NORWOOD

HCC
Compliance Guide

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LETTER FROM JASON JOBES
2025: The Year of Compliance

If you've been following the news, you've seen the flurry of Office of Inspector General (OIG) audits of Medicare Advantage Organizations (MAO). These came out steadily in 2024, but the end of the year was a flood. And the fines were heavy.

That makes 2025 the year of compliance.

I cover these releases on LinkedIn and elsewhere and the HCC Compliance Guide reprints some of my pieces here. Risk adjustment is a multifaceted concept that touches many areas in healthcare. This report focuses on four key aspects: Legal, technological, financial, and provider documentation.

The **OIG helps reduce fraud, abuse, and waste, preventing and detecting the misuse of public funds and public property.** Their targeted audits typically don't reveal a pretty picture. The fines levied against MAOs have been heavy, and are getting far heavier with the use of extrapolation.

This report is not meant to scare but to demonstrate with powerful, tangible examples that the "wild west" of risk adjustment is over, and a new sheriff has arrived: an era of accuracy and compliance.

That's why **I've also provided a top 10 compliance checklist to help guide your efforts** in what will be a pivotal year for the important but embattled program. Please keep the HCC Compliance Guide as a desktop reference as you navigate the year ahead.

Finally, Norwood specializes in risk adjustment, complete provider documentation and accurate, impactful coding. We're your partners in compliance and financial health. Our mission is simple: To improve the health of hospital's bottom lines, so that you can get back to the business of caring for patients.

We're here to help. I love talking with folks in the field; drop me an email or call anytime.

All the best,

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SCAN ME

TECHNOLOGY

University of Colorado Health $23M Settlement a Red Flag for Over-reliance on Automated Coding

The University of Colorado Health agreed to pay the United States **$23M for false claims tied to E/M levels billed for emergency department services.**

A whistleblower suit against UCHealth was filed alleging that UCHealth used technology inappropriately in assigning E/M levels for emergency department visits.

It is vital to state that this suit does not represent an admission of guilt. The settlement states this "is neither an admission of liability by UCHealth nor a concession by the United States that its claims are not well founded."

The suit says that from 11/1/2017 to 3/31/2021 certain **UCHealth hospitals allegedly automatically coded certain claims for ER visits using CPT 99285.**

This automation was performed whenever providers at UCHealth Hospitals checked a set of the patient's vital signs more times than total hours that the patient was present in the ED, excepting patients who were in the ED for fewer than 60 minutes, despite the severity of the patient's medical condition or the hospital resources necessary to manage the patient's health and treatment.

UCHealth sometimes referred to this coding rule as the "frequent monitoring of vital signs."

TECHNOLOGY

University of Colorado Health $23M Settlement a Red Flag for Over-reliance on Automated Coding

What jumps out to me is the following paragraph from the filing:

"The United States alleges that UCHealth knew that this automatic coding rule associated with **"frequent monitoring of vital signs"** did not satisfy the requirements of the CPT code description for CPT 99285 and did not reasonably reflect the facility resources utilized by the UCHealth Hospitals.

UCHealth received **numerous complaints from its coding employees warning about the use of CPT 99285** based on the automatic coding rule associated with "frequent monitoring of vital signs." UCHealth also received and responded to individual patient complaints, but did not adjust its automatic coding rule systemically.

Further, UCHealth was consistently identified, in reports received from the Centers for Medicare & Medicaid Services, as a **"High Outlier" for its CPT 99285 E/M billing during the Covered Period.**"

At its core technology makes good—or bad—processes move faster.

It's a support mechanism and operates as programmed. In this way a potential imperfection in the algorithm had rippling effects.

Further, when identified there was limited action taken to review and rectify the concern.

Here are 3 things to consider:

- **Evaluate your risk**—level 5 visits are a known risk area. Perform regular reviews of high-risk areas.
- If risk is high, **understand what** processes and technology **may contribute to risk.**
- Ensure there are **adequate feedback loops** to address team member and patient concerns, especially in high-risk areas.

The whistleblower in this case received $3.91M of the proceeds from the settlement.

