpatient setting only

In the clinic setting:

- Use **Z86.73**, Personal history of TIA or CVA without residual deficits if the patient is asymptomatic
- Code from **I69.3x** – Sequela of cerebral infarction, if the patient is symptomatic (has a late effect) such as:
  - I69.321 Dysphasia following cerebral infarction (non-HCC)
  - I69.351 Hemiplegia and hemiparesis following cerebral infarction affecting right dominant side (HCC)

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Outpatient Chart Example: CVA

A&P:
Stroke with cerebral ischemia - Chronically works with physical therapy/exercises due to left hemiparesis caused by the stroke. Also sees Dr. Smith for spasticity related to this also. Continue aspirin therapy plus statin therapy and hypertension control. He works at doing exercise and is undergoing PT.

I63.9 Cerebral Infarction, unspecified (active)

30

Outpatient Chart Example: CVA

A&P:
Stroke with cerebral ischemia - Chronically works with physical therapy/exercises due to left hemiparesis caused by the stroke. Also sees Dr. Smith for spasticity related to this also. Continue aspirin therapy plus statin therapy and hypertension control. He works at doing exercise and is undergoing PT.

✓ **I69.354 Hemiplegia and/or hemiparesis following cerebral infarction affecting left non-dominant side**

⊘ **I63.9 Cerebral Infarction, unspecified (active)**

⊘ **Z86.73 Personal history of transient ischemic attack (TIA), and cerebral infarction without residual deficits**

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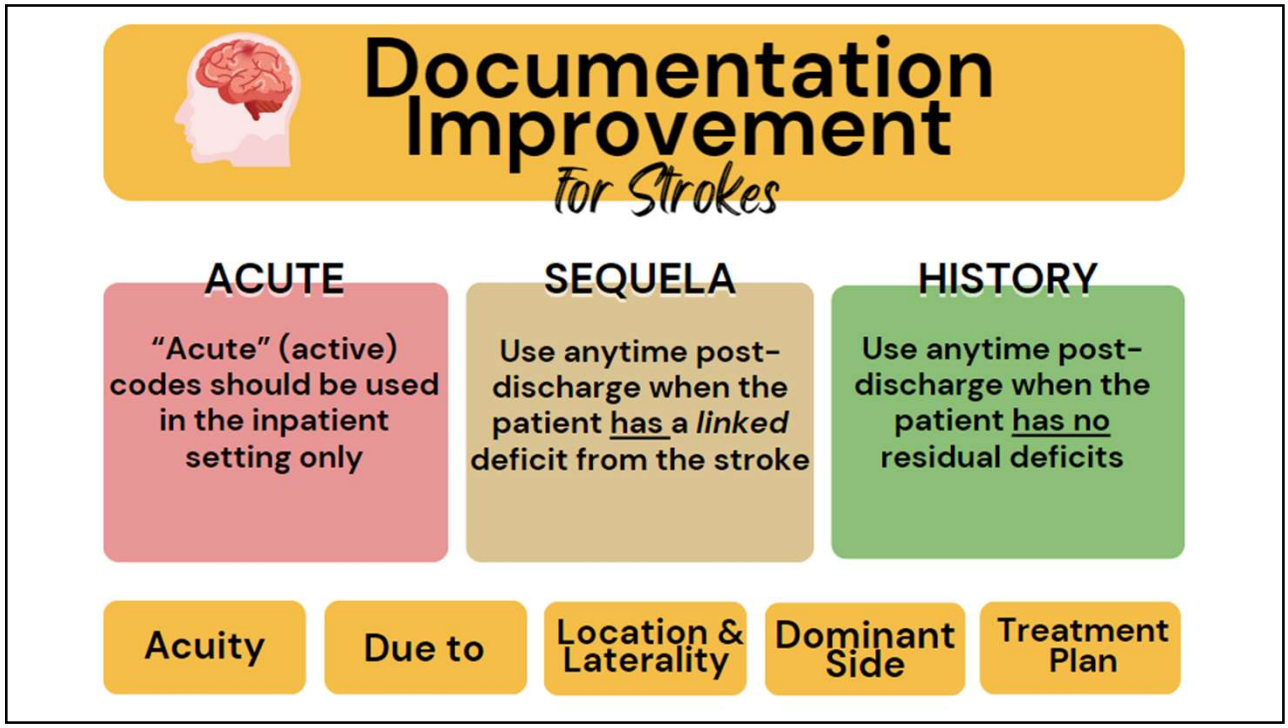

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What can we Learn?

