Office of Inspector General Toolkit

On December 14, 2023, the U.S. Department of Health and Human Services Office of Inspector General (OIG) released comprehensive guidance to help decrease improper Medicare Advantage (MA) payments through the identification of high-risk diagnosis codes. The OIG toolkit contains data analyses that can be used to identify high-risk conditions consistently submitted to the Centers for Medicare & Medicaid Services (CMS) as well as information about the circumstances under which these diagnosis codes could be miscoded.

Under the MA program, CMS makes payments each month to MA organizations based on two principal components:

- Base rate: Determined by the relationship between the county-level benchmark and the plan bid. CMS compares each bid to a specific benchmark amount for each geographic area to determine the base rate that the MA organization is paid for each of its members.
- Risk score: CMS calculates risk scores based on the member's health status using diagnosis codes that the member received from an acceptable provider type for one year and demographic characteristics (such as age, gender, disability status, etc.). This process results in a personalized risk score for each member, which CMS calculates every year.

If the diagnosis codes used for the member are incorrect, the hierarchical condition categories (HCC) are unvalidated causing an incorrect risk score calculation; consequently, CMS would overpay the MA organization.

After a member receives a medical service, the provider generates a claim for payment from the MA organization. These claims include services that can be used for risk adjustment purposes (physician, outpatient, and inpatient) as well as claims whose services are not used for risk adjustment purposes (home health services, durable medical equipment, x-rays, etc.). The OIG developed a computerized program to access and analyze these claims data to identify services that contain the risk-adjusted diagnoses and how often those diagnoses were submitted throughout the service year.

The OIG Analysis entries in this newsletter are quoted from the OIG Toolkit available at OIG.HHS.gov/OAS/Reports/Region7/72301213.pdf.

High-Risk Diagnosis Groups

Acute Stroke

OIG Analysis

"For the acute stroke high-risk group, we focused on enrollees who received one acute stroke diagnosis (that mapped to the HCC for Ischemic or Unspecified Stroke (HCC 100)) on one physician claim during the service year but did not have an acute stroke diagnosis on a corresponding inpatient or outpatient hospital claim. In these instances, a diagnosis of history of stroke (which does not map to an HCC) typically should have been used."

Example Diagnosis Codes in OIG Analysis (not exhaustive list)

- I63.00 Cerebral Infarction (CI) due to thrombosis of unspecified precerebral artery
- I63.033 Cerebral infarction due to thrombosis of bilateral carotid arteries
- I63.211 Cerebral infarction due to unspecified occlusion or stenosis of right vertebral artery
- I63.89 Other cerebral infarction

CMS HCC Categories

- Model V24: HCC 100 Ischemic or Unspecified Stroke
- Model V28: HCC 249 Ischemic or Unspecified Stroke

Additional Information

An acute stroke also known as cerebrovascular accident (CVA) represents a medical emergency that requires prompt medical treatment. The acute episode of stroke is rarely coded in the outpatient office setting.

- Any remaining neurological deficits are considered a sequela/late effect and should be coded from category **I69-Sequelae of cerebrovascular disease**.
- Without remaining neurological deficits, assign code **Z86.73 Personal history of transient ischemic attack (TIA), and cerebral infarction without residual deficits** in conjunction with **Z79.01 Long term (current) use of anticoagulants** to describe any associated long-term use of anticoagulant therapy.

Acute Myocardial Infarction

OIG Analysis

"For the acute myocardial infarction high-risk group, we focused on enrollees who received one diagnosis (that mapped to the HCC for Acute Myocardial Infarction (HCC 86)) on only one physician or outpatient claim during the service year but did not have an acute myocardial infarction diagnosis on a corresponding inpatient hospital claim (either within 60 days before or 60 days after the physician or outpatient claim). In these instances, a diagnosis indicating a history of myocardial infarction (which does not map to an HCC) typically should have been used."

Example Diagnosis Codes in OIG Analysis (not exhaustive list)

- I21.09 ST elevation (STEMI) myocardial infarction involving other coronary artery of anterior wall
- I21.3 ST elevation (STEMI) myocardial infarction of unspecified site
- I22.0 Subsequent ST elevation (STEMI) myocardial infarction of anterior wall
- I22.9 Subsequent ST elevation (STEMI) myocardial infarction of unspecified site

CMS HCC Categories

- Model V24: HCC 86 Acute Myocardial Infarction
- Model V28: HCC 228 Acute Myocardial Infarction

Additional Information

An acute myocardial infarction (MI), commonly called heart attack, occurs when the blood flow that brings oxygen to the heart muscle is severely reduced or cut off completely. If blood flow is not restored promptly, an MI can cause permanent heart damage or death. A myocardial infarction described as acute or with a duration of four weeks (28 days) or less is classified in category **I21.- Acute myocardial infarction**. If the MI is older than four weeks (28 days) and does not require further care, assign diagnosis code I25.2 Old myocardial infarction. When the patient continues to receive care related to the MI, the appropriate aftercare diagnosis code should be assigned.

