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The risks of risk adjustment coding

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As you have likely seen by now, there is heightened scrutiny surrounding the Medicare Advantage (MA) risk adjustment reimbursement program. Oversight is coming from several entities, including the U.S. Department of Justice (DOJ), U.S. Department of Health & Human Services Office of Inspector General (OIG), and the Centers for Medicare & Medicaid Services (CMS). In fact, OIG just added hierarchical condition coding (HCC) to their Work Plan for June, announcing they will be conducting nationwide audits. The buzz surrounding risk adjustment coding—also known as HCC—is nothing to take lightly.

Historically, the healthcare provider community viewed this largely as a "payer" problem. However, providers are not immune to risk adjustment enforcement actions. Providers have been subject to the False Claims Act (FCA) settlements related to their submission of HCC conditions, with one of the largest providers' FCA settlements coming in at $90 million, coupled with a stringent corporate integrity agreement (CIA). Inspector General Christi Grimm delivered comments regarding the OIG's interest in risk adjustment reimbursement at the 2023 Health Care Compliance Association Compliance Institute. During her address, she announced that risk adjustment coding is one of OIG's top two priorities. She also emphasized the significant dollars at stake in managed care and indicated OIG had identified more than $6.5 billion in improper risk-adjusted payments in just one year.

Given the current government focus surrounding risk adjustment reimbursement and proper reporting of HCC conditions, the time for providers to closely examine their own process and compliance is now. In this article, we will discuss the fundamentals of risk adjustment reimbursement, explore operational considerations, examine recent settlements and enforcement actions, and provide recommendations to achieve success and mitigate compliance risk associated with your HCC program.

Fundamentals of risk adjustment reimbursement

Under the MA program, CMS makes monthly payments to MA organizations based on the anticipated cost of providing Medicare benefits to an enrollee while accounting for differences in demographics, as well as certain characteristics for each beneficiary and risk factors such as age, gender, and health status.[1] This risk adjustment system relies, in part, on MA organizations collecting diagnosis codes (ICD–10) from their providers and submitting them to CMS. This is known as risk adjustment coding or HCC reporting. As shown in Figure 1, certain ICD–10 diagnosis codes are categorized as HCC conditions and are eligible for increased risk adjustment payments based on their payment group assignment.

Simply put, MA plans receive larger payments for beneficiaries with more severe diagnoses and, in turn, providers receive increased reimbursement for managing more complex patients. Each year, the risk adjustment payment rates are reset and established based on the conditions reported the prior year. This means there may be fluctuations in risk adjustment payments from year to year based on the conditions addressed and captured for reporting.

The two keys for accurate risk adjustment reimbursement are (1) correct and complete provider documentation and (2) exact and complete ICD–10 reporting. As you can imagine, incomplete and nonspecific medical record documentation, as well as improper, suboptimal, and missed reporting of ICD–10 codes, can result in lost reimbursement or, conversely, overpayments and, most assuredly, increased compliance risk.

In review of recent risk adjustment audit reports, there are recurring themes in virtually every case:

1. Inadequate auditing, monitoring, and oversight of providers by the MA plans, and
2. Improper provider reporting of HCCs.

On January 30, CMS issued the Medicare Advantage Risk Adjustment Data Validation Final Rule. The rule was issued in response to the growing concerns surrounding improper risk adjustment reimbursement. CMS stated the rule was designed to incentivize MA plans to conduct more effective auditing of providers to identify improperly reported HCC conditions and thereby improve the accuracy of the data they report to CMS—which will reduce improper risk adjustment payments in the future. The rule also gives CMS the authority to extrapolate overpayments made to the MA plan back to 2018 and recoup actual overpayments for 2011–2017. It is expected that providers will start seeing the effects of the new rule as MA plans implement measures to reduce their own risk and financial liability. It is almost certain that MA plans will begin ramping up auditing of provider HCC coding and recouping identified overpayments.

ICD–10 and "MEAT" (and no, we aren't referring to burgers)

ICD–10 code assignment is driven by a particular set of guidelines and includes, in part, the following instructions:[2]

- Primary reported diagnosis should reflect the condition chiefly responsible for the encounter/service provided;
- Secondary (additional) diagnoses may be reported to describe additional conditions managed during the encounter and/or conditions that impacted the care/management;
- Do not code conditions that were not managed at the encounter and did not impact the care/management provided;
- "Do not code conditions that were previously treated and no longer exist" (except for personal/family history conditions that impact care);

- Do not code signs and symptoms of a definitive diagnosis; and
- Do not code differential or unconfirmed diagnoses such as probable, suspected, consistent with or rule out.