Acute MI

DATA MINING CRITERIA:
Acute Heart Attack: An enrollee received ***one*** diagnosis during the service year that mapped to either the HCC for Acute Myocardial Infarction or to the HCC for Unstable Angina and Other Acute Ischemic Heart Disease (Acute Heart Attack HCCs) on ***only one*** physician or outpatient claim during the service year but did not have that diagnosis on a corresponding inpatient hospital claim (either within 60 days before or 60 days after

"The medical records in each case did not support the submitted diagnosis that mapped to an Acute Heart Attack HCC….however…we identified support for another diagnosis"

- Angina
- Old MI

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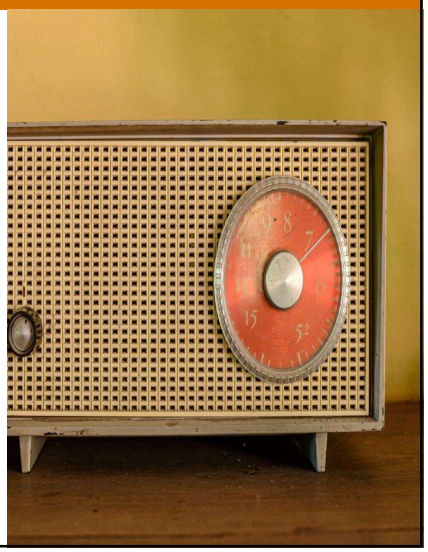

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High Risk Diagnosis: Acute MI

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Myocardial Infarction (MI)

ACUTE

MIs are considered acute for 4 weeks/28 days

Through day 28, use the appropriate acute MI code such as:

- I21.01 ST elevation (STEMI) myocardial infarction involving left main coronary artery
- I21.4 Non-ST elevation (NSTEMI) myocardial infarction

HISTORY

After 4 weeks:

Z51.89 Other specified ***aftercare*** if the patient still requiring active care after the 4-week period (symptomatic)

I25.2 ***Old MI*** if the patient is considered healed (asymptomatic)

There is no time limit on the use of I25.2

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Post Audit Report – CarePlus Health Plans, Inc.

October 2023

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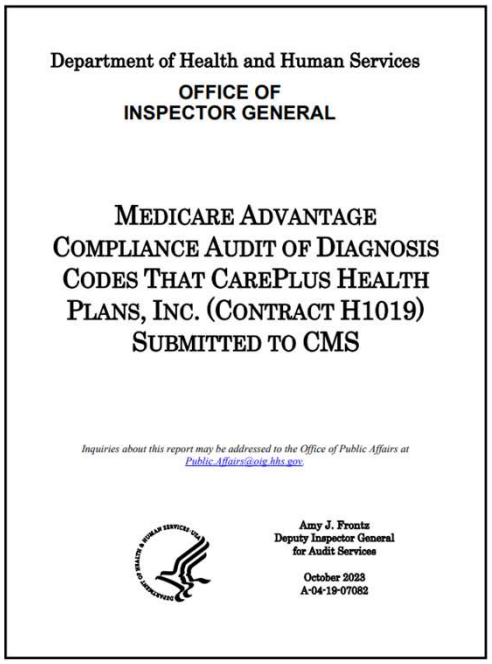

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

MEDICARE ADVANTAGE COMPLIANCE AUDIT OF DIAGNOSIS CODES THAT CAREPLUS HEALTH PLANS, INC. (CONTRACT H1019) SUBMITTED TO CMS

Inquiries about this report may be addressed to the Office of Public Affairs at Public.Affairs@oig.hhs.gov

Amy J. Frontz
Deputy Inspector General
for Audit Services

October 2023
A-04-19-07062

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CarePlus Health Plans

1656 HCCs reviewed	1210 Supported	446 Unsupported	$641,467 Overpayments identified	$117 million ***estimated*** Overpayments

"CarePlus received $641,467 in net overpayments (consisting of $682,274 of overpayments and **$40,807 of underpayments**) "

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ENROLLEE A	
AS SUBMITTED BY CAREPLUS	
Number of HCCs	7
Monthly CMS payment	$983
AS AUDITED	
Number of HCCs	5
Monthly CMS payment	$869
OVERPAYMENT	
Monthly	**$114**
Annually	**$1,368**

ENROLLEE D	
AS SUBMITTED BY CAREPLUS	
Number of HCCs	4
Monthly CMS payment	$582
AS AUDITED	
Number of HCCs	8
Monthly CMS payment	$1,095
UNDERPAYMENT	
Monthly	**$513**
Annually	**$6,156**

CarePlus Health Plans

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"there is no documentation of any condition that will result in the assignment of [the HCC for Angina Pectoris]. There is documentation of chest pain . . . that does not result in an HCC."

"the medical records did not support the diagnosis Diabetes With Other Specified Manifestations, Type II or Unspecified Type, Not Stated as Uncontrolled. However, there was support for the diagnosis Diabetes Mellitus Without Mention of Complication, Type II"

Lacking documentation

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Post Audit Report – Aetna, Inc.

October 2023

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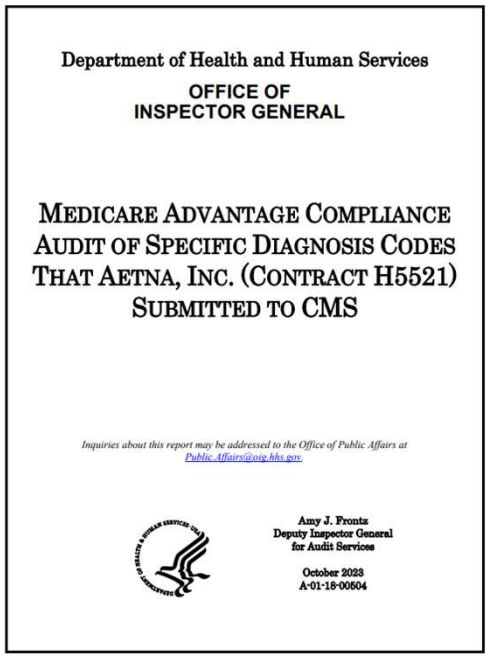