Reference

Department of Justice, UCHealth Agrees to Pay $23M to Resolve Allegations of Fraudulent Billing for Emergency Department Visits
https://www.justice.gov/opa/pr/uchealth-agrees-pay-23m-resolve-allegations-fraudulent-billing-emergency-department-visits

DOCUMENTATION

Less than One-quarter of High-risk Conditions Reviewed by the OIG Possess Sufficient Documentation

Only 23.9% of high-risk diagnoses reviewed by the OIG have sufficient documentation. Let that sink in a moment.

The OIG conducted a total of 28 targeted HCC reviews between 2022-2024. I have gone through and analyzed each of these reports to summarize the findings to help you know where to focus.

There are 14 conditions that the OIG has reviewed during this period—and their findings are telling, revealing a likely pattern of focus moving forward. Overall, more than 75% of reviewed conditions fail validation.

However, when you look deeper, the failure rates can exceed 80% or even 90% —while other dx seem to hold up well.

Conditions likely to remain in focus include the following:

- **Heart attacks**
- **Strokes**
- **Cancers**
- **Embolisms**

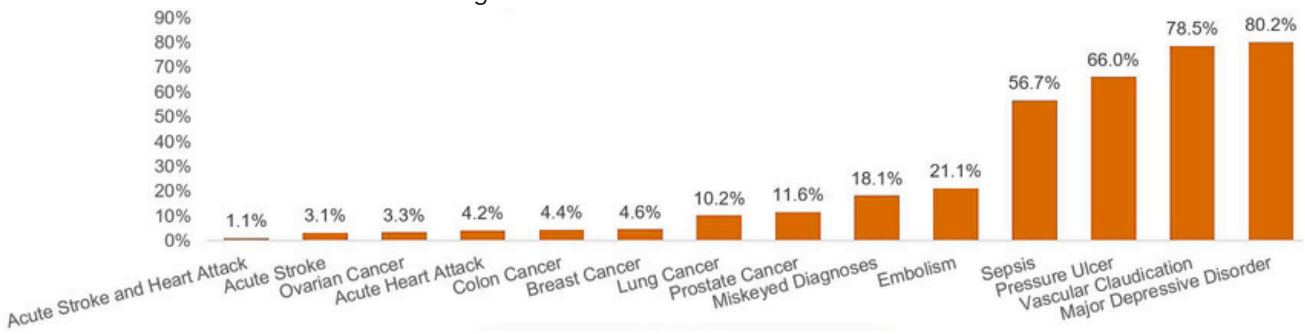
Conditions likely to be **less** of a focus moving forward:
1) **Miskeyed Diagnoses**: ICD-10 resolved a lot of this risk
2) **Major Depression**: Only 20% of this diagnosis failed to be validated. Resources will shift elsewhere with higher error rates
3) **Vascular Claudication**: This was only seen in 1 of the 7 reports released in 2024 and has higher validation rates

New conditions in focus in 2024 reports include the following:
1. **Sepsis**: Present in 3 of 7 reports in 2024
2. **Pressure Ulcers**: Present in 2 of 7 reports in 2024
3. **Ovarian Cancer**: Present in 1 of 7 reports in 2024

High Risk HCCs Validation Rates Reviewed by the OIG

The OIG leverages data submitted by payers to look for risks of unsupported conditions. Their validation rates show how they use the data to identify a larger percentage of conditions without support

Validation Rates by Condition
Targeted Reviews Published 2022-2024



23.9%
Percent of HCCs reviewed were supported by the medical record

LEGAL

Near $100M Settlement includes Individual Responsibility for Fraud

Right before the holidays the Department of Justice dropped a nearly $100M settlement alert with a new twist—individual responsibility.

Compliance isn't just a checkbox or a nice to have—a massive $98M False Claims Act (FCA) settlement, one of the biggest we've seen, proves that it's mandatory, and must be at the top of your 2025 list of priorities.

Buffalo-based Medicare Advantage provider Independent Health and its subsidiary, DxID, agreed to pay up to **$98 million to resolve allegations of submitting unsupported diagnosis codes to inflate risk scores and boost Medicare payments.** The result? An FCA lawsuit and a five-year Corporate Integrity Agreement (CIA).

