

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**RISK ADJUSTMENT
DATA VALIDATION OF
PAYMENTS MADE TO
PARAMOUNT CARE, INC.,
FOR CALENDAR YEAR 2007
(CONTRACT NUMBER H3653)**

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



**Daniel R. Levinson
Inspector General**

**September 2012
A-05-09-00044**

Office of Inspector General

<http://oig.hhs.gov>

The mission of the Office of Inspector General (OIG), as mandated by Public Law 95-452, as amended, is to protect the integrity of the Department of Health and Human Services (HHS) programs, as well as the health and welfare of beneficiaries served by those programs. This statutory mission is carried out through a nationwide network of audits, investigations, and inspections conducted by the following operating components:

Office of Audit Services

The Office of Audit Services (OAS) provides auditing services for HHS, either by conducting audits with its own audit resources or by overseeing audit work done by others. Audits examine the performance of HHS programs and/or its grantees and contractors in carrying out their respective responsibilities and are intended to provide independent assessments of HHS programs and operations. These assessments help reduce waste, abuse, and mismanagement and promote economy and efficiency throughout HHS.

Office of Evaluation and Inspections

The Office of Evaluation and Inspections (OEI) conducts national evaluations to provide HHS, Congress, and the public with timely, useful, and reliable information on significant issues. These evaluations focus on preventing fraud, waste, or abuse and promoting economy, efficiency, and effectiveness of departmental programs. To promote impact, OEI reports also present practical recommendations for improving program operations.

Office of Investigations

The Office of Investigations (OI) conducts criminal, civil, and administrative investigations of fraud and misconduct related to HHS programs, operations, and beneficiaries. With investigators working in all 50 States and the District of Columbia, OI utilizes its resources by actively coordinating with the Department of Justice and other Federal, State, and local law enforcement authorities. The investigative efforts of OI often lead to criminal convictions, administrative sanctions, and/or civil monetary penalties.

Office of Counsel to the Inspector General

The Office of Counsel to the Inspector General (OCIG) provides general legal services to OIG, rendering advice and opinions on HHS programs and operations and providing all legal support for OIG's internal operations. OCIG represents OIG in all civil and administrative fraud and abuse cases involving HHS programs, including False Claims Act, program exclusion, and civil monetary penalty cases. In connection with these cases, OCIG also negotiates and monitors corporate integrity agreements. OCIG renders advisory opinions, issues compliance program guidance, publishes fraud alerts, and provides other guidance to the health care industry concerning the anti-kickback statute and other OIG enforcement authorities.

Notices

THIS REPORT IS AVAILABLE TO THE PUBLIC
at <http://oig.hhs.gov>

Section 8L of the Inspector General Act, 5 U.S.C. App., requires that OIG post its publicly available reports on the OIG Web site.

OFFICE OF AUDIT SERVICES FINDINGS AND OPINIONS

The designation of financial or management practices as questionable, a recommendation for the disallowance of costs incurred or claimed, and any other conclusions and recommendations in this report represent the findings and opinions of OAS. Authorized officials of the HHS operating divisions will make final determination on these matters.

EXECUTIVE SUMMARY

BACKGROUND

Under the Medicare Advantage (MA) program, the Centers for Medicare & Medicaid Services (CMS) makes monthly capitated payments to MA organizations for beneficiaries enrolled in the organizations' health care plans. Subsections 1853(a)(1)(C) and (a)(3) of the Social Security Act require that these payments be adjusted based on the health status of each beneficiary. CMS uses the Hierarchical Condition Category (HCC) model (the CMS model) to calculate these risk-adjusted payments.

Under the CMS model, MA organizations collect risk adjustment data, including beneficiary diagnoses, from hospital inpatient facilities, hospital outpatient facilities, and physicians during a data collection period. MA organizations identify the diagnoses relevant to the CMS model and submit them to CMS. CMS categorizes the diagnoses into groups of clinically related diseases called HCCs and uses the HCCs and demographic characteristics to calculate a risk score for each beneficiary. CMS then uses the risk scores to adjust the monthly capitated payments to MA organizations for the next payment period.

Paramount Care, Inc. (Paramount), is an MA organization owned by ProMedica Health. For calendar year (CY) 2007, Paramount had one contract with CMS, contract H3653, which we refer to as "the contract." Under the contract, CMS paid Paramount approximately \$134 million to administer health care plans for approximately 14,000 beneficiaries.

OBJECTIVE

Our objective was to determine whether the diagnoses that Paramount submitted to CMS for use in CMS's risk score calculations complied with Federal requirements.

SUMMARY OF FINDINGS

The diagnoses that Paramount submitted to CMS for use in CMS's risk score calculations did not always comply with Federal requirements. For 56 of the 100 beneficiaries in our sample, the risk scores calculated using the diagnoses that Paramount submitted were valid. The risk scores for the remaining 44 beneficiaries were invalid because the diagnoses were not supported for 1 or more of the following reasons:

- The documentation did not support the associated diagnosis.
- The documentation did not include the provider's signature or credentials.
- Paramount did not provide any documentation to support the associated diagnosis.
- The diagnosis was unconfirmed.

Paramount did not have written policies and procedures for obtaining, processing, and submitting diagnoses to CMS until after our audit period. Furthermore, Paramount's practices were not effective in ensuring that the diagnoses that it submitted to CMS complied with the requirements of the *2006 Risk Adjustment Data Basic Training for Medicare Advantage Organizations Participant Guide* (the 2006 Participant Guide) and the *2007 Risk Adjustment Data Basic Training for Medicare Advantage Organizations Participant Guide* (the 2007 Participant Guide). Paramount officials stated that providers were responsible for the accuracy of the diagnoses that Paramount submitted to CMS.

As a result of these unsupported diagnoses, Paramount received \$205,534 in overpayments from CMS. Based on our sample results, we estimated that Paramount was overpaid approximately \$18,216,541 in CY 2007.

RECOMMENDATIONS

We recommend the following:

- Paramount should refund to the Federal Government \$205,534 in overpayments identified for the sampled beneficiaries.
- Paramount should work with CMS to determine the correct contract-level adjustment for the projected \$18,216,541 of overpayments. (This amount represents our point estimate. However, it is our policy to recommend recovery of overpayments at the lower limit of the 90-percent confidence interval, which is \$13,572,796. See Appendix B.)
- Paramount should monitor the effectiveness of its newly developed written policies and procedures for obtaining, processing, and submitting valid risk adjustment data.
- Paramount should improve its current practices to ensure compliance with Federal requirements.

PARAMOUNT COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

In written comments on our draft report, Paramount stated that it had “commenced and strengthened several initiatives” that address our recommendations to monitor the effectiveness of its newly developed written policies and procedures and to improve its current practices for ensuring compliance with Federal requirements. However, Paramount disagreed with our recommended refund to the Federal Government and contested several HCCs that we questioned in our draft report. After considering Paramount's written comments, we requested, and Paramount provided, additional documentation in support of its written comments. We provided this documentation to our medical review contractor and revised our findings using the results of this third medical review.

In preparing our final report, we also considered the written comments of other MA organizations included in this series of audits. Some MA organizations stated that our audit results did not account for error rates inherent in Medicare fee-for-service (FFS) data,

specifically the disparity between FFS claim data and FFS medical records data and its potential impact on MA payments. Although an analysis to determine the potential impact of error rates inherent in FFS data on MA payments was beyond the scope of our audit, we acknowledge that CMS is studying this issue and its potential impact on audits of MA organizations. Therefore, because of the potential impact of these error rates on the CMS model that we used to recalculate MA payments for the beneficiaries in our sample, we (1) modified one recommendation to have Paramount refund only the overpayments identified for the sampled beneficiaries rather than refund the projected overpayments and (2) added a recommendation that Paramount work with CMS to determine the correct contract-level adjustments for the projected overpayments.

Paramount's comments are included in their entirety as Appendix D.

TABLE OF CONTENTS

	<u>Page</u>
INTRODUCTION	1
BACKGROUND	1
Medicare Advantage Program	1
Risk-Adjusted Payments	1
Federal Requirements	1
Paramount Care, Inc.....	2
OBJECTIVE, SCOPE, AND METHODOLOGY	2
Objective	2
Scope.....	2
Methodology	3
FINDINGS AND RECOMMENDATIONS	4
FEDERAL REQUIREMENTS	5
UNSUPPORTED HIERARCHICAL CONDITION CATEGORIES	6
Unsupported Diagnosis Coding	6
Missing Signatures and Credentials.....	6
No Documentation Provided.....	7
Unconfirmed Diagnoses.....	7
CAUSES OF OVERPAYMENTS	7
ESTIMATED OVERPAYMENTS	7
RECOMMENDATIONS	8
PARAMOUNT COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE	8
Audit Procedures.....	9
Diagnosis Coding.....	9
Unsupported Codes.....	10
Signatures/Credentials....	11
No Documentation Provided.....	12
Sample Selection.....	12
Refund Recommendation Based on Unconfirmed Discrepancies	12

APPENDIXES

A: SAMPLE DESIGN AND METHODOLOGY

B: SAMPLE RESULTS AND ESTIMATES

C: DOCUMENTATION ERRORS IN SAMPLE

D: PARAMOUNT COMMENTS

INTRODUCTION

BACKGROUND

Medicare Advantage Program

The Balanced Budget Act of 1997, P.L. No. 105-33, established Medicare Part C to offer beneficiaries managed care options through the Medicare+Choice program. Section 201 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, P.L. No. 108-173, revised Medicare Part C and renamed the program the Medicare Advantage (MA) program. Organizations that participate in the MA program include health maintenance organizations, preferred provider organizations, provider-sponsored organizations, and private fee-for-service (FFS) plans. The Centers for Medicare & Medicaid Services (CMS), which administers the Medicare program, makes monthly capitated payments to MA organizations for beneficiaries enrolled in the organizations' health care plans (beneficiaries).

