Your Risk of False Claims Act Violations When Filing Medicare Advantage Claims

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Agenda and Learning Objectives

- Understand the “big picture”: Growth of MA and DOJ enforcement trends
- Review FCA fundamentals
- Types of FCA liability related to MA risk adjustment
- Closer look at the Cigna settlement – why is it important?
- Appreciate the role of whistleblowers in reporting and deterring fraud
- Auditing tips to minimize risk of FCA liability

Concept of Risk Adjustment

- Statistical method most commonly used to reimburse Medicare Advantage plans for the patient-specific risk they are taking on when they enroll a Medicare eligible beneficiary.
- The Medicare Advantage plans are referred to as Medicare Part C and are provided by private/commercial payers (Blue Cross Blue Shield, United Health Care, Aetna, etc.).
- Prior to the introduction and implementation of Risk Adjustment, Medicare Advantage plans were paid a lump sum amount that was calculated based solely on the number of beneficiaries covered by the plan.
- This resulted in variances in payment that did not factor in the changing health of patients.
- Risk Adjustment Applies to EVERYONE!!
  - Even when your organization is not involved in a shared savings or risk based contract, your claims are still being reviewed for Risk Adjustment purposes at the payer level

Overview of Risk Adjustment Claims Process for Medicare Advantage (MA) Plans

Patient Encounter	• The patient is seen by the physician
Physician Documentation	• The physician documents the encounter including current conditions they are managing and any complicating factors
Coding	• The ICD-10-CM codes are selected to the highest level of specificity supported by the documentation
Claim Submission	• The ICD-10-CM codes are entered and billed on the CMS 1500 claim form with the CPT/HCPCS codes for the current date of service
MA Plan Review	• The MA plan reviews the data for accuracy and calculates the risk score
MA Submission to CMS	• The data and risk scores are submitted to CMS for review and adjustments when applicable
Payment Transfer Calculation	• CMS calculates the payment and transfers to the MA plan

Supporting documentation must be representative of the face-to-face visit with the patient and provider and represent the work of the encounter on that specific day

The Big Picture: Collision Between the Practice of Medicine, the Business of Medicine, and a Complex Reimbursement System

- Dramatic increase in MA enrollment and expenditures.
- Presence of large financial incentives to "capture" HCC diagnoses (and provide less care).
- Limited government oversight and accountability.
- Multiple layers of often ambiguous guidance.
- Fallibility of human (and corporate) nature: Increase profits by any means possible.
- Powerful but uncertain new technologies and capabilities (e.g., generative AI).

The Result: Increased privatization of Medicare. Fraudulent billing and overpayments. Inaccuracies in patient medical records. Denial of medically necessary services to MA beneficiaries. False Claims Act risks (and opportunities for whistleblowers).

Medicare Advantage is a DOJ Priority

DOJ Press Release (Jan. 15, 20235):

"The Justice Department continued to pursue cases alleging false claims in the Medicare Advantage . . . Program. As Medicare Part C is now the largest component of Medicare, both in terms of federal dollars spent and the number of beneficiaries impacted, the work of the Justice Department in this area is of critical importance."

PRESS RELEASE

False Claims Act Settlements and Judgments Exceed $2.9B in Fiscal Year 2024

Wednesday, January 15, 2025

For Immediate Release
Office of Public Affairs

Highest Number of Qui Tam Actions Filed in History

Settlements and judgments under the False Claims Act exceeded $2.9 billion in the fiscal year ending Sept. 30, 2024, Principal Deputy Associate Attorney General Benjamin C. Mizer and Principal Deputy Assistant Attorney General Brian M. Boynton, head of the Justice Department's Civil Division, announced today. The government and whistleblowers were party to 558 settlements and judgments, the second highest total after last year's record of 566 recoveries, and whistleblowers filed 979 qui tam lawsuits, the highest number in a single year. Settlements and judgments since 1986, when Congress substantially strengthened the civil False Claims Act, now total more than $78 billion.