The standards for reporting HCC conditions closely align with the instructional guidelines for assigning ICD–10 codes. To appropriately report an HCC condition, the corresponding medical record documentation for the encounter must support the following "MEAT" criteria:[3]

- *M*onitoring of signs, symptoms, disease progression, disease regression
- *E*valuation of test results, medication effectiveness, response to treatment
- *A*ssessment/addressing of ordered tests, discussion, review of records, counseling
- *T*reatment with medications, therapies, or other modalities

Understanding the rules for documentation and reporting ICD–10 codes, including HCC conditions, is a critical first step toward reducing risk and ensuring appropriate reimbursement.

Operational considerations

The HCC reporting process varies amongst providers. There are several factors that impact how HCC conditions are identified and captured for reporting. Variables that may impact the HCC process include electronic health record (EHR) capabilities, quality, and coding resources. We have illustrated a common HCC workflow (Figure 2). However, it is important to understand your organization's HCC capture process, as it could be different.

Common obstacles to achieving HCC accuracy

1. The problem lists themselves may be inaccurate. The lists are often generated from historical data that contain conditions the patient may or may not have.
2. Providers might feel pressured to document and address conditions they are not managing. The financial incentives in the current risk adjustment reimbursement model could lead to upcoding and the temptation to use diagnoses with greater severity to obtain higher reimbursement rates.
3. Providers aren't typically coding experts. The ICD–10 rules are extremely complex, and it is not reasonable to expect clinical providers to also be masters of diagnosis coding.
4. Organizations may have limited coding resources. Encounter volumes often exceed these coding resources.
5. Coders may not have HCC expertise. The rapid expansion of managed care has impacted most organizations. Many coders have been thrown into the role of HCC coding without experience or specific risk adjustment training or certification.

Competing priorities and risks

The risk adjustment reimbursement process has created an environment of competing priorities amongst stakeholders. An organization's desire to "capture" HCCs and risk adjustment reimbursement may pressure providers to document conditions they do not (and perhaps should not) manage and associated quality and practice risks. The balance between revenue cycle, finance, and compliance can be delicate when trying to prevent underreporting of HCCs and lost revenue opportunities with the risk of improper HCC reporting and increased compliance risk. Organizational policies may also impede the ability to correct condition and diagnosis

errors within the health record when identified. Providers should also consider the value of MA plan contracts and participation with risk adjustment reimbursement and the increased cost and resources necessary to maintain an HCC program.

Considering all the enforcement activities and competing priorities, building or maintaining a successful risk adjustment/HCC capture program may feel overwhelming. Regardless of where your organization is in this process, confirming that your program has the right foundation is essential. Forming a risk adjustment/HCC capture committee that includes individuals with expertise in HCC coding, data analytics, compliance, clinical documentation improvement, revenue cycle, and physician leadership to oversee your program is a key step. While there is likely no single solution that will satisfy all stakeholders, there is a better chance for success if you work together.

Recent settlements and enforcement

The publication of OIG audit reports and DOJ settlements is a tremendous resource for compliance professionals. It allows identification of overpayment trends, root causes, and government expectations for performance. Over the last year, OIG has issued more than a dozen risk adjustment audit reports.

Within those audit reports, OIG has identified the following conditions as "high risk" for HCC reporting errors:

- Acute stroke
- Acute heart attack
- Embolism
- Major depressive disorder
- Vascular claudication

OIG reports also outline root causes of specific errors, including:

- Reporting past medical conditions as current;
- Reporting conditions not documented as definitive diagnoses (e.g., probably, suspected, possible);
- Reporting conditions that were documented as definitively ruled out;
- Reporting conditions as "severe" when the documentation specified the condition as mild;
- Reporting of current conditions for which the documentation did not reflect any active treatment or impact care; and
- Reporting conditions not documented in the medical record.