Risk-Adjusted Payments

Subsections 1853(a)(1)(C) and (a)(3) of the Social Security Act require that payments to MA organizations be adjusted based on the health status of each beneficiary. In calendar year (CY) 2004, CMS implemented the Hierarchical Condition Category (HCC) model (the CMS model) to calculate these risk-adjusted payments.

Under the CMS model, MA organizations collect risk adjustment data, including beneficiary diagnoses, from hospital inpatient facilities, hospital outpatient facilities, and physicians during a data collection period.¹ MA organizations identify the diagnoses relevant to the CMS model and submit them to CMS. CMS categorizes the diagnoses into groups of clinically related diseases called HCCs and uses the HCCs, as well as demographic characteristics, to calculate a risk score for each beneficiary. CMS then uses the risk scores to adjust the monthly capitated payments to MA organizations for the next payment period.²

Federal Requirements

Regulations (42 CFR § 422.310(b)) require MA organizations to submit risk adjustment data to CMS in accordance with CMS instructions. CMS issued instructions in its *2006 Risk Adjustment Data Basic Training for Medicare Advantage Organizations Participant Guide* (the 2006 Participant Guide) that provided requirements for submitting risk adjustment data for the CY 2006 data collection period. CMS issued similar instructions in its *2007 Risk Adjustment Data Training for Medicare Advantage Organizations Participant Guide* (the 2007 Participant Guide).

¹ Risk adjustment data also include health insurance claim numbers, provider types, and the "from" and "through" dates for the service.

² For example, CMS used data that MA organizations submitted for the CY 2006 data collection period to adjust payments for the CY 2007 payment period.

Diagnoses included in risk adjustment data must be based on clinical medical record documentation from a face-to-face encounter; coded according to the *International Classification of Disease, Ninth Revision, Clinical Modification* (ICD-9-CM) (the Coding Guidelines); assigned based on dates of service within the data collection period; and submitted to the MA organization from an appropriate risk adjustment provider type and an appropriate risk adjustment physician data source. The 2006 and 2007 Participant Guides described requirements for hospital inpatient, hospital outpatient, and physician documentation.

Paramount Care, Inc.

Paramount Care, Inc. (Paramount), is an MA organization owned by ProMedica Health. For CY 2007, Paramount had one contract with CMS, contract H3653, which we refer to as “the contract.” Under the contract, CMS paid Paramount approximately \$134 million to administer health care plans for approximately 14,000 beneficiaries.

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

Our objective was to determine whether the diagnoses that Paramount submitted to CMS for use in CMS’s risk score calculations complied with Federal requirements.

Scope

Our review covered approximately \$105 million of the CY 2007 MA organization payments that CMS made to Paramount on behalf of 8,863 beneficiaries. These payments were based on risk adjustment data that Paramount submitted to CMS for CY 2006 dates of service for beneficiaries who (1) were continuously enrolled under the contract during all of CY 2006 and January of CY 2007³ and (2) had a CY 2007 risk score that was based on at least one HCC. We limited our review of Paramount’s internal control structure to controls over the collection, processing, and submission of risk adjustment data.

We asked Paramount to provide us with the one medical record that best supported the HCC(s) that CMS used to calculate each risk score. If our review found that a medical record did not support one or more assigned HCCs, we gave Paramount the opportunity to submit an additional medical record for a second medical review.

We performed our fieldwork at Paramount in Maumee, Ohio, and at CMS in Baltimore, Maryland, from October 2008 through December 2009.

³ We limited our sampling frame to continuously enrolled beneficiaries to ensure that Paramount was responsible for submitting the risk adjustment data that resulted in the risk scores covered by our review.

Methodology

To accomplish our objective, we did the following:

- We reviewed applicable Federal laws, regulations, and guidance regarding payments to MA organizations.
- We interviewed CMS officials to obtain an understanding of the CMS model.
- We obtained the services of a medical review contractor to determine whether the documentation that Paramount submitted supported the HCCs associated with the beneficiaries in our sample.
- We interviewed Paramount officials to gain an understanding of Paramount’s internal controls for obtaining risk adjustment data from providers, processing the data, and submitting the data to CMS.
- We obtained enrollment data, CY 2007 beneficiary risk score data, and CY 2006 risk adjustment data from CMS and identified 8,863 beneficiaries who (1) were continuously enrolled under the contract during all of CY 2006 and January of CY 2007 and (2) had a CY 2007 risk score that was based on at least 1 HCC.
- We selected a simple random sample of 100 beneficiaries with 254 HCCs. (See Appendix A for our sample design and methodology.) For each sampled beneficiary, we:
 - analyzed the CY 2007 beneficiary risk score data to identify the HCC(s) that CMS assigned;
 - analyzed the CY 2006 risk adjustment data to identify the diagnosis or diagnoses that Paramount submitted to CMS associated with the beneficiary’s HCC(s);
 - requested that Paramount provide us with the one medical record that, in Paramount’s judgment, best supported the HCC(s) that CMS used to calculate the beneficiary’s risk score;
 - obtained Paramount’s certification that the documentation provided represented “the one best medical record to support the HCC”;⁴ and
 - submitted Paramount’s documentation and HCCs for each beneficiary to our medical review contractor for a first review and requested additional

⁴ The 2006 Participant Guide, sections 8.2.3 and 8.2.3.1, and the 2007 Participant Guide, sections 7.2.3 and 7.2.3.1, required plans to select the “one best medical record” to support each HCC and indicated that the best medical record may include a range of consecutive dates (if the record is from a hospital inpatient provider) or one date (if the record is from a hospital outpatient or physician provider).

documentation from Paramount for a second review if the contractor found that documentation submitted during the first round did not support the HCCs.

- For the HCCs we questioned in our draft report with which Paramount disagreed,⁵ we requested additional documentation and/or explanations from Paramount and submitted that information to our medical review contractor for a third review.
- For the sampled beneficiaries that we determined to have unsupported HCCs, we (1) used the medical review results to adjust the beneficiaries' risk scores, (2) recalculated CY 2007 payments using the adjusted risk scores, and (3) subtracted the recalculated CY 2007 payments from the actual CY 2007 payments to determine the overpayments and underpayments made on behalf of the beneficiaries.
- We estimated the total value of overpayments based on our sample results. (See Appendix B for our sample results and estimates.)

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 objective.

FINDINGS AND RECOMMENDATIONS

The diagnoses that Paramount submitted to CMS for use in CMS's risk score calculations did not always comply with Federal requirements. For 56 of the 100 beneficiaries in our sample, the risk scores calculated using the diagnoses that Paramount submitted were valid. The risk scores for the remaining 44 beneficiaries were invalid because the diagnoses were not supported for 1 or more of the following reasons:

- The documentation did not support the associated diagnosis.
- The documentation did not include the provider's signature or credentials.
- Paramount did not provide any documentation to support the associated diagnosis.
- The diagnosis was unconfirmed.⁶

⁵ Paramount disagreed with 41 of the 81 HCCs in our draft report. Of the 41 HCCs, we accepted attestations on 10 HCCs and submitted the remaining 31 HCCs for a third medical review.

⁶ The 2006 and 2007 Participant Guides state that physicians and hospital outpatient departments may not code diagnoses documented as "probable," "suspected," "questionable," "rule out," or "working." The Participant Guides consider these diagnoses as unconfirmed. (See section 5.4.2 of the 2006 Participant Guide and section 6.4.2 of the 2007 Participant Guide.)

Paramount did not have written policies and procedures for obtaining, processing, and submitting diagnoses to CMS until after our audit period. Furthermore, Paramount's practices were not effective in ensuring that the diagnoses it submitted to CMS complied with the requirements of the 2006 and 2007 Participant Guides. Paramount officials stated that providers were responsible for the accuracy of the diagnoses that Paramount submitted to CMS.

As a result of these unsupported diagnoses, Paramount received \$205,534 in overpayments from CMS. Based on our sample results, we estimated that Paramount was overpaid approximately \$18,216,541 in CY 2007.

FEDERAL REQUIREMENTS

Regulations (42 CFR § 422.310(b)) state: "Each MA organization must submit to CMS (in accordance with CMS instructions) 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. CMS may also collect data necessary to characterize the functional limitations of enrollees of each MA organization." The 2007 Participant Guide, section 8.7.3, and the 2006 Participant Guide, section 7.7.3, state that "MA organizations are responsible for the accuracy of the data submitted to CMS."

Pursuant to section 2.2.1 of the 2007 and 2006 Participant Guides, risk adjustment data submitted to CMS must include a diagnosis. Pursuant to the 2007 Participant Guide, section 7.1.4, and the 2006 Participant Guide, section 8.1.3, the diagnosis must be coded according to the Coding Guidelines. Section III of the Coding Guidelines states that for each hospital inpatient stay, the hospital's medical record reviewer should code the principal diagnosis and "... all conditions that coexist at the time of admission, that develop subsequently, or that affect the treatment received and/or length of stay. Diagnoses that relate to an earlier episode which have no bearing on the current hospital stay are to be excluded." Sections II and III of the Coding Guidelines state that "if the diagnosis documented at the time of discharge is qualified as 'probable,' 'suspected,' 'likely,' 'questionable,' 'possible,' or 'still to be ruled out,' code the condition as if it existed or was established."