Specific MA Risk Adjustment Activities Under Scrutiny

- Chart Reviews
- HRAs and Annual Wellness Visits
- Medical Record Addenda
- Natural Language Processing (NLP)
- Physician Incentives/Disincentives
- EMR queries and physician prompts
- Auditing and compliance programs
- Annual attestations
- Marketing to MA benes
- Payments to steer benes to plans

FCA Settlements Involving MA Risk Adjustment

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2010
U.S. v. Janke (S.D. Fla.) ($22.6 M)

2012 & 2018
U.S. ex rel. Swoben v. SCAN Health Plan (C.D. Cal.) ($319 M)
U.S. ex rel. Swoben v. *Secure Horizons* (C.D. Cal.) ($270 M)

2017
U.S. & State of Florida ex rel. Sewell v. Freedom Health, Inc. (M.D. Fla.) ($32.5 M & CIA)

2019
U.S. ex rel. Nutter v. Beaver Medical Group LP (C.D. Cal.) ($5 M & CIA)

2020
U.S. ex rel. Ross v. Group Health Cooperative (W.D.N.Y) ($6.4 M with GHC; ongoing as to other defendants)

2021
U.S. ex rel. Ormsby v. Sutter Health (N.D. Cal.) ($90 M & CIA)

2023
U.S. ex rel. Helzner v. Complete Physician Services (E.D. Pa.) ($1.5 M)

U.S. ex rel. Wilbur v. Martin's Point Health Care, Inc. (D. Me.) ($22.5 M)

U.S. ex rel. Cutler v. Cigna Corp., et al. (M.D. Tenn.) ($172.3 M & CIA)

2024
U.S. ex rel. Ross v. Independent Health, et al. (W.D.N.Y.) ($98 M)

Multiple Alleged Fraud Schemes Becoming Increasingly Sophisticated Over Time

- Adding HCC diagnoses w/o any basis in record.
- Clinically inaccurate HCC diagnoses.
- Unsupported HCC diagnoses.
- Invalid HCC diagnoses (e.g., diagnoses don't affect treatment, care, or management in service year).
- Pressuring or misleading physicians (e.g., financial incentives or disincentives, required remedial training, coding "parties").
- Failure to correct or delete false or invalid diagnoses.

Accuracy of Diagnoses Supported by Documentation

Risk Adjustment Documentation Tips

- **Highest level of specificity for each code category** do not document and code as unspecified when the specific information is known
- **Co-existing conditions** that are present at time of encounter and affect treatment/management
- **Current status of each individual condition**
- **Identify late effects** is a condition is a residual effect of an illness or injury
- **Do not document as history of** unless a condition is no longer active and is resolved with no further treatment
- **Anatomical site/location**
- **Laterality**
- **Etiology and manifestation**
- **Severity of each illness**
- **Episode of care (initial, subsequent, sequela)**
- **Do use sign/symptoms unspecified if a definitive diagnosis has not been established**

M.E.A.T.

- **Monitoring**
  - Signs and symptoms
  - Disease progression or disease regression
  - Is the specific condition stable, worsening or improving?
- **Evaluation**
  - Documentation of discussion of diagnostic results
  - Statement of response to medication
  - Patient's response to previously implemented treatment
- **Assessment**
  - Patient's current status and/or severity of the conditions
  - Current condition and contributing factors
- **Treatment**
  - The provider's plan for the patient treatment and/or need for follow up

Supporting Documentation for Diagnoses Reported on the Claim

Assessments

1. Encounter for general adult medical examination without abnormal findings - Z00.00 (Primary)
2. Mixed hyperlipidemia - E78.2
3. Other specified hypothyroidism - E03.8
4. Sicca syndrome, unspecified - M35.00
5. Major depressive disorder, recurrent, in remission, unspecified - F33.40
6. Gastro-esophageal reflux disease with esophagitis, without bleeding - K21.00
7. Age-related osteoporosis without current pathological fracture - M81.0
8. Unilateral primary osteoarthritis, left hip - M16.12
9. Encounter for screening mammogram for malignant neoplasm of breast - Z12.31
10. Inconclusive mammogram - R92.2
11. Vitamin D deficiency, unspecified - E55.9
12. Diarrhea, unspecified - R19.7
13. Mild cognitive impairment, so stated - G31.84

Treatment

1. Encounter for general adult medical examination without abnormal findings
Notes: Anticipatory guidance for cardiovascular risk reduction performed. Anticipatory guidance for age appropriate cancer screenings performed. Anticipatory guidance for immunizations health appropriate performed..

