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DOJ Penalizes Cigna for Inaccurate Diagnosis Codes

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CMS pays MA plans a fixed monthly amount per beneficiary but adjusts these monthly payments based on patients' risk factors to ensure that MA plans are paid more for beneficiaries expected to incur higher healthcare costs and less for healthier beneficiaries expected to incur lower costs. In order to make these adjustments accurately, CMS collects risk adjustment data, including medical diagnosis codes from MA plans.

The DOJ alleged that Cigna submitted false diagnosis codes in order to inflate its received Medicare Part C payments, then failed to withdraw the inaccurate and untruthful diagnosis data and repay Medicare. Additionally, Cigna falsely certified in writing to CMS that its data was accurate and truthful.

Inflating the Numbers

The DOJ alleged that Cigna operated a chart review program for payment years 2014 to 2019 in which it retrieved medical records (i.e., charts) from healthcare providers documenting services they had previously rendered to Medicare beneficiaries enrolled in Cigna's plans. Cigna retained coders to review those charts to identify all medical conditions that the charts supported and to assign the beneficiaries diagnosis codes for those conditions.

Using these charts, Cigna not only submitted additional diagnosis codes for reimbursement that providers had never indicated, but also did not report when it found unsubstantiated codes that were previously reported and, therefore, required reimbursement to Medicare. Thus, the United States alleged that Cigna used the results of its chart reviews to identify instances where Cigna could seek additional Medicare payments, while improperly failing to use those same results to identify when Cigna was overpaid.

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The United States further alleged that Cigna reported diagnosis codes that were based solely on forms completed by vendors retained and paid by Cigna to conduct in-home assessments of plan members. The healthcare providers (typically nurse practitioners) who conducted these home visits did not perform or order the diagnostic testing or imaging that would have been necessary to reliably diagnose the serious, complex conditions reported, and were in many cases prohibited by Cigna from providing any treatment during the home visits for the medical conditions they purportedly found. The diagnoses at issue were not supported by the information documented on the forms completed by the vendors and were not reported to Cigna by any other healthcare provider who saw the patient during the year in which the home visit occurred. Nevertheless, Cigna submitted these diagnoses to claim increased payments, and falsely certified each year that the diagnosis data it submitted was accurate, complete, and truthful.

Additionally, the United States alleged that Cigna knowingly submitted and/or failed to delete or withdraw inaccurate and untruthful diagnosis codes for morbid obesity for payment years 2016 to 2021 to increase its received Medicare payments. Individuals lacking a body mass index (BMI) of at least 35 were repeatedly diagnosed with morbid obesity so Cigna could retrieve increased payments.

The Settlement

In connection with the settlement, Cigna has entered into a five-year Corporate Integrity Agreement (CIA) with the U.S. Department of Health and Human Services Office of Inspector General. The CIA requires that Cigna implement numerous accountability and auditing provisions. On an annual basis:

- ⇒ Top executives and board members must make certifications about Cigna's compliance measures,
- ⇒ Cigna must conduct annual risk assessments and other monitoring, and

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⇒ An independent review organization will conduct multifaceted audits focused on risk adjustment data.

The civil settlement of the home visit allegations includes the resolution of claims brought under the *qui tam* or whistleblower provisions of the False Claims Act by Robert A. Cutler, a former part-owner of a vendor retained by Cigna to conduct home visits.

Reference: DOJ Website