Section IV of the Coding Guidelines states that for each outpatient and physician service, the provider should "[c]ode all documented conditions that coexist at the time of the encounter/visit, and require or affect patient care treatment or management." The Coding Guidelines also state that conditions should not be coded if they "... were previously treated and no longer exist. However, history codes ... may be used as secondary codes if the historical condition or family history has an impact on current care or influences treatment." Additionally, in outpatient and physician settings, uncertain diagnoses, including those that are "probable," "suspected," "questionable," or "working," should not be coded.

The 2007 Participant Guide, section 7.1.4, and the 2006 Participant Guide, section 8.1.3, require that documentation support the diagnoses that MA organizations submit for use in CMS's risk score calculations. The documentation must include an acceptable physician signature and specialty credentials. The 2007 Participant Guide, section 7.2.4.5, and the 2006 Participant Guide, section 8.2.4.4, state: "[A]ll dates of service that are identified for review must be signed

(with credentials) and dated by the physician or an appropriate physician extender (e.g., nurse practitioner).” Examples of acceptable physician signatures include handwritten signatures or initials, signature stamps that comply with State regulations, and electronic signatures with authentications by the respective providers. Typed names; signatures of nonphysicians or nonphysician extenders (e.g., medical students); and signatures without credentials are unacceptable for risk adjustment purposes.

UNSUPPORTED HIERARCHICAL CONDITION CATEGORIES

To calculate beneficiary risk scores and risk-adjusted payments to MA organizations, CMS must first convert diagnoses to HCCs. During our audit period, Paramount submitted to CMS at least one diagnosis associated with each HCC that CMS used to calculate each sampled beneficiary’s risk score for CY 2007. The risk scores for 44 sampled beneficiaries were invalid because the diagnoses that Paramount submitted to CMS (1) were not supported, (2) were missing signatures or credentials, (3) had no documentation, and/or (4) were unconfirmed. Appendix C shows a total of 76 errors associated with the 60 HCCs. These errors included unsupported diagnosis coding, missing signatures and credentials, no documentation provided, and unconfirmed diagnoses.

Unsupported Diagnosis Coding

The documentation that Paramount submitted to us for medical review did not support the diagnoses associated with 46 HCCs.

For example, for one beneficiary, Paramount submitted the diagnosis code for “chronic airway disease, not elsewhere classified.” CMS used the HCC associated with this diagnosis in calculating the beneficiary’s risk score. However, the documentation that Paramount provided indicated that the patient’s complaint was shoulder and back pain. The documentation indicated a history of chronic obstructive pulmonary disease but did not indicate that the presence or history of this condition affected the care, treatment, or management provided during the encounter.

Missing Signatures and Credentials

Sixteen HCCs were unsupported because the documentation that Paramount provided did not include the physicians’ signatures or credentials.

For example, for one beneficiary, Paramount submitted the diagnosis code for “congestive heart failure, unspecified.” CMS used the HCC associated with this diagnosis in calculating the beneficiary’s risk score. However, the documentation that Paramount submitted was not signed by the provider and did not include the provider’s credentials.

No Documentation Provided

Ten HCCs were unsupported because Paramount did not provide any documentation.

For example, for one beneficiary, Paramount submitted a diagnosis code for “diabetes with neurologic or other specified manifestation.” CMS used the HCC associated with this diagnosis in calculating the beneficiary’s risk score. However, Paramount officials indicated during our review that they could not obtain any medical records to support the HCC.

Unconfirmed Diagnoses

Four HCCs were unsupported because the diagnoses submitted to CMS were unconfirmed.

For example, for one beneficiary, Paramount submitted a diagnosis code for “atrial fibrillation.” CMS used the HCC associated with this diagnosis in calculating the beneficiary’s risk score. The documentation that Paramount submitted noted “(?) A-fib, paroxysmal and ordered a Holter Monitor for confirmation.” Diagnoses that are “probable,” “suspected,” “questionable,” or “working” should not be coded.

CAUSES OF OVERPAYMENTS

During our audit period, Paramount did not have written policies and procedures for obtaining, processing, and submitting risk adjustment data to CMS. Paramount officials informed us that Paramount had since developed written policies and procedures, which were implemented on July 1, 2009.

According to Paramount officials, Paramount had practices, including chart validation, to ensure the accuracy of the diagnoses that it submitted to CMS. Chart validation is a review of documentation to ensure that the diagnoses submitted to CMS are correctly coded. However, Paramount officials stated that Paramount did not routinely use chart validation as a preventive practice; instead, Paramount used chart validation as a response to external auditors’ requests for documentation that best supported the diagnoses already submitted to CMS.

As demonstrated by the significant error rate found in our sample, Paramount’s practices were not effective in ensuring that the diagnoses submitted to CMS complied with the requirements of the 2006 and 2007 Participant Guides. Paramount officials stated that providers were responsible for the accuracy of the diagnoses that Paramount submitted to CMS.

ESTIMATED OVERPAYMENTS

As a result of the unsupported diagnoses in our sample, Paramount received \$205,534 in overpayments from CMS. Based on our sample results, we estimated that Paramount was overpaid approximately \$18,216,541 in CY 2007. However, we acknowledge that CMS is studying the potential impact of error rates inherent in FFS data on MA payments to MA organizations.⁷

⁷ 75 Fed. Reg. 19749 (April 15, 2010).

Therefore, because of the potential impact of these error rates on the CMS model that we used to recalculate MA payments for the beneficiaries in our sample, we (1) modified one recommendation to have Paramount refund only the overpayments identified for the sampled beneficiaries rather than refund the projected overpayments and (2) added a recommendation that Paramount work with CMS to determine the correct contract-level adjustments for the projected overpayments.

RECOMMENDATIONS

We recommend the following:

- Paramount should refund to the Federal Government \$205,534 in overpayments identified for the sampled beneficiaries.
- Paramount should work with CMS to determine the correct contract-level adjustment for the projected \$18,216,541⁸ of overpayments.
- Paramount should monitor the effectiveness of its newly developed written policies and procedures for obtaining, processing, and submitting valid risk adjustment data.
- Paramount should improve its current practices to ensure compliance with Federal requirements.

PARAMOUNT COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

In written comments on our draft report, Paramount stated that it had “commenced and strengthened several initiatives” that address our recommendations to monitor the effectiveness of its newly developed written policies and procedures and to improve its current practices for ensuring compliance with Federal requirements. However, Paramount disagreed with our recommended refund to the Federal Government and contested 41 of the 81 HCCs that we questioned in our draft report. After considering Paramount’s written comments, we requested, and Paramount provided, additional documentation in support of its written comments. We provided this documentation to our medical review contractor and revised our findings using the results of this third medical review.⁹

This report is part of a series of reviews conducted to determine whether diagnoses that MA organizations submit to CMS for use in CMS’s risk score calculations complied with Federal requirements. In preparing our final report, we considered the written comments of other MA organizations¹⁰ included in this series of audits. Some MA organizations stated that our audit

⁸ This amount represents our point estimate. However, it is our policy to recommend recovery of overpayments at the lower limit of the 90-percent confidence interval, which is \$13,572,796. See Appendix B.

⁹ Paramount disagreed with 41 of the 81 HCCs in our draft report. Of the 41 HCCs, we accepted attestations on 10 HCCs and submitted the remaining 31 HCCs for a third medical review.

¹⁰ For example, see comments on Appendix D of *Risk Adjustment Data Validation of Payments Made to PacifiCare of Texas for Calendar Year 2007 (Contract Number H4590)*, A-06-09-00012, issued May 30, 2012.

results did not account for error rates inherent in Medicare FFS data, specifically the disparity between FFS claim data and FFS medical records data and its potential impact on MA payments. Although an analysis to determine the potential impact of error rates inherent in FFS data on MA payments was beyond the scope of our audit, we acknowledge that CMS is studying this issue and its potential impact on audits of MA organizations.¹¹ Therefore, because of the potential impact of these error rates on the CMS model that we used to recalculate MA payments for the beneficiaries in our sample, we (1) modified one recommendation to have Paramount refund only the overpayments identified for the sampled beneficiaries rather than refund the projected overpayments and (2) added a recommendation that Paramount work with CMS to determine the correct contract-level adjustments for the projected overpayments.

Paramount's comments, which we summarize below, are included in their entirety as Appendix D.

Audit Procedures

Paramount Comments

Paramount stated that "it is unclear what process OIG followed in completing the Draft RADV [Risk Adjustment Data Validation] Audit report" and that our audit "reflects substantial deviations from the 2007 Participant Guide."

Office of Inspector General Response

We are not required to follow CMS guidance and regulations governing RADV audits. Pursuant to the Inspector General Act of 1978, 5 U.S.C. App., our audits are intended to provide an independent assessment of U.S. Department of Health and Human Services programs and operations. We did not perform an RADV audit pursuant to the guidelines that CMS established in its 2007 Participant Guide. Those reviews are a CMS function. We designed our review to determine whether diagnoses that Paramount submitted to CMS for use in CMS's risk score calculations complied with Federal requirements. We based our findings on criteria in CMS's 2007 Participant Guide.

