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Documentation That Stands Up To Audit:

Lessons Learned from a RADV Case Review

What is RADV & Why RADV Matters

34 Million MA Beneficiaries → MA plans paid by CMS based on diagnosis → Documentation must support diagnosis codes → RADV = Can MA plan prove it

2026 CMS Updates

- Accelerated audit strategy (PY2018-2024)
- Sample 35-200 enrollees based on plan size
- 2 records per HCC
- 5 – month submission window
- Approximately every 3 months audit cadence
- Secure new technology, powered by artificial intelligence
- Expanded workforce

Audits Are Intensifying. The Pace is Accelerating. Oversight Is Expanding.

CMS Rolls Out Aggressive Strategy to Enhance and Accelerate Medicare Advantage Audits | CMS
https://www.cms.gov/newsroom/press-releases/cms-rolls-out-aggressive-strategy-enhance-and-accelerate-medicare-advantage-audits

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Audit Scope: Humana Health Benefit of Louisiana

PAYMENT YEARS

2017-2018

FOCUS

Eight high-risk diagnosis groups reviewed

OBJECTIVE

Validate documentation support for submitted diagnosis

IMPLICATIONS

Possible repayment and documentation improvement

SOURCE

OIG Audit A-06-21-02001

Medicare Advantage Compliance Audit of Specific Diagnosis Codes Humana Health Benefit of Louisiana (Contract H1951) Submitted to CMS, A-06-21-02001

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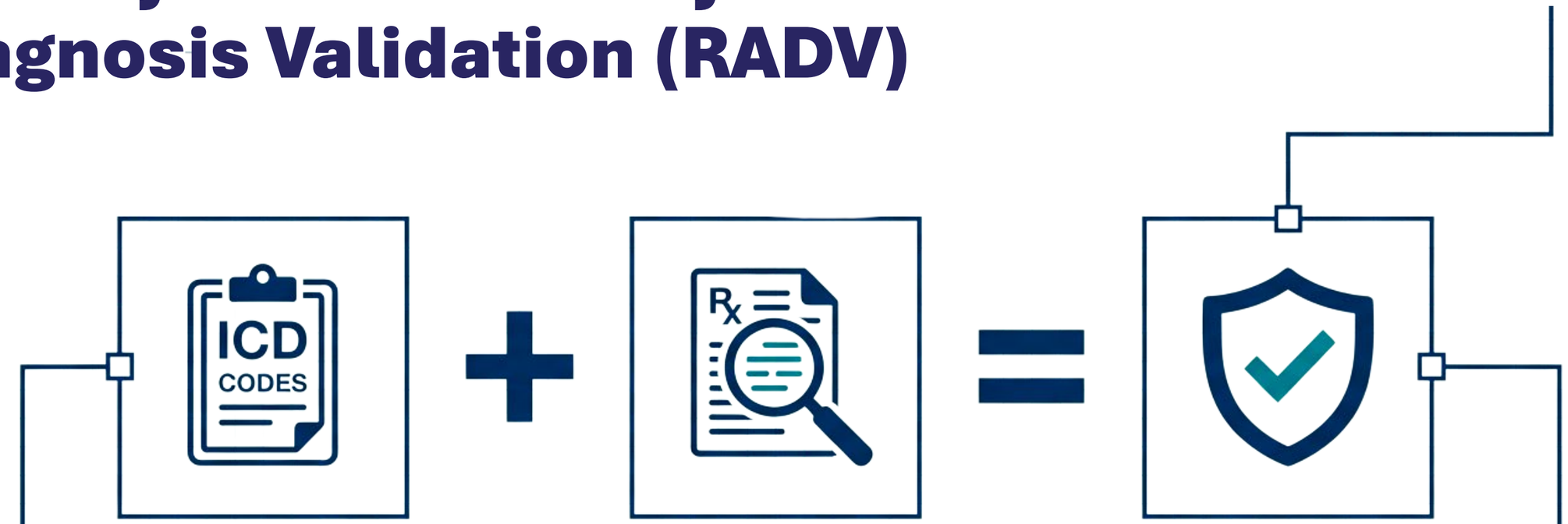
The Objective: Risk Adjustment Diagnosis Validation (RADV)



Submitted Codes:
The diagnosis codes submitted by Medicare Advantage plans that impact risk-adjusted payments.

Clinical Evidence:
Proper documentation that clinically supports the diagnosis

Protected Program Integrity:
Identifying and removing unsupported diagnoses to reduce overpayments.

Think of RADV as turning "We coded it" into "We can prove it."