Embolism

OIG Analysis

"For the embolism high-risk group, we focused on enrollees who received one diagnosis that mapped to either the HCC for Vascular Disease or to the HCC for Vascular Disease With Complications (Embolism HCCs) (HCCs 107 & 108) during the service year but did not have an anticoagulant medication dispensed on their behalf. An anticoagulant medication is typically used to treat an embolism. In these instances, a diagnosis of history of embolism (an indication that the provider is evaluating a prior acute embolism diagnosis, which does not map to an HCC) typically should have been used."

Example Diagnosis Codes in OIG Analysis (not exhaustive list)

- I26.99 Other pulmonary embolism without acute cor pulmonale
- I82.449 Acute embolism and thrombosis of unspecified tibial vein
- I82.B11 Acute embolism and thrombosis of right subclavian vein
- I74.9 Embolism and thrombosis of unspecified artery

CMS HCC Categories

Model V24

- HCC 107 Vascular Disease with Complications
- HCC 108 Vascular Disease

Model V28

- HCC 264 Vascular Disease with Complications
- HCC 267 Deep Vein Thrombosis and Pulmonary Embolism

Additional Information

Embolism and thrombosis are both blood clots that reduce or block blood flow inside the blood vessels.

A pulmonary embolism is a clot that lodges in the lungs, blocking the pulmonary arteries and reducing blood flow to the lungs and heart. Pulmonary embolic disease can be acute or chronic. Pulmonary embolism is commonly treated with anticoagulants (e.g., Coumadin) to dissolve the clot and prevent new ones. If the pulmonary embolism has completely resolved and the anticoagulants are prescribed for prophylactic treatment, assign diagnosis code **Z86.711 Personal history of pulmonary embolism** in conjunction with **Z79.01 Long term (current) use of anticoagulants to describe any associated long-term use of anticoagulant therapy**.

Thrombosis occurs when a blood clot has formed in a vein and/or artery, venous thrombosis, and/or arterial thrombosis. Deep vein thrombosis (DVT) is the most common type. Treatment involves anticoagulants to dissolve the clot and prevent new ones. If the deep vein thrombosis has completely resolved and the anticoagulants are prescribed for prophylactic treatment, assign diagnosis code **Z86.718 Personal history of other venous thrombosis and embolism** in conjunction with **Z79.01 Long term (current) use of anticoagulants** to describe any associated long-term use of anticoagulant therapy.

Cancer

Lung Cancer OIG Analysis

"For the lung cancer high-risk group, we focused on enrollees who received one lung cancer diagnosis (that mapped to the HCC for Lung and Other Severe Cancers (HCC 9)) during the service year but did not have surgical therapy, radiation treatments, or chemotherapy drug treatments administered within a 6-month period either before or after the diagnosis. In these instances, a diagnosis of history of lung cancer (which does not map to an HCC) typically should have been used."

Breast Cancer OIG Analysis

"For the breast cancer high-risk group, we focused on enrollees who received one breast cancer diagnosis (that mapped to the HCC for Breast, Prostate, and Other Cancers and Tumors (HCC 12)) during the service year but did not have surgical therapy, radiation treatments, or chemotherapy drug treatments administered within a 6-month period before or after the diagnosis. In these instances, a diagnosis of history of breast cancer (which does not map to an HCC) typically should have been used."

Colon Cancer OIG Analysis

"For the colon cancer high-risk group, we focused on enrollees who received one colon cancer diagnosis (that mapped to the HCC for Colorectal, Bladder, and Other Cancers (HCC 11)) during the service year but did not have surgical therapy, radiation treatments, or chemotherapy drug treatments administered within a 6-month period before or after the diagnosis (Table 6.1). In these instances, a diagnosis of history of colon cancer (which does not map to an HCC) typically should have been used."