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

MEDICARE ADVANTAGE COMPLIANCE AUDIT OF SPECIFIC DIAGNOSIS CODES THAT AETNA, INC. (CONTRACT H5521) SUBMITTED TO CMS

Inquiries about this report may be addressed to the Office of Public Affairs at Public.Affairs@oig.hhs.gov

Amy J. Frontz
Deputy Inspector General
for Audit Services

October 2023
A-01-18-00504

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Aetna

210 Records reviewed	55 Supported	155 Unsupported	$632,070 Overpayments identified	$25.5 million ***estimated*** Overpayments

"For the 2015 and 2016 payment years (audit period), CMS paid Aetna approximately **$12.7 billion** to provide coverage to its enrollees"

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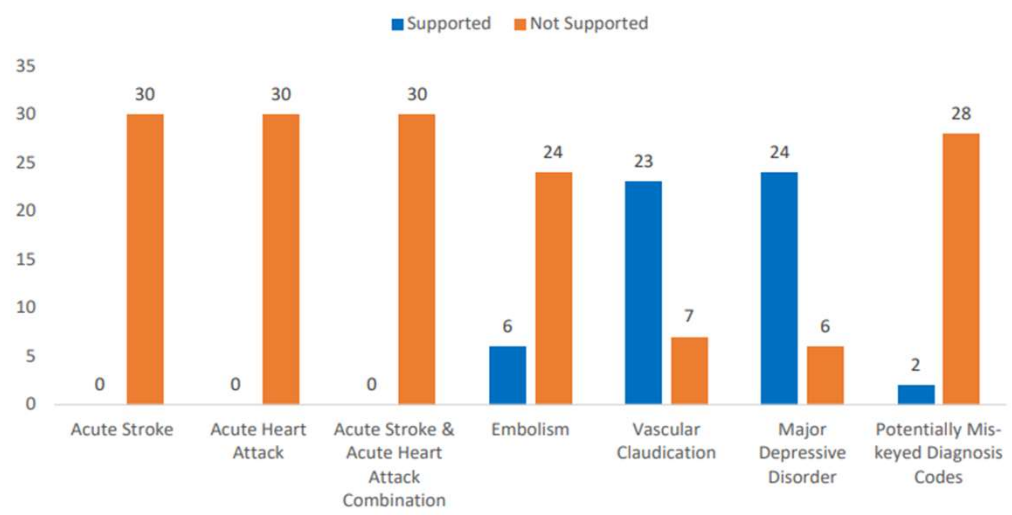
Aetna



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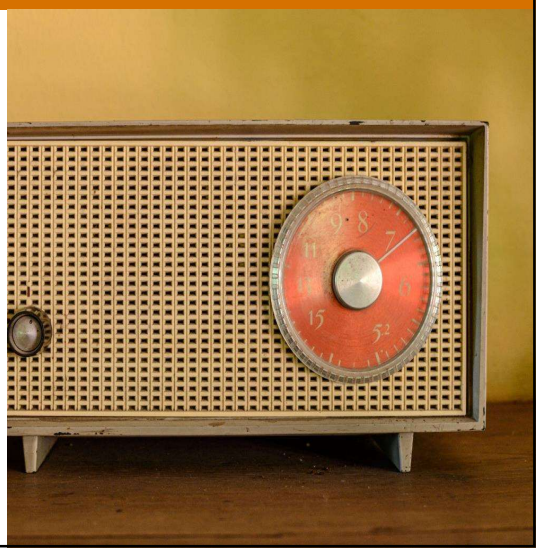
What can we Learn?

Embolism

"An enrollee received **one diagnosis** that mapped to either the HCC for Vascular Disease or 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.

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."



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High Risk Diagnosis: Embolism

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OIGs Findings *(and data mining criteria!)*

Cigna incorrectly submitted diagnosis codes for embolism for **22** of 30 (enrollees).

- the independent medical review contractor stated that "there is no documentation of any condition that will result in the assignment of [the] HCC [for Vascular Disease]. **Per . . . ultrasound test results, there was no evidence of deep vein thrombosis**." [22]
- "there is no documentation of any condition that will result in the assignment of [the] HCC [for Vascular Disease]. There is documentation of a **past medical history** of deep vein thrombosis [diagnosis] that does not result in an HCC."
  - **Embolism**: An enrollee received one diagnosis that mapped to either the HCC for Vascular Disease … but **did not have an anticoagulant medication dispensed**.
  - An anticoagulant medication is **typically** used to treat an embolism. In these instances, a diagnosis of *history of embolism* … typically should have been used.

Source: Medicare Advantage Compliance Audit of Specific Diagnosis Codes That Cigna-HealthSpring Life & Health Insurance Company, Inc. (Contract H4513) Submitted to CMS, A-07-19-01192 (hhs.gov)

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Acute versus chronic

The American Heart Association advises generally a thrombus is referred to as "acute" within the first two weeks after the thrombus forms; "subacute" when more than two weeks and potentially up to six months after thrombus forms; or "chronic" once the thrombus is more than six months old.