Diagnosis Coding

Paramount Comments

Paramount stated that, like any other MA organization, it does not engage in ICD-9 coding. Although Paramount acknowledged that it was responsible for the accuracy of risk adjustment data submitted to CMS, it believed coding to be a provider issue. Additionally, Paramount took exception to the fact that our audit "tested whether a medical record reflecting a diagnosis could be found in the same year as an associated HCC," stating that "a diagnosis is not necessarily limited to a particular year."

¹¹ 75 Fed. Reg. 19749 (April 15, 2010).

Office of Inspector General Response

We agree that accurate coding may also be a provider issue. Nevertheless, Paramount, is ultimately responsible for the accuracy of risk adjustment data submitted to CMS.

Regarding whether a diagnosis is not limited to a particular year, section 7.1.4 of CMS's 2007 Participant Guide states that "The risk adjustment diagnosis must be based on clinical medical record documentation from a face-to-face encounter, coded according to the ICD-9-CM Guidelines for Coding and Reporting; assigned based on dates of service within the data collection period" Therefore, diagnoses assigned to a beneficiary before or after the relevant data collection period (in our case, CY 2006) are irrelevant for determining a beneficiary's risk score. Accordingly, we considered and analyzed the diagnosis data that Paramount submitted to CMS during the CY 2006 data collection period.

Unsupported Codes

Paramount Comments

Paramount stated that it had identified discrepancies with our coding determinations and included information on 41 HCCs as an appendix to its response. Paramount provided additional documentation that was not provided to us during our fieldwork that it believed would support these 41 HCCs. Paramount divided these discrepancies into three general groups. First, it noted those beneficiaries for whom we concluded that (1) the risk adjustment data were invalid or (2) there was an absence of medical records because there was no provider's signature and stated that we had not allowed Paramount to provide attestations. Second, Paramount listed specific reasons it believed our coders came to incorrect conclusions based on the medical records that Paramount had provided us. Finally, Paramount identified those HCCs that it believed were supported by medical records that may not fully comply with CMS guidelines but nevertheless may lead to a conclusion that the HCC was valid.

Paramount stated that it had "identified several more general problems with the OIG's coding effort." For instance, Paramount stated that "it appears the coders the OIG used would compare dates of service in the medical records submitted" and "if one date service supported a diagnosis, but that diagnosis was not mentioned on other dates of service in the same record, OIG's coders would 'disallow' the diagnosis." Paramount stated that this practice conflicts with the 2007 Participant Guide. Paramount also stated that "the Draft RADV Audit discusses the use of a single medical review contractor that engaged in two rounds of review for HCCs that were determined to be unsupported by the submitted medical records. But the 2007 Participant Guide provides for two separate and independent contractors to review medical records (§7.1.6)."

Office of Inspector General Response

As stated previously, we did not design our review to be an RADV audit, and we are not required to follow CMS's RADV audit protocol. Although we did not have two independent contractors review Paramount's medical record documentation, we ensured that our medical review contractor had an independent review process in place. If the initial medical reviewer identified

discrepancies, another medical reviewer, independent of the initial review, performed a second review. If the results of both reviews differed, the contractor's medical director made the final determination. If we found that medical records did not support one or more assigned HCCs, we asked Paramount to submit additional records. Any additional records Paramount provided followed the process described above.

Also, we accepted medical records Paramount provided in addition to the "one best medical record." All HCCs that were not validated during the initial medical review underwent the second medical review. Finally, after we issued our draft report, we accepted and evaluated the additional documentation that Paramount provided with its comments on our draft report. In cases when (1) Paramount provided new documentation or (2) Paramount provided a new explanation as to why the documentation validated the selected HCC, we submitted the additional documentation to our medical review contractor for a third medical review.

We accepted the additional inpatient, outpatient, and physician records with CY 2006 dates of service to help validate the 41 HCCs with which Paramount disagreed during the first 2 rounds of medical review. Of these 41 HCCs, we accepted attestations on 10 HCCs and submitted the remaining 31 HCCs for a third medical review. For the third medical review, our medical review contractor followed the same protocol used during each of the first two reviews. Therefore, we disagree with Paramount's assertion that our medical review contractor considered only limited data on medical records provided. Our medical review contractor considered all information on medical records provided, including additional documentation that validated 10 of the 31 HCCs. We revised our findings accordingly.

Signatures/Credentials

Paramount Comments

Paramount stated that our audit deemed 25 HCCs to be unsupported because Paramount did not provide physician signatures or credentials. Paramount stated that we made this determination without affording Paramount the opportunity to provide physician attestation as permitted by CMS.

Office of Inspector General Response

We did not initially accept physician attestations because the 2007 Participant Guide, section 7.2.4.5, and the 2006 Participant Guide, section 8.2.4.4, stated that documentation supporting the diagnosis must include an acceptable physician signature. However, pursuant to a 2010 change in Federal regulations (42 CFR § 422.311), we accepted attestations and revised our findings accordingly.

No Documentation Provided

Paramount Comments

Paramount stated that our audit found 12 HCCs to be unsupported because Paramount did not provide any documentation. Paramount stated that a “more accurate description of this situation would be that Paramount was unable to obtain documentation from the provider.”

Office of Inspector General Response

Although Paramount was unable to obtain some documentation from providers, according to the 2007 Participant Guide, section 8.7.3, and the 2006 Participant Guide, section 7.7.3, Paramount is ultimately responsible for supporting the risk adjustment data that it submits to CMS.

Sample Selection

Paramount Comments

Paramount stated that our draft report should have detailed the steps taken to ensure that the sample was statistically valid given the “large amount involved and the small sample size.” Additionally, Paramount stated that because the audit did not identify a single instance of underpayment, there was a strong indication that either underpayments were ignored or the sample was not representative.

Office of Inspector General Response

Our sample size of 100 beneficiaries provided a fair and unbiased representation of the 8,863 beneficiaries in our sampling frame. A sample of 100 beneficiaries is both consistent with our established policy and sufficient to ensure valid sample results. Additionally, our medical review processes considered the potential for underpayments. In five instances, our medical reviewer determined that different diagnoses were appropriate, and we raised or lowered the corresponding beneficiary risk scores.

Refund Recommendation Based on Unconfirmed Discrepancies

Paramount Comments

Paramount stated that the 2007 Participant Guide provides for payment adjustments only on confirmed risk adjustment discrepancies. For this reason, Paramount believed that the estimated overpayment did not comport with the 2007 Participant Guide.

Office of Inspector General Response

Pursuant to the Inspector General Act of 1978, 5 U.S.C. App., our audits are intended to provide an independent assessment of U.S. Department of Health and Human Services programs and operations. Accordingly, we do not always determine, nor are we required to determine, whether our payment calculation and extrapolation methodology is consistent with CMS’s methodology

or the 2007 Participant Guide. However, we considered written comments from other MA organizations reviewed and modified our first recommendation to seek a refund only of the overpayments identified for the sampled beneficiaries.

APPENDIXES

APPENDIX A: SAMPLE DESIGN AND METHODOLOGY

SAMPLING FRAME

The sampling frame consisted of 8,863 beneficiaries on whose behalf the Centers for Medicare & Medicaid Services paid Paramount Care, Inc. (Paramount), approximately \$105 million in calendar year (CY) 2007. These beneficiaries (1) were continuously enrolled under contract H3653 during all of CY 2006 and January of CY 2007 and (2) had a CY 2007 risk score that was based on at least one Hierarchical Condition Category.

SAMPLE UNIT

The sample unit was a beneficiary.

SAMPLE DESIGN

We used a simple random sample.

SAMPLE SIZE

We selected a sample of 100 beneficiaries.

SOURCE OF THE RANDOM NUMBERS

We used the Office of Inspector General, Office of Audit Services (OAS), statistical software to generate the random numbers.

METHOD OF SELECTING SAMPLE ITEMS

We consecutively numbered the sample units in the sampling frame from 1 to 8,863. After generating 100 random numbers, we selected the corresponding frame items.

ESTIMATION METHODOLOGY

We used the OAS statistical software to estimate the total value of overpayments.

