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DOJ and OIG ramp up enforcement of risk adjustment coding: 5 compliance tips for providers

Medicare Advantage plans and providers need to be aware of the recent increase in government enforcement of risk adjustment coding issues. In the past few years, the Office of the Inspector General (OIG) and the Department of Justice (DOJ) have focused on risk adjustment coding as an area susceptible to fraud which will likely continue into 2022. See below for an overview of risk adjustment coding, recent enforcement examples, and five tips for providers to help ensure accurate coding.

Risk Adjustment

Under the Medicare Advantage program, the Centers for Medicare & Medicaid Services (CMS) pays Medicare Advantage organizations (MAOs) a fixed per enrollee per month (PEPM) amount. For each enrollee, CMS adjusts the PEPM using diagnoses and demographics to determine a risk score which is intended to predict how much such enrollee's health care will cost for the plan year. In order to calculate the risk score for an enrollee, CMS uses the diagnostic codes submitted by the enrollee's health care providers. Ultimately, CMS pays the MAO more for enrollees with higher risk scores and less for enrollees with lower risk scores.

Since a higher risk score means a greater payment, there can be an incentive for certain providers (depending on how they're paid by an MAO) to inflate risk scores which can lead to overpayments from CMS and potentially False Claims Act liability.

Recent Examples

Below are several recent examples of the DOJ and OIG cracking down on improper risk adjustment coding:

- In January of 2022, the OIG released a report examining payments to an MAO and its providers. This audit found numerous upcoding issues by the MAO's providers that were not supported by the medical records and resulted in net overpayments to the MAO for over $500,000.
- In October of 2021, Sutter Health, in its role as a provider, settled a False Claims Act case for $90 million for knowingly submitting inaccurate diagnosis codes. Sutter allegedly had several aggressive programs that ultimately resulted in the submission of unsupported diagnoses.
- Also in October of 2021, the DOJ filed a complaint against Kaiser Permanente for allegedly defrauding CMS of $1 billion by pressuring physicians to retrospectively add approximately half a million diagnosis codes to patients' medical records that were non-existent or unrelated to the visit. This pressure was accompanied by financial incentives and rewards to the physicians.
- In September of 2021, the OIG released a report that indicated that chart reviews and health risk assessments were being used by MAOs to inflate risk scores.
- In September of 2021, the DOJ filed a False Claims Act lawsuit against Independent Health for forming an affiliate company to conduct retrospective reviews of medical records to capture additional diagnosis codes. This affiliate company allegedly submitted forms to the providers requesting signatures on additional diagnosis codes that were not supported in the medical records.

- In March of 2020, the DOJ filed a False Claims Act suit against Anthem for failure to conduct two-way medical chart reviews. Anthem allegedly used chart reviews to identify and submit additional diagnosis codes but failed to delete previously submitted codes that were not supported by the review causing to overpayments from CMS.

Five Tips for Providers

Below are high-level tips for providers to help ensure accurate risk-adjustment coding:

1. Implement policies and procedures and education programs to ensure coding follows ICD-10 guidelines and CMS guidance.
2. Be aware of potential issues related to coding from problem lists, programs that mine data for diagnoses and/or pre-populate diagnosis codes, and incentives or rewards to providers related to submission of diagnoses and/or scheduling assessments.
3. If the provider reviews charts for missing diagnoses, ensure the review also identifies diagnosis codes that should be deleted from the patients' records.
4. Implement robust auditing processes to monitor coding practices.
5. Take corrective actions with respect to providers that report unsupported diagnoses.

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