- However, a coder cannot apply these time frames to determine whether to code DVT as acute or chronic.
- Rather, code assignment is strictly based on the specific DVT description documented by the provider in the medical record.

Acute vs. Chronic (DVT/PE)

Source: *docushare-app (humana.com)

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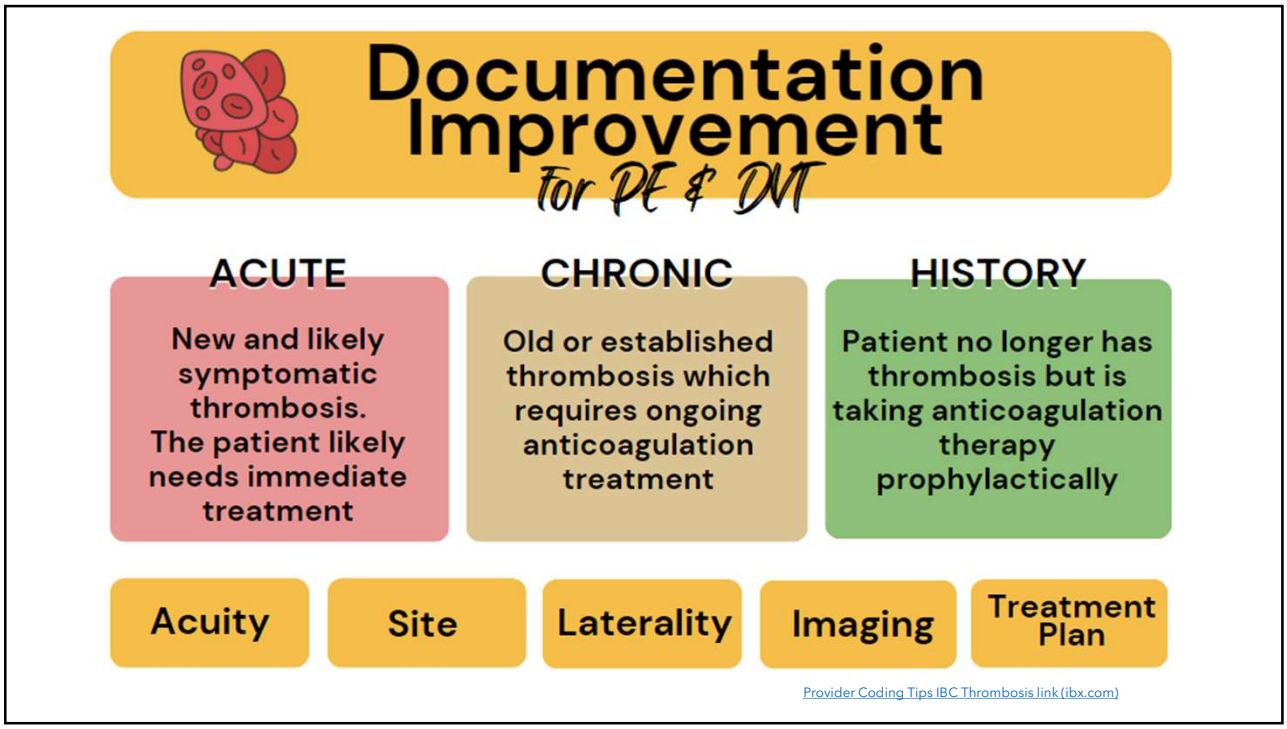
Documentation Improvement
For PE & DVT
ACUTE
New and likely symptomatic thrombosis. The patient likely needs immediate treatment
CHRONIC
Old or established thrombosis which requires ongoing anticoagulation treatment
HISTORY
Patient no longer has thrombosis but is taking anticoagulation therapy prophylactically
Acuity
Site
Laterality
Imaging
Treatment Plan
Provider Coding Tips IBC Thrombosis link (ibx.com)