Prostate Cancer OIG Analysis

"For the prostate cancer high-risk group, we focused on enrollees who were 74 years old or younger and received one prostate cancer diagnosis (that mapped to the HCC for Breast, Prostate, and Other Cancers and Tumors HCC 12)) during the service year but did not have surgical therapy, radiation treatments, or chemotherapy drug treatments administered within a 6-month period before or after the diagnosis. In these instances, a diagnosis of history of prostate cancer (which does not map to an HCC) typically should have been used."

Example Diagnosis Codes in OIG Analysis (not exhaustive list)

- C34.01 Malignant neoplasm of right main bronchus
- C50.012 Malignant neoplasm of nipple and areola, left female breast
- C18.9 Malignant neoplasm of colon, unspecified
- C61 Malignant neoplasm of prostate

CMS HCC Categories

Model V24
- HCC 9 Lung and Other Severe Cancers
- HCC 11 Colorectal, Bladder, and Other Cancers
- HCC 12 Breast, Prostate, and Other Cancers and Tumors

Model V28
- HCC 20 Lung and Other Severe Cancers
- HCC 22 Bladder, Colorectal, and Other Cancers
- HCC 23 Prostate, Breast, and Other Cancers and Tumors

Additional Information

Malignant neoplasm (cancer) is a disease in which body cells grow uncontrollably, extending beyond the primary site and spreading to other parts of the body.

Generally, cancer is coded as current when:

- A malignancy previously excised requires further active treatment such as chemotherapy, radiation therapy, or adjuvant therapy (active treatment vs. prophylactic treatment).

- Active surveillance involves monitoring or watchful waiting on a confirmed diagnosis over time, attempting treatment only if necessary. The medical record must clearly show the cancer is active.
- The patient has refused any further treatment. The medical record must clearly show the cancer is active.

Monitoring for recurrence of a previously treated and/or excised malignant neoplasm is not considered active treatment. Assign a history of code from subcategories Z85.0-Z85.8-.

Potentially Mis-keyed Diagnosis Codes

OIG Analysis

"For the high-risk group involving potentially mis-keyed diagnosis codes, we focused on enrollees who received multiple diagnoses for a condition but received only one—potentially mis-keyed—diagnosis for an unrelated condition (which mapped to a possibly unvalidated HCC). For example, ICD-10 diagnosis code I720 (which maps to the HCC for Vascular Disease) could be transposed as diagnosis code I270 (which maps to the HCC for Congestive Heart Failure and in this example would be unvalidated). Using an analytical tool that we developed, we identified 3,780 scenarios in which diagnosis codes could have been mis-keyed because numbers were transposed or because other data-entry errors occurred that could have resulted in the assignment of an unvalidated HCC."

Example Diagnosis Codes in OIG Analysis (not exhaustive list) and CMS HCC Categories

Diagnosis Code	CMS HCC Category Model	Potentially Mis-keyed Diagnosis Code	CMS HCC Category Model
G91.0 Communicating hydrocephalus	V24: HCC 51 Dementia With Complications V28: HCC 127 Dementia, Mild or Unspecified	G90.1 Familial dysautonomia [Riley-Day]	V24: HCC 72 Spinal Cord Disorders/Injuries V28: HCC 182 Spinal Cord Disorders/Injuries
I21.3 ST elevation (STEMI) myocardial infarction of unspecified site	V24: HCC 86 Acute Myocardial Infarction V28: HCC 228 Acute Myocardial Infarction	I23.1 Atrial septal defect as current complication following acute myocardial infarction	V24: HCC 87 Unstable Angina and Other Acute Ischemic V28: HCC 229 Unstable Angina and Other Acute Ischemic Heart Disease

Additional Information

The provider's stated final diagnosis must match the electronic medical record (EMR) inserted diagnosis code with its description. Mis-keyed diagnosis codes can result in the assignment of an unvalidated HCC. To identify gaps and discrepancies so they can be corrected, include an ongoing auditing of the documentation in the compliance plan.

For medical conditions to be correctly captured and validated, the medical record must contain evidence of the medical conditions addressed at the time of the encounter. Proactive education and auditing of medical record documentation is essential to ensure accuracy and high-quality documentation to support HCC reporting.

Florida Blue
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References

[Toolkit To Help Decrease Improper Payments in Medicare Advantage (HHS.gov)](#)

Announcement of Calendar Year (CY) 2024 Medicare Advantage (MA) Capitation Rates and Part C and Part D Payment Policies

American Hospital Association (AHA) Coding Clinic

ICD-10-CM Official Guidelines for Coding and Reporting