2. Mixed hyperlipidemia
Continue Rosuvastatin Calcium Tablet, 10 MG, 1 tablet, Orally, Once a day

3. Sicca syndrome, unspecified
Notes: Stable at this time.

4. Age-related osteoporosis without current pathological fracture
Continue Calcium + D Tablet, 600-200 MG-UNIT, 1 tablet with food, Orally, Twice a day

5. Unilateral primary osteoarthritis, left hip
Notes: Seeing [redacted] next week for eval and discuss, possible replacement.

6. Encounter for screening mammogram for malignant neoplasm of breast
IMAGING: MA MAMM 3D SCREENING BIL

7. Inconclusive mammogram
IMAGING: MA MAMM 3D SCREENING BIL

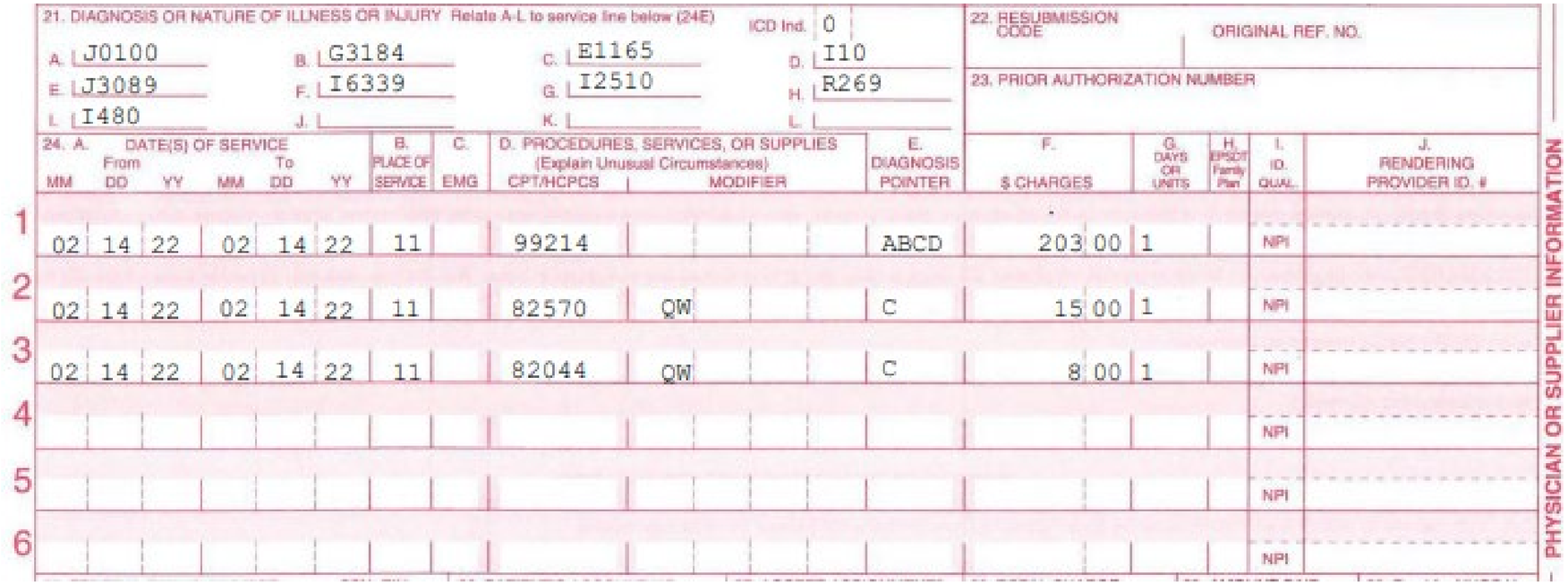
The following risk adjust and do not have a status and/or management documented:

- F33.40 for depressive disorder
- K21.00 for GERD with esophagitis
- E03.8 for hypothyroidism

An active problem list does not support risk adjustment. The note must show how the problems were addressed personally by the treating provider on that date.

Accuracy of the Claims Submission

- Diagnoses reported on the claim form directly impact the risk adjustment process and are required to be supported in documentation.
- Diagnoses submitted are not just “informational only”. There is a direct tie to monies disbursed.



21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) — ICD Ind. 0

A. J0100	B. G3184	C. E1165	D. I10
E. J3089	F. I6339	G. I2510	H. R269
I. I480	J.	K.	L.

22. RESUBMISSION CODE — ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

	24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1	02	14	22	02	14	22	11		99214		ABCD	203 00	1		NPI	
2	02	14	22	02	14	22	11		82570	QW	C	15 00	1		NPI	
3	02	14	22	02	14	22	11		82044	QW	C	8 00	1		NPI	
4															NPI	
5															NPI	
6															NPI	

PHYSICIAN OR SUPPLIER INFORMATION

Whistleblower Risks and Rewards

- Who can be a whistleblower?
- What are the risks?
- Can the risks be mitigated?
- What are the potential rewards?