A closer look into a provider settlement

Consistent with current trends, in a 2021 settlement with a healthcare provider, the government alleged unsupported diagnosis codes were knowingly submitted for beneficiaries, resulting in inflated payments. It was also alleged that once aware of the problem, the provider "failed to take sufficient corrective action to identify and delete additional unsupported diagnosis codes."[4] The government further alleged that the provider:

- Prepopulated beneficiaries' medical records with diagnosis codes before the patients were seen or

diagnosed;

- Allowed coders to review medical records and add codes that the provider "missed" or change the physician codes to more severe conditions;
- Prohibited internal auditors from deleting false diagnosis codes; and
- Ignored red flags and concerns raised by auditors and treating physicians.

As a result of the settlement, the provider entered into a CIA. The CIA—the first specific to risk adjustment reimbursement—gives clear insight into the government's expectations and can be used as a gold standard for other organizations. Under the CIA, the organization must engage an independent review organization to perform documentation and coding reviews. These reviews will determine whether the diagnosis data submitted was supported, correctly documented, and coded per ICD–10 coding guidelines. For any errors identified, the CIA also requires that basis for the error be identified and includes the following:

- Understanding controls that are in place to ensure HCCs submitted are appropriately documented and coded;
- Reviewing systems and processes that may have generated the unsupported diagnoses (e.g., improper use of an electronic problem list);
- Identifying any problems or weaknesses that may have resulted in the unsupported diagnosis; and
- Providing recommendations on suggested improvements to the system(s), process(es), and controls.

Auditing and monitoring

Routine auditing of risk adjustment coding is a must. Consider conducting documentation and coding reviews of MA beneficiary encounters with at least one reported HCC condition. Also, consider larger, focused reviews of conditions flagged as high risk by OIG. Prior to initiating a review, establish how you will define an error, as many ICD–10 codes map to the same HCC payment category. Will you count any ICD–10 difference as an error, or only those that impact payment?

When conducting reviews of HCC coding, address whether:

- The documentation MEATs the criteria to support the ICD–10 (HCC) reported;
- The ICD–10 codes were assigned to the highest level of specificity;
- All conditions managed/treated during the encounter were captured; and
- There is a documented assessment and plan for each presenting problem(s).

Ensure that errors and improvement opportunities are communicated to your providers and that your coders and processes are appropriately updated to prevent future errors.

Recommendations

1. Take a critical look at your HCC process. How are HCC conditions assigned? Who is responsible for assigning them? What controls are in place to ensure appropriate reporting?
2. Review your documentation and coding policies. Do you have HCC-specific policies? If not, formal policies

and procedures addressing appropriate documentation and capturing HCC conditions should be created.

3. Audit for accuracy.
4. Compare your audit findings to your MA plan provider reports.
5. Educate providers, coding, and administrative staff.
6. Have appropriate corrective action and mitigation processes for identified errors and repeat offenders.
7. Be mindful of the newest audit reports, settlements, and compliance trends!

Takeaways

- As a top enforcement priority, risk adjustment payment accuracy is not only a payer problem.
- Providers are responsible for the accuracy of all diagnoses they report.
- All reported hierarchical condition coding (HCC) conditions must "MEAT" (monitoring, evaluation, assessment, treatment) documentation requirements.
- Improper HCC reporting may be subject to payment recoupments, False Claims Act liability, and corporate integrity agreements.
- The time to evaluate your risk adjustment/HCC capture program is now.

1 42 U.S.C. § 1395w-23(a)(1)(C); 42 U.S.C. § 1395w-23(a)(3); 42 C.F.R. § 422.308(c).
2 Centers for Medicare & Medicaid Services, "ICD-10-CM Official Guidelines for Coding and Reporting FY 2023," updated April 1, 2023, https://www.cms.gov/files/document/fy-2023-icd-10-cm-coding-guidelines-updated-01/11/2023.pdf.
3 Monica M. Watson, "Documentation and Coding Practices for Risk Adjustment and Hierarchical Condition Categories," *Journal of American Health Information Management Association* 89, no. 6 (June 2018): extended online version, https://bok.ahima.org/doc?oid=302516.
4 U.S. Department of Justice, Office of Public Affairs, "Sutter Health and Affiliates to Pay $90 Million to Settle False Claims Act Allegations of Mischarging the Medicare Advantage Program," news release, August 30, 2021, https://www.justice.gov/opa/pr/sutter-health-and-affiliates-pay-90-million-settle-false-claims-act-allegations-mischarging.