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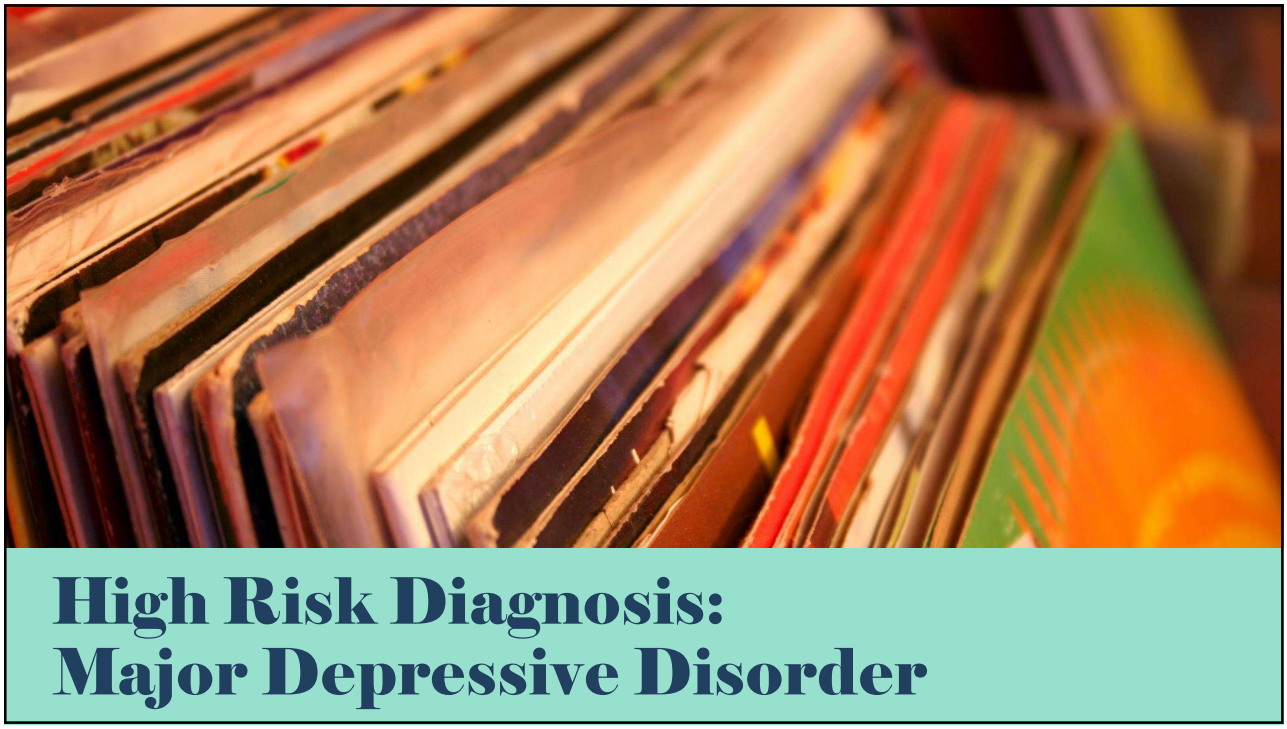
High Risk Diagnosis:
Major Depressive Disorder

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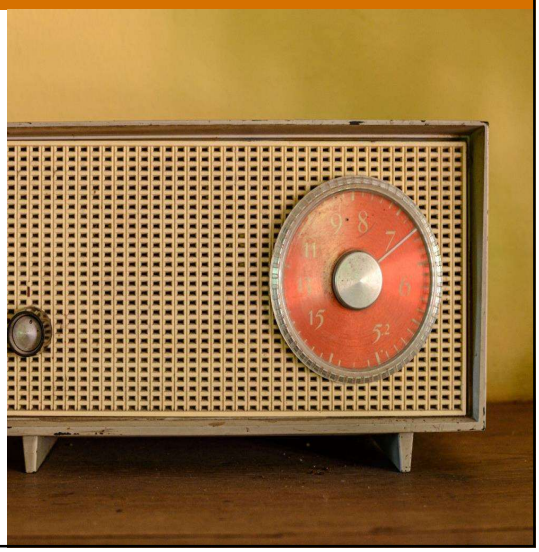
What can we Learn?

Major Depressive Disorder
Data mining criteria: "An enrollee received **one** major depressive disorder diagnosis during the service year but **did not have an antidepressant medication** dispensed on his or her behalf. In these instances, the major depressive disorder
diagnoses may not be supported in the medical records.
…there is no documentation of any condition that will result in the assignment of HCC [Major Depressive, Bipolar, and Paranoid Disorders]. There is documentation of depression [diagnosis] which does not result in an HCC "



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Documentation Requirements…

- **Documentation needed to get to the correct code:**
  - Episode
    - single or recurrent
  - Severity
    - mild
    - moderate
    - severe
      - without psychotic features
      - with psychotic features
  - Status
    - current
    - partial **remission**
    - full **remission**

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REMISSION or History of?

- Partial remission
- Full remission
- History of

* During any type of remission, it is acceptable if the patient's symptoms are controlled with medication

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High Risk Diagnosis: Cancer

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Prostate Cancer

"There is documentation of a past medical history of prostate cancer which does not result in an HCC. The provider has documented, 'S/P Prostate Ca'. The Surgical History section of the note documents treatment completed a **year prior** to the date of service. There is **no indication that the prostate cancer is still *active* or is recurring.** Patient awaiting follow up **surveillance prophylactically**. "

https://oig.hhs.gov/oas/reports/region6/61905002.pdf

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Chapter 2: Neoplasms

- I.C.2.d Primary malignancy previously excised
- When a primary malignancy has been previously excised or eradicated from its site and there is no further treatment directed to that site and there is no evidence of any existing primary malignancy at that site, a code from category Z85, Personal history of malignant neoplasm, should be used to indicate the former site of the malignancy.

- I.C.2.m Current malignancy versus personal history of malignancy
- When a primary malignancy has been excised but further treatment, such as an additional surgery for the malignancy, radiation therapy or chemotherapy is directed to that site, the primary malignancy code should be used until treatment is completed.

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Adjuvant vs. Prophylactic

Adjuvant

Adjuvant therapy targets cancer cells that primary cancer treatment didn't destroy. Having adjuvant therapy means more time spent in cancer treatment but reduces the chance you'll have the same cancer again. Adjuvant therapy is often used as follow-up treatment for breast, colon and lung cancers.