This is a Compliance Wake-Up Call (use of caps is deliberate) and proves why mid-revenue cycle leaders must prioritize it.

Per the details of the settlement, DxID was employed to retrospectively search medical records and query physicians for information that would support additional diagnoses that could be used to generate higher risk scores. DxID provided these services to Independent Health and other MA Plans —including the likes of Kaiser.

Another interesting detail: Founder and CEO Betsy Gaffney will separately pay $2,000,000 in penalties.

Here's the bottom line: **Medicare Advantage plans rely on accurate data.** Inflated or unsupported codes undermine the system's integrity, leading to steep penalties, reputational damage, and long-term oversight.

What Can We Learn?

Data Accuracy Matters
Whether it's risk scores or coding reviews, ensuring every piece of submitted data reflects reality is non-negotiable. Retrospective coding audits should always align with medical records.

Whistleblower Risks are Real
This case began with a whistleblower claim. Building a compliance-first culture where employees feel empowered to raise concerns internally can help mitigate external legal risks.

Oversight Pays Off
Independent Health's CIA now requires annual third-party reviews. Avoiding this level of enforcement starts with robust internal controls and proactive audits.

Compliance is more than just meeting standards–it's about protecting your organization's reputation, revenue, and ability to serve patients effectively. The FCA is a powerful reminder that the stakes are high, and the government is watching.

Reference
Department of Justice, Medicare Advantage Provider Independent Health to Pay Up To $98M to Settle False Claims Act Suit:

https://www.justice.gov/opa/pr/medicare-advantage-provider-independent-health-pay-98m-settle-false-claims-act-suit

FINANCIAL

Targeted Review of Conditions Leads to Potential 51x Penalty, Thanks to Extrapolation

The OIG's targeted conditions review of Medicare Advantage plans in 2024 are an eye-opener due to the power of extrapolation. Here are two examples.

Triple-S Advantage, LLC

While the penalty assessed against this Medicare Advantage plan was only $297k, the risk found was 51X the penalty. I repeat... 51 times.

The OIG's targeted reviews focused on conditions identified as having an extreme likelihood for overpayment. Nothing is necessarily new in this report, especially since the dates of service were 2015 and 2016 dates of service.

But what is new is the extrapolated amount.

The details:

- Nine different clinical conditions were reviewed for potential over-capture. All nine of these have been on prior reports. However, this is the first time vascular claudication has shown up in a 2024 report. I suspect that is because the dates of service are older and not representative of an increased emphasis on the condition.
- 73% of conditions reviewed failed to have supporting documentation. This number is consistent with prior reviews by the OIG.
- Interestingly, depression and vascular claudication were supported in 93% of the reviews. This is on the high end, and also one of the reasons the OIG has decreased emphasis on these conditions.
- 90% of heart attack, stroke, and cancer patients reviewed failed to have supporting documentation.

The OIG found that in total the overpayment was $297k. However, this is because the sampling was limited by condition, and extrapolated payment penalties were not yet allowed for these dates of service. Had they been, the penalty would have been 51x higher since the OIG identified $15.3M of risk for these conditions.

Now let's look at a case where extrapolation was applied.

FINANCIAL

Targeted Review of Conditions leads to potential 51x Penalty, thanks to Extrapolation

UCare Minnesota

A second report shows the OIG audit results of UCare Minnesota for 2017 and 2018 dates of service. Like prior targeted reviews, this review focused on 10 conditions that often have high levels of unsupported conditions on claims. In fact, **86% of conditions reviewed lacked supporting documentation.**

A few key findings:

- The report found that 254 of the 294 conditions reviews lacked documentation support for the diagnosis placed on the claim.
- These unsupported conditions accounted for $869k in unsupported payments. However, due to extrapolation, the OIG has requested $4.7M in repayments. The OIG originally found $5.7M of risk from high-risk diagnoses.
- The OIG highlighted a new condition category. This is the first review that I have seen ovarian cancer called out. The OIG highlighted this HCC as being at risk when a diagnosis is only on one claim and there is no evidence of treatment within 6 months before or after the date the code is on a claim.
- Sepsis and Pressure Ulcers (both new in 2024 reports) were seen. The trend continues that the failure rate on these is much less than cancer and other acute episodes.