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High-Risk Diagnosis Groups

Table 1: Sampled Enrollee-Years (Strata for Sample Design Based on High-Risk Groups)

High-Risk Group	Number of Sampled Enrollee-Years		
	Payment Year 2017	Payment Year 2018	Total
1. Acute stroke	11	19	30
2. Acute myocardial infarction	12	18	30
3. Embolism	13	17	30
4. Sepsis	20	10	30
5. Lung cancer	15	15	30
6. Breast cancer	11	19	30
7. Colon cancer	20	10	30
8. Prostate cancer	11	19	30
Total for All High-Risk Groups	**113**	**127**	**240**

Humana provided medical records as support for the selected diagnosis codes associated with 238 of the 240 sampled enrollee-years. 24 We used an independent medical review contractor

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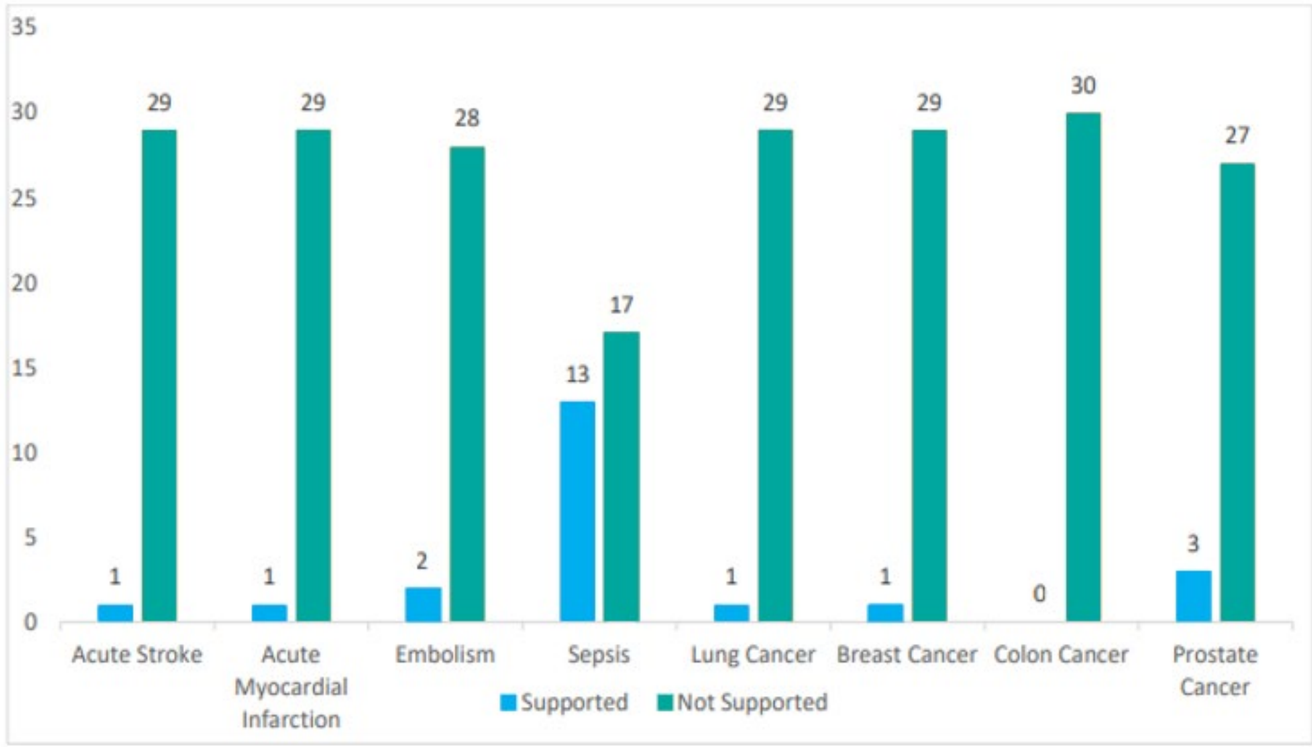
High-Risk Diagnosis Codes Compliance Findings

- Most high-risk diagnosis codes Humana submitted to CMS did not meet the Federal requirements.
- Only 22 of 240 sampled enrollee had validated HCCs.
- 218 enrollee had unsupported or missing records resulting in $553,049 in over payments.

Figure: Analysis of High-Risk Groups



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Estimated Financial Impact

Estimated total overpayments: $10,565,875 for 2017–2018.

Federal regulations limit RADV extrapolation to 2018+, so recommended refund: $5,470,725.

$280,578 for sampled 2017 enrollee-years.

$5,190,147 estimated for 2018.

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Incorrectly Submitted Acute Stroke Diagnosis Codes

Humana incorrectly submitted acute stroke diagnosis codes for 29 of 30 enrollee-years.

24 cases: Medical records showed *history of stroke*, not an acute event.

4 cases: Documentation did NOT support an acute stroke diagnosis (e.g., CVA ruled out; TIA instead).

1 case: Diagnosis came from a provider not acceptable for CMS risk adjustment (radiologist-only report).

Result: HCC for Ischemic/Unspecified Stroke not validated → $53,846 in overpayments.

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Acute Stroke Diagnosis Codes

Important Consideration

Acute Stroke is **rarely diagnosed in outpatient settings** unless the provider is witnessing the event in real time.
Most acute strokes are diagnosed in emergency or inpatient settings with imaging confirmation (CT/MRI).
Do not code “acute stroke” based on patient history or symptoms alone without diagnostic confirmation.