A shining example of a successful whistleblower: Kathy Ormsby (Sutter Health)

See the interview with Kathy about the Sutter Health case: Fraud in America Podcast, available:

https://www.taf.org/podcasts/whistleblower-kathy-ormsby/.

FCA Liability Related to MA Risk Adjustment

- 1. What is the "claim" in the MA risk adjustment context?
  - Diagnosis data submissions (e.g., from provider to plan, or plan to CMS)
  - Invoices for payment (e.g., from vendor to provider, from provider to plan)
  - Annual attestations to CMS (or to MAOs)

- 2. What determines "falsity" in the MA context?
  - Violation of a legal obligation in a contract, statute, regulation, government guidance, or industry standard.
  - Sources of legal obligations:
    - Contract with CMS
    - Federal statutes, regulations, and guidance
    - Industry standards

Primary Legal Obligations Related to MA Risk Adjustment

Diagnosis codes submitted for payment are valid only if they are ***documented in the medical record*** as a result of a ***face-to-face encounter*** between a patient and a ***qualified provider; during the service year***. *See, e.g., CMS, Medicare Managed Care Manual*, Ch. 7 § 40 (Rev. 118, Sept. 19, 2014).

- Diagnosis codes must be based on documented conditions that exist at the patient visit and that ***"require or affect patient care treatment or management"*** for the visit. ICD-10 Guidelines § IV.J.

- After initial diagnosis, ***chronic diseases "treated on an ongoing basis*** may be coded and reported as many times as the patient ***receives treatment and care for the condition(s)."*** ICD-10 Guidelines § IV.I.

Documented Only as a Result of a Face-to-Face Encounter

History of Present Illness

Mandatory Structured Measures:

BMI Management

Adult - BMI management provided *Yes eats healthy diet, fruits and vegetables, no discussion due to the recent events in his history-bah*

Fall Risk Assessment > 50

Fall Risk Assessment: *No falls in the past year TUG Score less than 14 secs, demonstrates normal gait and mobility*

Community Resources Assessed

Assessed/guide given *Yes Patient evaluated for any need for community resources, no needs identified at this time, Social Determinants of Health addressed*

Do you skip doses or try to stretch out your medication due to concerns about the cost *No*

Are you eating less than you feel you should because ther wasn't enough money for food? *No*

Do you skip healthcare appointments because you don't have a way to get there? *No*

Are you having trouble paying your heat or electric bill? *No*

Are you worried that in the next 2 months, you may not have stable housing? *No*

Do you have a family member, friend or neighbor you'd feel comfortable calling at a moment's notice if you need help? *Yes*

Depression Screening:

PHQ-9

Little interest or pleasure in doing things *Nearly every day*

Feeling down, depressed, or hopeless *More than half the days*

Trouble falling or staying asleep, or sleeping too much *More than half the days*

Feeling tired or having little energy *Nearly every day*

Poor appetite or overeating *Not at all*

Feeling bad about yourself or that you are a failure, or have let yourself or your family down *Not at all*

Trouble concentrating on things, such as reading the newspaper or watching television *Not at all*

Moving or speaking so slowly that other people could have noticed; or the opposite, being so fidgety or restless that you have been moving around a lot more than usual *Not at all*

Thoughts that you would be better off dead or of hurting yourself in some way *Not at all*

Intervention

Depression Screening Findings *Positve*

Follow-Up for Depression *Emotional support assessment*

Score 10. moderate depression.

Assessments

1. Routine medical exam - Z00.00 (Primary)
2. Screening for colon cancer - Z12.11
3. Screening for depression - Z13.31
4. Morbid (severe) obesity due to excess calories - E66.01
5. Body mass index [BMI] 36.0-36.9, adult - Z68.36
6. Essential hypertension - I10
7. Gastroesophageal reflux disease without esophagitis - K21.9
8. ED (erectile dysfunction) - N52.9
9. Stress incontinence - N39.3
10. Prostate cancer - C61
11. Family hx of aortic aneurysm - Z82.49
12. Pulmonary nodule - R91.1
13. History of prostate cancer - Z85.46
14. Current moderate episode of major depressive disorder without prior episode - F32.1
15. Stem cells transplant status - Z94.84
16. Hx of acute lymphoid leukemia in remission - Z85.6

Treatment

1. Screening for colon cancer

Referral To:of Northern Michigan Digestive Health Associates Gastroenterology

Reason:screening colosncopy

Preventive Medicine

Counseling:

Community Resources

Community Resources Assessed *Yes*

Diet: Discussed today.