APPENDIX B: SAMPLE RESULTS AND ESTIMATES

Sample Results

Sampling Frame Size	Sample Size	Value of Sample	Number of Beneficiaries With Incorrect Payments	Value of Overpayments
8,863	100	\$1,342,254	44	\$205,534

Estimated Value of Overpayments

(Limits Calculated for a 90-Percent Confidence Interval)

Point estimate	\$18,216,541
Lower limit	13,572,796
Upper limit	22,860,286

APPENDIX C: DOCUMENTATION ERRORS IN SAMPLE

A	Unsupported diagnosis coding
B	Missing signature and credentials
C	No documentation provided
D	Unconfirmed diagnoses

	Hierarchical Condition Category	A	B	C	D	Total Errors
1	Specified heart arrhythmias	X				1
2	Ischemic or unspecified stroke	X				1
3	Diabetes with neurologic or other specified manifestation			X		1
4	Ischemic or unspecified stroke	X				1
5	Vascular disease	X	X			2
6	Cardiorespiratory failure and shock	X				1
7	Angina pectoris/old myocardial infarction	X			X	2
8	Vascular disease	X				1
9	Breast, prostate, colorectal, and other cancers and tumors	X				1
10	End-stage liver disease	X				1
11	Specified heart arrhythmias	X	X			2
12	Chronic obstructive pulmonary disease	X	X			2
13	Vascular disease	X				1
14	Unstable angina and other acute ischemic heart disease	X				1
15	Chronic obstructive pulmonary disease	X				1
16	Unstable angina and other acute ischemic heart disease	X				1
17	Chronic obstructive pulmonary disease	X	X			2
18	Cardiorespiratory failure and shock	X				1
19	Angina pectoris/old myocardial infarction		X			1
20	Vascular disease	X				1
21	Vascular disease with complications	X				1
22	Congestive heart failure	X	X			2
23	Breast, prostate, colorectal, and other cancers and tumors	X				1
24	Unstable angina and other acute ischemic heart disease	X	X			2
25	Diabetes with neurologic or other specified manifestation			X		1
26	Diabetes with ophthalmologic or unspecified manifestation	X				1
27	Septicemia/shock	X				1
28	Septicemia/shock	X				1
29	Bone/joint/muscle infections/necrosis	X				1
30	Major complications of medical care and trauma	X				1
31	Breast, prostate, colorectal, and other cancers and tumors	X	X			2
32	End-stage liver disease			X		1
33	Diabetes with renal or peripheral circulatory manifestation	X	X			2
34	Severe hematological disorders		X		X	2
35	Breast, prostate, colorectal, and other cancers and tumors	X				1
36	Cardiorespiratory failure and shock	X				1

	Hierarchical Condition Category	A	B	C	D	Total Errors
37	Cardiorespiratory failure and shock	X				1
38	Diabetes with neurologic or other specified manifestation	X	X			2
39	Unstable angina and other acute ischemic heart disease	X				1
40	Spinal cord disorders/injuries			X		1
41	Specified heart arrhythmias	X			X	2
42	Breast, prostate, colorectal, and other cancers and tumors			X		1
43	Diabetes with ophthalmologic or unspecified manifestation			X		1
44	Pancreatic disease	X	X			2
45	Inflammatory bowel disease	X				1
46	Hip fracture/dislocation	X			X	2
47	Major complications of medical care and trauma	X				1
48	Vascular disease			X		1
49	Vascular disease	X				1
50	Pancreatic disease			X		1
51	Breast, prostate, colorectal, and other cancers and tumors			X		1
52	Severe hematological disorders	X	X			2
53	Breast, prostate, colorectal, and other cancers and tumors	X	X			2
54	Breast, prostate, colorectal, and other cancers and tumors	X				1
55	Diabetes with neurologic or other specified manifestation	X				1
56	Cerebral hemorrhage		X			1
57	Breast, prostate, colorectal, and other cancers and tumors	X				1
58	Vascular disease		X			1
59	Major complications of medical care and trauma			X		1
60	Ischemic or unspecified stroke	X				1
	Total	46	16	10	4	76

APPENDIX D: PARAMOUNT COMMENTS



CERTIFIED – RETURN RECEIPT REQUESTED



July 30, 2010

Mr. James C. Cox
Regional Inspector General for Audit Services
Department of Health & Human Services
Office of Audit Services, Region V
233 North Michigan Avenue, Suite 1360
Chicago, IL 60601

Re: Report Number: A-05-09-00044 – Draft Audit dated June 2010

Dear Mr. Cox:

We received a draft copy of the "Risk Adjustment Data Validation of Payments Made to Paramount Care, Inc. for Calendar Year 2007" ("Draft RADV Audit") under your cover letter dated June 15, 2010. In that cover letter you requested that Paramount Care, Inc. ("Paramount") provide the Department of Health and Human Services, Office of Inspector General, Office of Audit Services ("OIG") with its comments within 30 days. The OIG subsequently provided Paramount with an additional 15 days to respond. Please accept this letter as Paramount's response to the Draft RADV audit. While we have endeavored to detail our views on the validity of the facts and reasonableness of the recommendations presented by the Draft RADV Audit, given the time limitations and the uncertainty concerning the audit procedures used by the OIG, there may well be additional issues raised by the Draft RADV Audit which we are presently unable to address.

This correspondence is provided in response to the OIG's request. While we are happy to cooperate with this request, the fact that both the final RADV Audit and this letter will be made publicly available necessarily limits the scope of this response. Paramount will raise those issues concerning its administrative appeal rights as well as possible grounds it may have to challenge the RADV audit process and results in the appropriate forum. Consequently, Paramount provides this response while reserving any rights it may have whether or not detailed herein and this response is made without prejudice to whatever assertions Paramount might make in the context of an administrative appeal or judicial proceeding.

Audit Procedures

As a threshold and general matter, it is unclear what process OIG followed in completing the Draft RADV Audit report. The audit commenced in December 2008 by means of a notification letter sent from OIG's Chicago office. While that correspondence referenced the audit language

Mr. James C. Cox
July 30, 2010
Page 2

contained in Paramount's contract with CMS and the OIG's regulatory authority to engage in audits, it did not identify the process or procedures that would be followed in conducting the audit. As of December 2008, CMS had established a RADV audit process as reflected in Module 7 of the 2007 Risk Adjustment Data Training for Medicare Advantage Organizations Participant Guide ("2007 Participant Guide"). While the Draft RADV Audit refers to the 2007 Participant Guide, it does not state that the OIG followed the procedures outlined therein. The Draft RADV Audit states that it was performed in accordance with generally accepted government accounting standards. However, as noted in more detail below, the Draft RADV Audit reflects substantial deviations from the 2007 Participant Guide, so it appears that the procedures outlined there were not followed.

While the OIG was performing this audit, CMS updated both the procedures it followed for risk adjustment data audits and the appeal process Medicare Advantage ("MA") Organizations had available. The result of that updating is now reflected in 42 C.F.R. §422.311 which became effective on June 7, 2010. (See CMS Memo Regarding "Effective date of final Medicare Part C and D policy and technical changes regulation" dated April 30, 2010, page 3). Paramount understands that its administrative appeal rights are now delineated by this regulation. The Draft RADV Audit, however, is not structured in the manner provided by § 422.311(b) (detailing payment adjustment to be made, timeframe for adjustment, and a description of appeal rights).

Given this context, Paramount would request that OIG clarify whether the Draft Audit Report is intended to be a product of the process outlined in the 2007 Participant Guide. If OIG intended to follow the 2007 Participant Guide, the RADV audit needs to be brought into compliance with its terms. If OIG intended to follow some other procedure or process, it should identify what that is and clarify that it is not following the RADV audit process outlined in the 2007 Participant Guide. Additionally, if Paramount is now required to pursue any administrative appeal through the regulations effective June 7, 2010, OIG should revise the Draft Audit Report to bring it into compliance with the requirements outlined in §422.311.

Diagnosis Coding

Like any other MA organization, Paramount does not engage in ICD-9 coding. Instead, Paramount receives that coding from providers. The Draft RADV Audit quotes a regulatory requirement that Paramount (as an MA organization) submit risk adjustment data to CMS. But the Draft RADV Audit fails to acknowledge that Paramount (like every other MA organization) is required to obtain that data from providers. Indeed, the very same regulations that were quoted in the Draft RADV Audit, obligates Paramount to obtain risk adjustment data (including ICD-9 coding) from providers. 42 C.F.R. §422.310(d)(3) ("MA organizations must obtain the risk adjustment data required by CMS from the provider, supplier, physician or other practitioner that furnished the item or service.") Moreover, MA organizations are prohibited from altering the diagnoses reported to them by providers. As a practical matter, prompt payment

Mr. James C. Cox
July 30, 2010
Page 3

requirements preclude MA organizations from double checking provider coding prior to payment.

While Paramount is responsible for the accuracy of risk adjustment data submitted to CMS, the source of that data is necessarily the providers. There was no indication in the Draft Audit Report that Paramount inaccurately reported any data that it had received from providers. The audit reflected by the Draft Audit Report was not designed to determine whether Paramount has access to a provider's medical records necessary to support the diagnosis submitted for risk adjustments. (As provide by §8.7.3 of the Participant Guide.) Rather, it was to determine if that diagnosis could be supported by "one" medical record supplied by a provider.

To the extent the Draft Audit Report concluded that some providers may not have been able to provide the "one" medical record necessary to support their ICD-9 coding, that is fundamentally an issue for the providers. While Paramount is required to accurately report the ICD-9 coding it receives from providers to CMS, if OIG is challenging the accuracy of the provider coding, that is more appropriately addressed directly with the providers. These same providers undoubtedly submit diagnosis codes to multiple MA organizations. Therefore, imposing a requirement on each MA organization to separately instruct providers on coding would lead to the potential for conflicting instructions. Moreover, providers submit ICD-9 codes to both MA organizations and to fee for service Medicare. If providers evidence coding issues, that would also present issues for the manner in which that particular provider codes in fee for service claims. Consequently, to the extent a provider requires training or instruction in coding, CMS and its Fiscal Intermediaries are in a far superior position to provide for that.

At the same time, the audit reflected in the Draft Audit report tested whether a medical record reflecting a diagnosis could be found in the same year as an associated HCC. However, diagnosis is not necessarily limited to a particular year. It is possible that a diagnosis supporting an HCC was made in a prior year but that would not be reflected in the audit results as the OIG limited the medical records sought to the year in question.