Additional

Prophylaxis/tic

In medicine, something that prevents or protects.

I.e., prophylactic mastectomy

Preventive

55

Active vs. History of: Cancer

ACTIVE

- A new diagnosis, awaiting treatment
- The patient has evidence of current disease
- The patient is actively receiving treatment for cancer (including s/p organ removal)
- The patient did not receive definitive treatment for their malignancy

PERSONAL HISTORY

- The patient has successfully completed treatment for malignancy
- There is no current evidence of the disease
- The patient is being seen for surveillance only
- The patient is on adjuvant therapy for *prophylactic/preventive* purposes

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Chart Example: Cancer

Ms. **XXX** is a 57-year-old woman who presents for initial consultation and to establish **ongoing care** for her **bilateral invasive lobular carcinoma** as detailed above. She is currently on **adjuvant tamoxifen** and really without complaints. She does have some discomfort in the right **reconstruction** due to some radiation fibrosis. She is considering revision and replacement of her subpectoral implants with prepectoral implants.

She denies any bone pain, shortness of breath, abdominal pain, headaches or neurologic symptoms.

Her diagnosis and treatment were in XXX, where she has been living for 20 years and recently moved back to the area.

She did undergo genetic testing and had a BRCA2 variant of uncertain significance (VUS)

ASSESSMENT:

1. Bilateral invasive lobular carcinoma (T3N2a) on the right. **Currently no evidence of disease now 8 years from her initial diagnosis and continuing on adjuvant tamoxifen.**

57

Chart Example: Cancer

Ms. **XXX** is a 57-year-old woman who presents for initial consultation and to establish **ongoing care** for her **bilateral invasive lobular carcinoma** as detailed above. She is currently on **adjuvant tamoxifen** and really

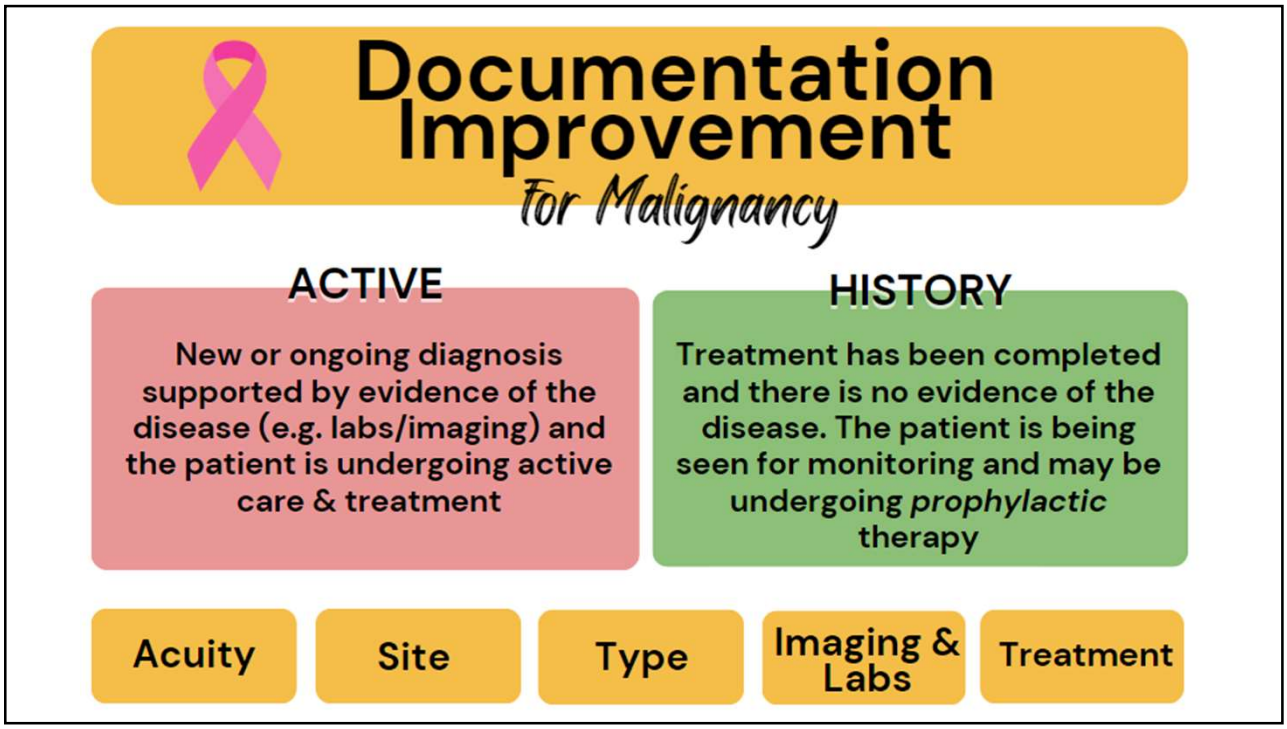
Provider Billed:
1) C50.911 - Malignant neoplasm of unspecified site of right female breast
2) C50.912 - Malignant neoplasm of unspecified site of left female breast

Correct Diagnosis:
Z85.3 Personal History of malignant neoplasm of breast

ASSESSMENT:

1. Bilateral invasive lobular carcinoma (T3N2a) on the right. **Currently no evidence of disease now 8 years from her initial diagnosis and continuing on adjuvant tamoxifen.**

58



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Internal Guidance?