Exercise: Discussed today.

Examples of conditions that risk adjustment:

- Morbid obesity E66.01
- HTN I10
- GERD K21.9
- Prostate Cancer C61

Does this annual visit support the Risk Adj Codes? NO!

The Cigna Settlement: Three Parts

1. **The FCA Qui Tam (SDNY & MDTN):** "Invalid Diagnoses" Based on Home Visits (2012 – 2019). Settlement Amount: $37M (including $18.5M restitution)

2. **DOJ's Own Investigation I (EDPA):** One-Way Look Chart Review Program (2014-2019). Settlement Amount: $116M (including $58M restitution)

3. **DOJ's Own Investigation II (EDPA):** Inaccurate and untruthful Morbid Obesity diagnoses (2016-2021). Settlement Amount: $19.5M (including $9.8M restitution)

Plus *5 year Corporate Integrity Agreement*!

Relator awarded **22% share** of the Qui Tam settlement: $8.1M

The Cigna Settlement: The "Covered Conduct"

1."Cigna violated the FCA by knowingly submitting to CMS for risk adjustment purposes false and invalid diagnoses of serious, complex medical conditions that:

a) Were ***based only on the home visits*** to Medicare Part C beneficiaries conducted by contracted health care providers;

b) Required specific testing or imaging to be reliably diagnosed, which was not performed; and

c) Were not reported to Cigna by any other healthcare provider who saw the beneficiary during the year in which the home visit occurred (the "Invalid Diagnoses")."

The Cigna Settlement: The "Covered Conduct" (cont'd)

2. "The Government further alleges that the Invalid Diagnoses were ***not supported by the information documented on forms*** completed by the contracted providers and ***did not conform with the [ICD Guidelines],*** as required by applicable federal regulations."

3. "The Government further alleges that Cigna ***falsely certified on an annual basis that the diagnosis data it submitted to CMS was 'accurate, complete, and truthful***.'"

The Cigna Settlement: Cigna's Admissions

To what portion of the "covered conduct," if any, did Cigna admit?

Paragraph 2.g: "According to diagnostic criteria disseminated by Cigna to the vendors, the clinical assessment of some of these diagnoses relies on laboratory evaluation, diagnostic imaging, or other diagnostic testing when making a particular diagnosis for the first time. In many cases, Cigna did not require 360 Program vendors conducting in-home assessments to have the equipment available to conduct such laboratory testing, imaging, or other diagnostic testing when diagnosing these conditions."

Paragraph 2.h: "In thousands of instances, the in-home assessments conducted by 360 Program vendors resulted in diagnoses of Cigna members, and the submission to CMS of resulting risk-adjusting diagnosis codes, that had not been previously reported to CMS by Cigna from any other encounter with a healthcare provider during the year in which the home visit occurred.

Paragraph 2.i: "Based on the in-home assessments of members completed by vendors pursuant to the 360 Program, in many instances Cigna reported to CMS diagnoses for Medicare Advantage Plan members where the 360 forms did not include clinical information that corroborated the diagnoses and did not reflect that the diagnostic testing necessary to make the diagnosis for the first time had been performed."

Best Auditing Practices to Minimize Risk of FCA Liability

- **Implement an audit plan if you have not already.**
  - Risk adjustment reviews go hand-in-hand with fee-for-service audits. Do not down play the diagnosis errors!
  - If a diagnosis is not supported towards billing an E/M and/or procedure it also does not support submission for risk adjustment purposes.
- **Be diligent in your reviews of documentation.** If you are questioning the source of the information have conversations about that internally.
- **Work on educating your providers!**
  - There is a lot of information being pushed by payers that incentivize providers to come close or cross the “compliance line”.
  - Implement educational processes to ensure the providers are aware of the documentation requirements and provide feedback related to their patient encounter notes directly.
- **Work internally to implement policies so everyone in the organization is on the same page.**

Questions?

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