Unsupported Codes

The discrepancies with the OIG's coding determinations which Paramount has identified to date are listed in Appendix A (attached). Those discrepancies are divided into three general groups. First, we have noted those beneficiaries where the OIG concluded either that the risk adjustment data was invalid or that there was an absence of medical records based on the absence of a providers' signature. As detailed below, OIG made these determinations without allowing Paramount to provide attestations. Second, we have listed specific reasons we believe that the coders OIG used came to the wrong conclusions based on the medical records submitted. Finally, Appendix A identifies those HCCs which are supported by medical records received

Mr. James C. Cox
July 30, 2010
Page 4

from providers that may not fully comply with CMS guidelines, but nevertheless may evidence a conclusion that the HCC associated with the beneficiary was valid.

In completing Appendix A, Paramount identified several more general problems with the OIG's coding effort. For instance, it appears that the coders the OIG used would compare dates of service in the medical records submitted. Thus, if one date service supported a diagnosis, but that diagnosis was not mentioned on other dates of service in the same record, OIG's coders would "disallow" the diagnosis. This conflicts with the 2007 Participant Guide (§7.1.4 "The coders that are hired to review the medical records . . . will not search beyond the date of service identified by the MA organization for the review.") Moreover, the process OIG used for reviewing medical records does not comport with the 2007 Participant Guide. Specifically, the Draft RADV Audit discusses the use of a single medical review contractor that engaged in two rounds of review for HCCs that were determined to be unsupported by the submitted medical records. But the 2007 Participant Guide provides for two separate and independent contractors to review medical records (§7.1.6).

Signatures/Credentials

The Draft Audit Report asserts that 25 HCCs were unsupported because Paramount did not provide physician signatures or credentials. That determination was made without allowing Paramount an opportunity to provide attestations from the physicians. Although CMS permits MA organizations to provide such attestations during RADV audits (42 C.F.R. §422.311(c)(1)), OIG refused to consider any such attestations here. On December 21, 2009 [REDACTED] of Paramount emailed [REDACTED] (of the OIG) to inquire as to whether Paramount could submit attestations. [REDACTED] responded that same day stating: "we are not considering attestations for the RADV audits." That is inconsistent both with CMS's practice under the 2007 Participant Guide and with the current RADV audit and appeal process.

Because the determinations with respect to physician signatures were made without allowing Paramount to provide attestations, these determinations should not be considered valid nor be included in the final report. To the extent OIG continues to assert a signature/credentialing problem with any of the sampled HCCs, Paramount should be allowed to provide attestations.

No Documentation Provided

The Draft Audit Report asserts that there were 12 HCCs that were unsupported because "Paramount did not provide any documentation." A more accurate description of this situation would be that Paramount was unable to obtain documentation from the provider. The inability to secure these records from providers may well be the result of the fact that the OIG's audit conflicted with RADV audit procedures outlined in the 2007 Participant Guide in two fundamental ways.

Office of Inspector General Note—The deleted text has been redacted because it contains personally identifiable information.

Mr. James C. Cox
July 30, 2010
Page 5

First, the audit procedures for obtaining medical records outlined in §7.2.2.3 of the 2007 Participant Guide provide that any RADV audit is supposed to facilitate the MA organizations acquisition of medical records from providers. The entity conducting the audit is supposed to provide the MA organization with a “comprehensive instruction package” that at a “minimum” includes:

- Detailed instructions for requesting records from providers and submitting to the IVC [initial validation contractor];
- Guidance and best practices to further assist organizations with the request process;
- CMS letters addressed to providers describing the overall risk adjustment data validation approach;
- HIPAA fact sheet to discuss HIPAA privacy;
- CMS sample request letter to providers; and
- Coversheet for each enrollee HCC.

As evidenced by this minimum list, MA organizations are supposed to be given documentation that would allow them to demonstrate to providers that the request for medical records comes from CMS. It can be assumed that providers will be more responsive to a request from the government than they might be to a request from Paramount. Yet, in conducting the survey underlying the Draft RADV Audit, the OIG did not provide this material to Paramount.

Second, the process outlined for RADV audits in the 2007 Participant Guide require reimbursement for the medical records submitted (Participant Guide §7.2.3.1). However, here, OIG refused any reimbursement and attributed any expense to the “cost of doing business with the government.” (See email dated May 19, 2009 from [REDACTED].) At this point, Paramount cannot determine which of the 12 HCCs the Draft RADV Audit identifies as lacking documentation did so because OIG failed to follow the established procedure for requesting and paying for those records in the course of a RADV audit.

Sample Selection

The Draft RADV Audit recommends that Paramount refund \$19,324,342 to CMS by extrapolating the results of a sample limited to 100 beneficiaries. Given the large amount involved and the small sample size, the Draft Audit Report should have detailed the steps taken to ensure that the sample was statistically valid. No such details are provided.

The Draft RADV Audit only identified HCCs which OIG now asserts were overpaid. In discussing the RADV audit process generally, CMS represented that it would not be limited to simply identifying HCCs that may have been subject to overpayment, but would include underpayments as well. 75 Fed. Reg. 19746 (April 15, 2010), (“Our RADV audit policy does account for both underpayments and overpayments.”) Both fairness and logic dictate that an

Office of Inspector General Note—The deleted text has been redacted because it contains personally identifiable information.

Mr. James C. Cox
July 30, 2010
Page 6

accurate audit of Paramount's payment experience take account of instances of underpayment. Yet the Draft RADV Audit failed to identify a single instance of underpayment. This provides a strong indication that either underpayments were ignored or that the sample used is not representative. This deficiency may also be the result of the fact that the Draft RADV Audit looked only at beneficiaries with HCCs. Excluding all beneficiaries without HCCs necessarily eliminates a large potential pool of beneficiaries for whom Paramount might have been underpaid.

Refund Recommendation Based on Unconfirmed Discrepancies

The 2007 Participation Guide provides that "payment adjustments are based on confirmed risk adjustment discrepancies" (§7.1.4; emphasis supplied). The Draft RADV Audit purports to confirm adjustment discrepancies for 56 beneficiaries enrolled in Paramount's Medicare Advantage plan during calendar year 2007.¹ Yet the overpayment "estimate" contained in the Draft RADV Audit cover all beneficiaries enrolled with Paramount that year who had any HCC adjustment (more than 8,800 beneficiaries). There are no confirmed adjustment discrepancies beyond those the Draft RADV Audit purports to have found for 56 beneficiaries. Rather, the estimated overpayment of \$19,324,342 in the Draft RADV Audit is based on an extrapolation from those results. As this is not based on confirmed discrepancies, it does not comport with the terms of the 2007 Participant Guide and should be removed from the final report.

The only refund that could legitimately be requested would have to be based on confirmed discrepancies that were found after a process that comports with the requirements of the 2007 Participant Guide (and arguably the new regulations). As noted above, the \$277,486 in purported overpayments reflected in the Draft Audit Report is not a product of such a process. Paramount believes that number will be greatly reduced once it is adjusted to both reflect confirmed discrepancies and a process that follows the 2007 Participant Guide which the OIG insists applies.

Recommendations

The Draft RADV Audit makes three recommendations. Paramount would respond to those as follows:

The first recommendation relating to making a large refund payment to the government and is addressed in detail above.

Paramount has commenced and strengthened several initiatives to address the second and third recommendations regarding monitoring effectiveness of Paramount's policies and ensuing

¹ As noted in more detail above, Paramount takes issue with these purported discrepancies. Paramount, thus, takes issue with the extrapolation based on them as well.

Mr. James C. Cox
July 30, 2010
Page 7

compliance with the 2007 Participant Guide. Through the use of part-time resources, Paramount began reviewing medical records in 2008 to support the Risk Adjustment (“RA”) process. In January 2009, Paramount implemented an RA team to review medical records full time, as well as to provide physician education relative to the RA process. The team included a Manager, who is an experienced registered nurse, and three certified medical coders. Management is currently reviewing the breadth and scope of this team to ensure more accurate diagnosis coding and ultimately proper HCC assignment. Management is also evaluating the need for additional resources to further enhance the results of this important monitoring process. Specific changes being evaluated include, but are not limited to:

- Moving to 100% physician office chart audits;
- Reviewing PCP offices on a year-around basis;
- Development of an audit database;
- Collaborate with providers in the development of a comprehensive H & P form (diagnosis specific) for inclusion in the medical record;
- Purchase of software to facilitate conversion to ICD 10;
- Identify additional resources for scanning medical records currently being done by coders;
- Provide team with access to all medical documentation systems available to hospital coders to assist with HCC tracking;
- Code all PCP medical records (specialists as needed) for under 65 disability members;
- Monitor claims submissions for new members for complex and specialty coding; and
- Conduct on-going data mining.

Paramount is also collaborating with affiliated physicians and facilities to improve the flow, accuracy and timeliness of information. Improved electronic medical record access from providers would advance both data integrity and team/office efficiency. ProMedica Physician Group (“PPG”) has its own medical record monitoring process. Paramount and PPG are discussing ways for them to expand their current internal compliance reviews of physician records to incorporate assessments of documentation impacting HCC results for Paramount. Assuming that synergies can be gained through leveraging this process, the Paramount RA team could focus more time on unaffiliated providers. In addition, Paramount will collaborate with ProMedica to develop a more targeted and comprehensive program to educate physicians on the importance of accurate diagnosis coding.