I expect that now that extrapolation is allowed we can expect to see more OIG reviews with larger penalties. If you aren't reviewing your risk then you are susceptible for much bigger takebacks than you anticipated.

Know your data.

References

Medicare Advantage Compliance Audit of Specific Diagnosis Codes That UCare Minnesota (Contract H2459) Submitted to CMS: https://oig.hhs.gov/reports/all/2024/medicare-advantage-compliance-audit-of-specific-diagnosis-codes-that-ucare-minnesota-contract-h2459-submitted-to-cms/

Medicare Advantage Compliance Audit of Specific Diagnosis Codes That Triple-S Advantage, Inc., (Contract H5774) Submitted to CMS: https://oig.hhs.gov/reports/all/2024/medicare-advantage-compliance-audit-of-specific-diagnosis-codes-that-triple-s-advantage-inc-contract-h5774-submitted-to-cms/

TOP 10
HCC Compliance Checklist

	ACTION	ACCOMPLISHED?
1	**KNOW YOUR DATA** Knowing your data is non-negotiable—and not only the data but how to connect the dots. Data tells stories.	☐
2	**REVIEW YOUR TECHNOLOGY / TOOLS** Do not assume your technology vendor has the same standards/tolerance levels as your providers or organization.	☐
3	**UNDERSTAND YOUR PAYER CONTRACTS** Contracts often specify your obligations for reporting, audits, and penalties for non-compliance. Understanding these reduces your risk of financial or legal consequences.	☐
4	**REVIEW MEDICARE ADVANTAGE REGULATIONS** Know the most important extant regulations and keep them bookmarked for handy reference and citation.	☐
5	**STAY INFORMED** New audit reports, payer updates, and changing regulations require constant education and monitoring.	☐
6	**UNDERSTAND YOUR LEVEL OF RISK** You might think that occasional supported dx and small fines are not an issue, but extrapolation has greatly upped the game	☐
7	**USE QUALIFIED, CREDENTIALED CODING/CDI STAFF** Correct coding and compliant queries require nuanced understanding of Official Coding Guidelines and industry regulations.	☐
8	**EDUCATE YOUR PROVIDERS** Reinforce the importance of detailed documentation that supports all submitted diagnoses in bite-sized, applicable chunks	☐
9	**CONDUCT PRE-BILL REVIEWS** Apply added scrutiny and ensure you meet MEAT criteria for high-risk HCCs before claims submission.	☐
10	**CONDUCT RETROSPECTIVE AUDITS** Targeted post-payment reviews can identify and address both unsupported claims and missed conditions, ensuring accurate risk scoring.	☐

NORWOOD

Your Mid-revenue Cycle Problems, Our Solutions

Norwood helps you solve your **most difficult revenue cycle challenges.** Partner with us and become the **hero of your healthcare organization.**

Our suite of services includes:

On-demand Talent

- Facility and Profee Coders
- Clinical Documentation Integrity
- HCC Auditors and Coders
- Trauma Registry Professionals
- Oncology Registry Professionals
- Department Leadership

CDI

Inpatient | Outpatient

Pediatric CDI

Chart Reviews & Compliance

CDI Program Implementations

Inpatient | Outpatient

Data Analysis

Payer Partnerships

Denials Management

Supplemental Diagnosis Submissions

Coding Audits

- CPT
- E/M
- HCPCS
- ICD-10-CM
- ICD-10-PCS
- HCC

MS-DRG

Optimization & Compliance

Managed Services

Outsourced Revenue Cycle Management

Risk Adjustment Factor (RAF)

Optimization & Compliance

Education

Live and Remote/Online

- CDI
- Coding
- Providers
- Outpatient CDI Boot Camp

If you don't see something here, ask. We're all about customization. You wouldn't expect to pluck an EHR off the shelf and use it. We feel the same about our solutions.

What Makes Us Different?

FLEXIBILITY

Whether implementing an outpatient CDI program, staffing your department, or auditing charts, we deliver flexibility with exceptional performance.

PEOPLE

We offer big-corporation resources with a small-company feel—Norwood is privately owned, independent, and values-driven.