In summary, we interpret the ICD-10 rule to allow for the continued use of a malignant neoplasm code when the patient has evidence of the disease or is still receiving ongoing treatment for the cancer.

In some scenarios where a patient is receiving adjuvant therapy, we consider this ongoing "treatment directed at the site" and support the use of an active cancer diagnosis over a code reflecting a personal history.

This may include scenarios where the cancer may not be detectable due to effectiveness of the adjuvant therapy/treatment.

The medical record should be clear that there is ongoing therapeutic treatment (therapy) for the malignancy.

An example of a statement to support this might be:

"This patient is receiving ongoing anti-estrogen therapy for her breast cancer. A significant portion of this visit was spent assessing the efficacy of this therapy as well as management of toxicity of this treatment."

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Other Documentation Tips

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Clinical vs. Coding Criteria

- The assignment of a diagnosis code is based on the provider's diagnostic statement that the condition exists….the provider's statement that the patient has a particular condition is sufficient.
- *Code assignment is not based on clinical criteria* used by the provider to establish the diagnosis. If there is conflicting medical record documentation, query the provider.

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"History of"

- *"Patient is a 67-year-old male with a personal history of hypertension, Type II diabetes with CKD, prostate cancer and low back pain..."*

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Are you prepared?

64

The Hospital received $16,693,564 in Medicare payments for 941 inpatient hospital claims that included a diagnosis code for a severe type of malnutrition from January 1, 2013, through June 30, 2015. For 401 of the 941 claims, removing diagnosis code 261 or 262 changed the DRG. **Of these 401 claims, we reviewed a random sample of 100 claims totaling $1,230,082.**

https://oig.hhs.gov/oas/reports/region3/31500011.asp

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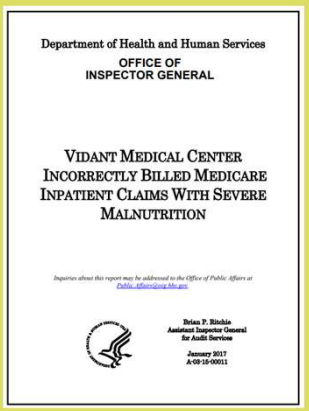
Vidant Health: *Severe Malnutrition*



Department of Health and Human Services
OFFICE OF INSPECTOR GENERAL

VIDANT MEDICAL CENTER INCORRECTLY BILLED MEDICARE INPATIENT CLAIMS WITH SEVERE MALNUTRITION

Inquiries about this report may be addressed to the Office of Public Affairs at Public_Affairs@oig.hhs.gov.

Brian P. Ritchie
Assistant Inspector General for Audit Services

January 2017
A-03-16-00011

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CMS' Initial Findings

- Of the **100** claims that we reviewed the hospital did not comply with Medicare billing requirements for the remaining **89** claims.

We recommend that the Hospital:

- refund to the Medicare program $1,403,132 for the incorrectly coded claims;
- exercise reasonable diligence to identify and return any additional similar overpayments outside of our audit period, in accordance with the 60-day rule, and identify any returned overpayments as having been made in accordance with this recommendation; and
- strengthen controls to ensure full compliance with Medicare billing requirements.

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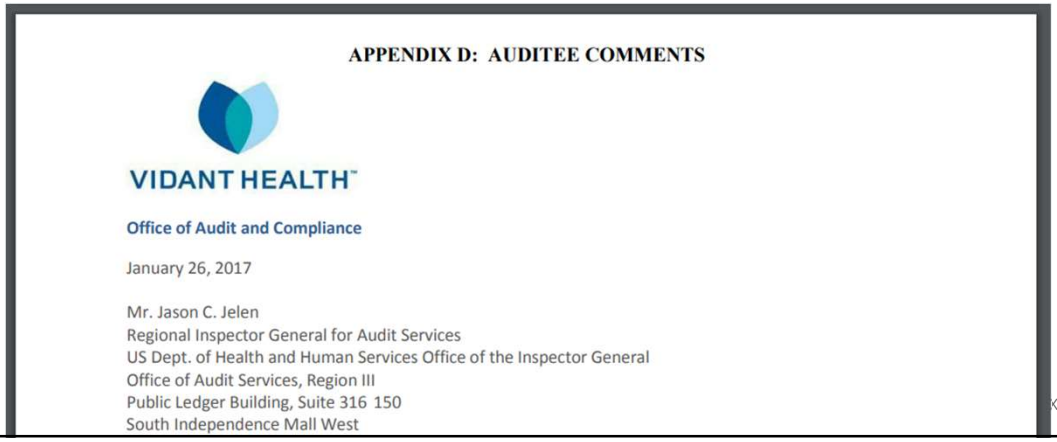
Vidant's Response

The Hospital agreed that 11 of the 89 claims found to be in error, were errors. They fought for the remaining 78