The ProMedica Health System Audit and Compliance Department (“Internal Audit”) will also be engaged to provide an added layer of audit oversight regarding Paramount’s RA process. Internal Audit and management will work together to re-design the annual Insurance Risk Assessment to identify more specific processes, such as HCC assignment. Internal Audit will also be evaluating the need for additional resources to provide more concentrated focus on

Mr. James C. Cox
July 30, 2010
Page 8

Paramount. Beginning in 2011, Internal Audit will incorporate 1-2 audits of Paramount's redesigned program. The program's effectiveness will be evaluated with future recommendations to be made, contingent on audit results.

In conclusion, Paramount would respectfully request that any final audit issued by OIG comport with the requirements for a RADV audit detailed in the 2007 Participant Guide. As the Draft RADV Audit we received on June 15, 2010, does not do so, Paramount would suggest that it be withdrawn and reformulated. As it did with respect to the OIG's original audit, Paramount is both ready and willing to provide any data and assistance required to complete that process.

Very truly yours,



Jeffrey W. Martin
Vice President, Operations and Finance

Attachment (Appendix A)

cc:



Office of Inspector General Note—The deleted text has been redacted because it contains personally identifiable information.

Paramount Health Care
Appeals
Appendix A

07/23/2010

Sample #	HCC Reversed	HCC Supported	Diagnoses Reversed	Supported Diagnoses (if any)	Reason Code	Medical Review Coordinator Comments	Paramount Response
H-9853-004	71	71	357.2	357.2	M2, M5a	Plan submitted second request. Encounter dated 02/09/2008 does support evaluation and treatment planning in patient's medical record. However, the dates progress note was not signed by the provider as required by RA Participant Guide 7.2.4.5.	Diagree - Source - 42 C.F.R. §422.311(c)(1) Attestation available upon request.
H-9853-022	19	19	189.0	189.0	M2, M5b	Plan submitted second request. Review of encounter dated 05/16/2008 supports evaluation and management of the patient's current diagnosis of renal cancer. However, no signature found on dated progress note. RA Participant Guide 7.2.4.5 states "All dates of service that are identified for review must be signed with credentials and dated by the physician or an appropriate extender. The physician must authenticate each note for which services are provided. Acceptable physician authentication comes in the forms of handwritten signatures, signature stamps, and electronic signatures". HCC 10 is supported but no acceptable provider signature is present.	Diagree - Source - 42 C.F.R. §422.311(c)(1) Attestation available upon request.
H-9853-044	108	108	495	493.70	M2, M5c	Plan submitted second request which included new additional documentation. Second record for dates of service 11/17 - 11/19/2008 included no documentation to support ICD-9 code 496. Review results from the first record submission indicated sufficient documentation to change the ICD-9 code from 498 to 493.20 Chronic obstructive asthma, unspecified, however, there still is no acceptable provider signature. HCC 108 is supported but the service still requires an acceptable provider signature.	Diagree - Source - 42 C.F.R. §422.311(c)(1) Attestation available upon request.
H-9853-064	154	None	694.42, 996.77, 996.47		M2, M9	Plan submitted second request but provided no new medical records. Medical records coversheet indicated, "No medical record could be obtained to support the HCC". Initial determination remains unchanged. No provider signature. HCC 164 is not validated.	Diagree - Source - 42 C.F.R. §422.311(c)(1) Attestation available upon request.
H-9853-066	15	19	250.62	250.00	M2, M5c	Plan submitted second request but provided no new medical records. Medical records coversheet indicated, "No medical record could be obtained to support the HCC". Initial determination remains unchanged. Diabetes with other specified manifestations, type II or unspecified type, uncontrolled is not supported by the initially submitted record. The record supports code 250.00 (diabetes mellitus without mention of complication, type II or unspecified type, not stated as uncontrolled), which is assigned HCC 19. However, the typed progress note was not signed by the physician. RA Participant Guide 7.2.4.5 states "All dates of service that are identified for review must be signed (with credentials) and dated by the physician or an appropriate extender. The physician must authenticate each note for which services are provided. Acceptable physician authentication comes in the forms of handwritten signatures, signature stamps, and electronic signatures". HCC 19 is supported but no acceptable provider signature is present. HCC 18 but is lacking an acceptable provider signature.	Diagree - Source - 42 C.F.R. §422.311(c)(1) Attestation available upon request. Source - Physician documentation of 250.00.
H-9853-076	105	105	443.9	443.9	M2, M9	Plan submitted second request but provided no new medical records. Medical records coversheet indicated, "No medical record could be obtained to support the HCC". Initial determination remains unchanged. Initial record submission supports ICD 9 code 419.9, no acceptable provider signature identified on encounter dated 08/17/2008. HCC 105 is supported but no acceptable provider signature identified.	Diagree - Source - 42 C.F.R. §422.311(c)(1) Attestation available upon request.
H-9853-094	80	80	428.0	428.0	M2, M5a	Plan submitted second request which included new additional documentation. Encounter dated 09/15/2008 supports evaluation and management of code 428.0. However, the dated progress note was initialed but does not indicate provider name or credentials. According to RA Participant Guide 7.2.4.5, "The MA organizations must ensure that the provider of service for face-to-face encounters is appropriately identified on medical records via signature and physician specialty credential. They must also ensure that the credential or the provider's name is present on the group practice's stationary. The provider's name on the stationary must be dated with the provider's name on the group practice's stationary. If the provider of services is not listed on the stationary, then the credentials must be part of the signature for that provider". ICD-9 code 428.0 is supported by the record, but no acceptable provider signature is present.	Diagree - Source - 42 C.F.R. §422.311(c)(1) Attestation available upon request.
H-9853-096	100	100	342.12	342.12	M2, M9	Plan submitted second request but provided no new medical records. Medical records coversheet indicated, "No medical record could be obtained to support the HCC". Initial determination remains unchanged. ICD-9 code 342.12 supported by the record but no acceptable provider signature identified.	Diagree - Source - 42 C.F.R. §422.311(c)(1) Attestation available upon request.

Paramount Health Care
Appeals
Appendix A

07/28/2010

Sample #	HCC Reviewed	HCC Supported	Diagnoses Reviewed	Supported Diagnoses (if any)	Reason Code	Medical Review Contractor Comments	Paramount Response
H3653-094	105	105	443.9, 467.1	443.9	M2, M9	Plan submitted second request but provided no new medical records. Medical records cover sheet indicated, "No medical record could be obtained to support the HCC". Initial determination remains unchanged. No acceptable provider signature identified on record. According to RA Participant Guide 7.2.4.5, "the RA organizations must ensure that the provider of service for face-to-face encounters is appropriately identified on medical records via their signature and physician specialty credentials. This means that the credentials for the provider of services must be somewhere on the medical record - either next to the provider's signature or pre-printed with the provider's name on the group practice's stationery. If the provider of services is not listed on the stationery, then the credentials must be part of the signature for that provider."	Disagree - Source - 42 C.F.R. §422.311(c)(1) Attestation available upon request.
H3653-097	108	108	466	466	M2, M9	Plan submitted second request but provided no new medical records. Medical records cover sheet indicated, "No medical record could be obtained to support the HCC". Initial determination remains unchanged. No acceptable provider signature identified on the encounter, as required by 7.2.4.5 of the RA Participant Guide	Disagree - Source - 42 C.F.R. §422.311(c)(1) Attestation available upon request.
H3653-098	105	105	443.9	443.9	M2, M9a	Plan submitted second request. Encounter dated 08/21/2006 notes a current diagnosis of claudication. However, the record was electronically signed by the physician on 10/18/2007, more than a year after the service was provided. Risk Adjustment Data Validation Frequently Asked Questions dated 04/18/2005 state, "medical records should be signed by the practitioner on a timely basis. Going back and obtaining a signature more than a year after the service date is unacceptable." HCC 105 is supported, but no acceptable signature was identified.	Disagree - Source - 42 C.F.R. §422.311(c)(1) Attestation available upon request. Signature Date Source - ICD-9-CM Official Guidelines for Coding and Reporting, Effective April 1, 2005 Section IV. Diagnostic Coding and Reporting Guidelines for Outpatient Services has no guidelines for timeliness of signatures
H3653-099	105	105	443.9	443.9	M2, M9a	Plan submitted second request but provided no new medical records. Medical records cover sheet indicated, "No medical record could be obtained to support the HCC". Initial determination remains unchanged. No acceptable provider signature identified on the encounter, as required by 7.2.4.5 of the RA Participant Guide	Disagree - Source - Documentation submitted - Hospital admission 11/26/06. ICD-9 453.41 should have been coded 453.9 - HCC 105 Member seen and admitted through ER with leg pain to rule out DVT. Venous doppler was ordered, as documented by the neurologist's progress note (1) for deep vein thrombosis but showed chronic thrombosis of the femoral vein (code 453.8). Code 453.41, venous embolism and thrombosis of deep vessels of proximal lower extremity was listed as one of the secondary diagnosis for hospital billing.
H3653-099	105	None	453.41	None	M7/M9	Plan submitted second request but provided no new medical records. Medical records cover sheet indicated, "No medical record could be obtained to support the HCC". Initial determination remains unchanged. ICD-9 code 413.9 is not supported. HCC 83 is not validated.	Disagree Source - Documentation submitted - Hospital admission 02/27/2006 - Operative note for CABG, DOS 02/28/2006, supports 413.9 - HCC 83
H3653-037	83	None	413.9	None	M7/M9	Plan submitted second request but provided no new medical records. Medical records cover sheet indicated, "No medical record could be obtained to support the HCC". Initial determination remains unchanged. No documentation provided to support ICD-9 code 40.1. HCC 105 is not validated.	Disagree Source - Documentation submitted - Progress Note 02/06/06 MRA study showed atherosclerotic plaques within the abdominal aorta should be assigned 440.0HCC 105
H3653-017	105	None	440.1	None	M5, M9	Plan submitted second request but provided no new medical records. Medical records cover sheet indicated, "No medical record could be obtained to support the HCC". Initial determination remains unchanged. ICD-9 code 413.9 is not supported. HCC 83 is not validated.	Disagree Source - Documentation submitted - Progress Note 10/03/06 The neurologist stated "I suspect multiple strokes" under the diagnosis of 436.0 Vascular Multi Infarct State including listing this as an "Active" status diagnosis
H3653-266	96	None	4156	None	M2, M9	Plan submitted second request but provided no new medical records. Medical records cover sheet indicated, "No medical record could be obtained to support the HCC". Initial determination remains unchanged. ICD-9 code 413.9 is not supported. HCC 83 is not validated.	Disagree Source - Documentation submitted - Progress Note 10/03/06 The neurologist stated "I suspect multiple strokes" under the diagnosis of 436.0 Vascular Multi Infarct State including listing this as an "Active" status diagnosis

Paramount Health Care
Appeals
Appendix A

07/28/2010

Sample #	HCC Reviewed	HCC Supported	Diagnosis Reviewed	Supported Diagnosis (if any)	Reason Code	Medical/Review Contractor Comments	Paramount Responses
H2653-096	95	None	431		M2_M5	Plan submitted second request but provided no new medical records. Medical records cover sheet indicated, "No medical record could be obtained to support the HCC". Initial determination was unchanged. Initial determination was supported by medical records dated 1/11/2006 from history of cerebral hemorrhage from motor vehicle accident in 1984 with residual spastic hemiparesis (coded as 342.12 - see record H2653-090/100). Record supports "History of conducta versus acute, current intracerebral hemorrhage. HCC 95 is not validated".	Disagree Source - Documentation submitted for DOS 11/14/06 does support ICD-9 907.014CC155. Patient with a left spastic hemiparesis due to residual effect of hemorrhage is seen by neurologist on 1/11/06. Discharge diagnosis 431. Hemiparesis should not be assigned since patient had her cerebral hemorrhage in 1984. Instead late effect of intracranial injury code 907.0 should be assigned. Physician coding error for ICD-9 of 431.
H2653-097	105	None	443.9		M5B	Plan submitted second request which included new additional documentation, but the initial determination remains unchanged. Inpatient encounter dated 01/11 - 01/13/2006 did not support any evaluation or treatment related to ICD-9 code 443.9 (Peripheral Vascular Disease, Unspecified). The patient was treated for angiodema and peptic ulcer disease (PUD), not peripheral vascular disease (PVD). HCC 105 is not validated.	Disagree Source - Documentation submitted with DOS 1/18/06 does support PVD with Plavix treatment. According to the physician dated 1/18/06, PVD is listed as one of the final impression diagnoses. Also, Plavix is listed as one of the medications patient is on.
H2653-098	2	None	038.49		M7M9	Plan submitted second request but provided no new medical records. Medical records cover sheet indicated, "No medical record could be obtained to support the HCC". Initial determination remains unchanged. The presence or history of this condition did not affect the care, treatment or the management provided during inpatient encounter dated 08/28 - 09/06/2006. HCC 108 is not validated.	Disagree Source - Documentation submitted Hospital admission 07/07/2006. Blood cultures on 7/7/2006 positive for Staphylococcus Coagulase Negative. 07/07/2006 Levafloxacin ordered with timing by Pharmacy.
H2653-099	108	None	486		M7M9	Plan submitted second request but provided no new medical records. Medical records cover sheet indicated, "No medical record could be obtained to support the HCC". Initial determination remains unchanged. The presence or history of this condition did not affect the care, treatment or the management provided during inpatient encounter dated 08/28 - 09/06/2006. HCC 108 is not validated.	Disagree Source - ICD-9-CM Official Guidelines for Coding and Reporting Effective April 1, 2005 Section IV - Diagnostic Coding and Reporting Guidelines for Outpatient Services. K - Codes all documented conditions that Coexist with hospital admission of 8/28/2006 - Member with acute myocardial infarction and stroke on 8/28/2006. Summary and all chronic conditions would be considered during this admission.
H2653-098	105	None	443.9		M7M9	Plan submitted second request but provided no new medical records. Medical records cover sheet indicated, "No medical record could be obtained to support the HCC". Initial determination remains unchanged. The presence or history of this condition did not affect the care, treatment or the management provided during inpatient encounter dated 08/28 - 09/06/2006. HCC 105 is not validated.	Disagree Source - ICD-9-CM Official Guidelines for Coding and Reporting Effective April 1, 2005 Section IV - Diagnostic Coding and Reporting Guidelines for Outpatient Services. K - Code all documented conditions that Coexist with hospital admission of 8/28/2006 - Member with acute episodes and multiple chronic diseases on Discharge Summary and all chronic conditions would be considered during this admission.

Paramount Health Care
Appeals
Appendix A

07/28/2010

Sample #	HCC Reviewed	HCC Supported	Diagnoses Reviewed	Supported Diagnoses (if any)	Reason Code	Medical Review Constructor Comments	Paramount Response
H3653-271	92	None	427, 31		M9	Plan submitted second request but provided no new medical records. Medical records coversheet indicated. "No medical record could be obtained to support the HCC". Initial determination remains unchanged. Initial record notes diagnosis as "T, A, B". According to RA Participant Guide 7.2.4.4, "unacceptable types of diagnoses include probable, suspect, questionable, rule out and working" in outpatient hospital and physician settings. HCC 92 is not validated.	Diagree Source - Ancillary documentation supports diagnosis.
H3653-272	10	None	185, 9		M1, M9	The initial review, the plan's coversheet indicates the medical record could be obtained to support the HCC indicated. No additional documentation provided. Plan submitted second request but provided no new medical records. Medical records coversheet indicated. "No medical record could be obtained to support the HCC". Initial determination remains unchanged. According to CD-9-CM coding guidelines, personal history codes (V codes) explain a patient's past medical condition that no longer exists and is not receiving any treatment but that has the potential for recurrence, and therefore may require continued monitoring. The diagnosis should be coded as V10.46, which does not have an assigned HCC. HCC 10 is not validated.	Diagree Source - Physician documents active disease. Ancillary documentation supports.
H3653-288	10	None	185	V10.46	M2, M9	Plan submitted second request but provided no new medical records. Medical records coversheet indicated. "No medical record could be obtained to support the HCC". Initial determination remains unchanged. According to CD-9-CM coding guidelines, personal history codes (V codes) explain a patient's past medical condition that no longer exists and is not receiving any treatment but that has the potential for recurrence, and therefore may require continued monitoring. The diagnosis should be coded as V10.3, which does not have an assigned HCC. HCC 10 is not validated.	Diagree Source - Physician documents active disease.
H3653-289	10	None	174, 9	V10.3	M7/M9	Plan submitted second request but provided no new medical records. Medical records coversheet indicated. "No medical record could be obtained to support the HCC". Initial determination remains unchanged. Encounter dated 09/13/2006 notes diagnosis as "H/O prostate cancer s/p seed implant 05/22/04". Unable to determine from record whether condition is current (code 185) or personal history of (code V10.46). HCC 10 is not validated.	Diagree Source - Physician documents active diagnosis.
H3653-294	10	None	185		M7/M9	Plan submitted second request but provided no new medical records. Medical records coversheet indicated. "No medical record could be obtained to support the HCC". Initial determination remains unchanged. According to CD-9-CM coding guidelines, personal history codes (V codes) explain a patient's past medical condition that no longer exists and is not receiving any treatment but that has the potential for recurrence, and therefore may require continued monitoring. The diagnosis should be coded as V10.46, which does not have an assigned HCC. HCC 10 is not validated.	Diagree Source - Physician documents active disease.
H3653-297	10	None	185	V10.46	M7/M9	Plan submitted second request but provided no new medical records. Medical records coversheet indicated. "No medical record could be obtained to support the HCC". Initial determination remains unchanged. No documentation was provided to support HCC code 433. According to CD-9-CM coding guidelines, personal history codes (V codes) explain a patient's past medical condition that no longer exists and is not receiving any treatment but that has the potential for recurrence, and therefore may require continued monitoring. The diagnosis should be coded as V12.59 which does not have an assigned HCC. HCC 96 is not validated.	Diagree Source - Physician documents active disease.
H3653-298	98	None	433, 11	V12.59	M7/M9	Additional documentation was submitted per second request for encounter dated 09/11/2006. While this document is signed by the provider, the record shows "a history of" prostate adenocarcinoma, as there is no evidence of active disease and no active treatment provided. According to CD-9-CM coding guidelines, personal history codes (V codes) explain a patient's past medical condition that no longer exists and is not receiving any treatment but that has the potential for recurrence, and therefore may require continued monitoring. The diagnosis should be coded as V10.46 (Personal history of malignant neoplasm, Prostate), which does not have an assigned HCC. HCC 10 is not validated.	Diagree Source - Ancillary documentation supports 433, 30/HCC 102.
H3653-212	10	None	185	V10.46	M8/M9		Diagree Source - Physician documents active disease.