APPENDIX D: AUDITEE COMMENTS

VIDANT HEALTH™

Office of Audit and Compliance

January 26, 2017

Mr. Jason C. Jelen
Regional Inspector General for Audit Services
US Dept. of Health and Human Services Office of the Inspector General
Office of Audit Services, Region III
Public Ledger Building, Suite 316 150
South Independence Mall West

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- [redacted] reviewers failed to use any identifiable guidelines for the assessment and diagnosis of malnutrition, such as the Academy of Nutrition and Dietetics (AND)/American Society for Parenteral and Enteral Nutrition (ASPEN) Guidelines described below.
- [redacted] in contrast to CMS and The Joint Commission guidance, failed to acknowledge the necessary and appropriate role of registered dietitians (RD) in the assessment, monitoring and/or treatment of malnutrition and as a result failed to consider all relevant documentation in the patient's medical record, undermining its findings.
- [redacted] failed to understand that diagnosis code 261 includes multiple conditions, including Severe Malnutrition Not Otherwise Specified (NOS), and in turn erroneously evaluated patient medical conditions and documentation against the presence of Nutritional Marasmus.
- [redacted] failed to apply basic standards of condition reportability according to nationally recognized coding guidelines and principles.
- [redacted] failed to understand the necessary and legitimate use of the query process to confirm diagnosis code assignment and to recognize such query documentation as a valid and appropriate part of the medical record.

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Podcast

Hear about Vidant's story:

- 10/4/2023
- 11/15/2023
- 3/6/2024

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Health Risk Assessments

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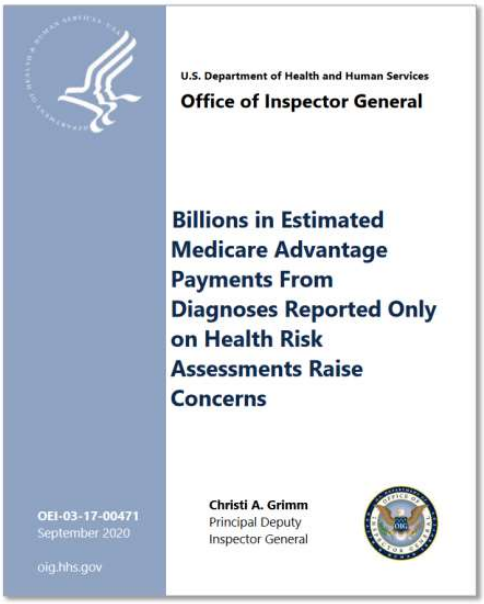
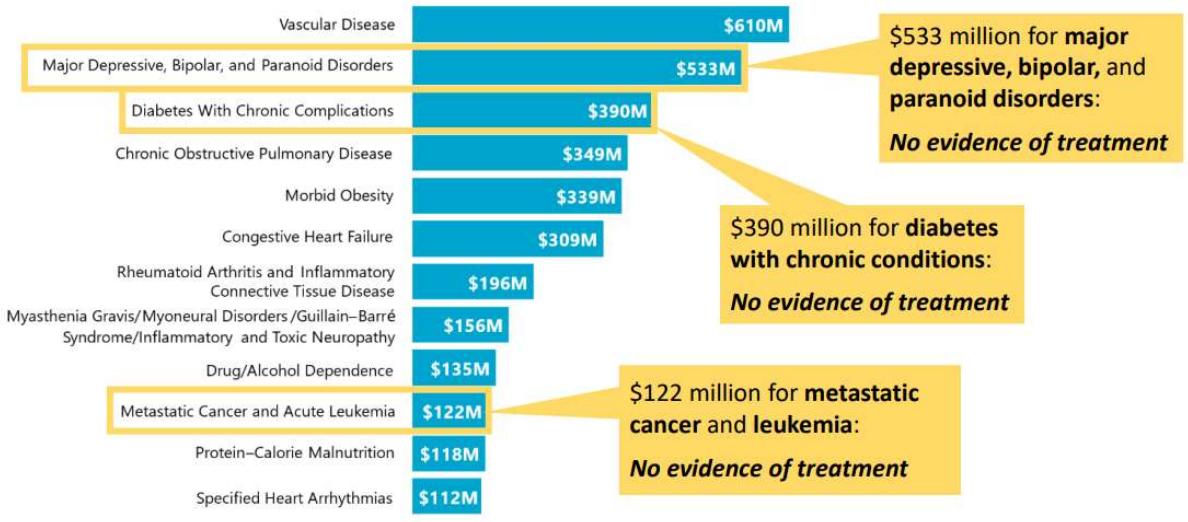


Eight companies conducted 89% of the in-home health risk assessments containing diagnoses that resulted in risk-adjustment payments, but **these diagnoses were not reported on any other encounter record for the beneficiaries.**

71

20 Companies | $5 Billion | No Evidence of Treatment



$533 million for **major depressive, bipolar,** and **paranoid disorders**:
No evidence of treatment

$390 million for **diabetes with chronic conditions**:
No evidence of treatment

$122 million for **metastatic cancer** and **leukemia**:
No evidence of treatment

OIG Report: OEI-03-17-00474

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In Summary...
Let's go mining

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Thank you!

Lrenner@saint-lukes.org

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