If You Suspect an Acute Stroke During the Visit
If the patient presents with new-onset symptoms (e.g., facial droop, unilateral weakness, slurred speech), and you witness the event or symptoms, you may document:

HPI: Include timing of symptom onset, progression, and associated symptoms.
Physical Exam: Document neurological findings (e.g., facial symmetry, limb weakness, speech changes).
Assessment: Use terms like “acute stroke suspected” or “possible CVA” but do not code as confirmed stroke unless imaging confirms it.
Plan: Immediate referral to ER or call EMS. Document the urgency and rationale.

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Acute Stroke Documentation Examples

Patient with a history of cerebral infarction 3 weeks ago comes in for follow up. She is not experiencing any residual effects.

A: Z86.73 Personal history of transient ischemic attack, and cerebral infarction without residual deficits.
P: Continue routine care; no residual deficits noted today. Reviewed signs/symptoms of stroke recurrence. Follow up as scheduled or sooner if symptoms develop.

Patient presents for a follow up after recently being discharged from a non-traumatic intracerebral hemorrhage with residual dysphagia and monoplegia of lower limb affecting the right side.

A: I69.121 Dysphasia following nontraumatic intracerebral hemorrhage and I69.141 Monoplegia of lower limb following nontraumatic intracerebral hemorrhage affecting right dominant side.
P: Continue current therapy and medications; residual dysphagia and right lower limb weakness remain stable. Refer to speech and physical therapy. Reviewed signs/symptoms of stroke recurrence. Follow up as scheduled or sooner if symptoms develop.

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Acute Stroke Aftercare Visit

ICD-10 code	ICD-10 description
I69	Code Sequela of Cerebrovascular Disease/Stroke (ICD-10 code I69*) anytime post diagnosis of any condition classifiable to ICD-10 codes I60 – I67. ✓ Providers must link the deficit with the stroke to be able to comply with the sequela code. ✓ Use codes from category I69 to specify the residual condition and the affected side of the patient (dominate or non-dominate).
Z86.73	History of Stroke (ICD-10 code Z86.73) ✓ The patient is seen in the outpatient setting after a confirmed diagnosis of a stroke, currently not experiencing a CVA, and shows no residual deficits. ✓ A diagnosis of a transient ischemic attack (TIA) was made and has been resolved.

Late effects

Cognitive	Speech and Language	Hemiplegia and Hemiparesis
Attention and Concentration Memory Deficits Visuospatial and spatial neglect Psychomotor Frontal Lobe and Executive Function Cognitive social or Emotional	Aphasia Dysphagia Dysarthria	Laterality Dominant or non-dominant side
		Other Paralytic Syndrome
	Monoplegia	Identify the type of paralytic syndrome
	Upper or Lower Limb Laterality Dominant or non-dominant side	

Do not document it as an acute stroke (I63.*) at a follow-up visit

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Incorrectly Submitted Acute Myocardial Infarction Codes

Humana incorrectly submitted acute myocardial infarction codes for 29 of 30 enrollee-years.

14 cases: Medical records showed *old MI*, not an acute MI.

7 cases: Acute MI not supported; documentation supported angina (less severe HCC).

5 cases: Only EKG results provided; not interpreted by acceptable provider type.

3 cases: Records did NOT support acute MI at all.

Result: HCC for Acute MI not validated → $39,543 in overpayments.

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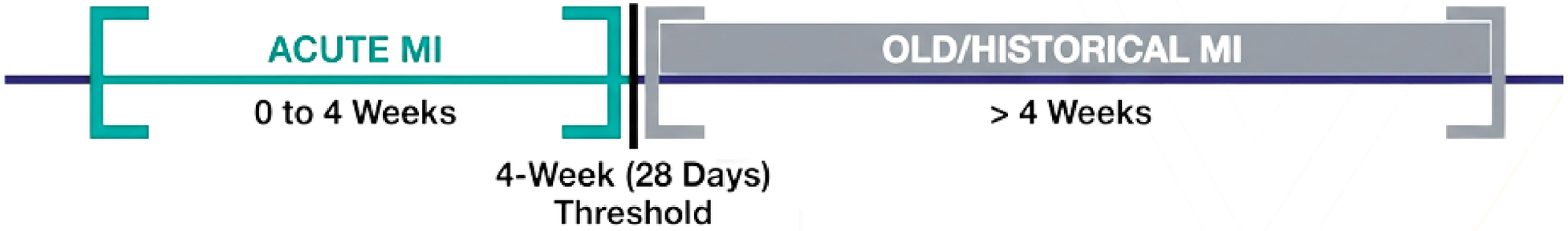
Myocardial Infarction

Diagnostic Precision: Myocardial Infarction (MI)



Avoid Vague Terms:
Never write "recent MI" without providing a specific date. Link symptoms to the MI only if clinically appropriate.

The 4-Week Threshold:
If the MI occurred more than 4 weeks (or 28 days) ago, it is no longer active.

Coding Old MI:
Use code I25.2 for an old or healed MI. The documentation must clearly state the MI is beyond the 28-day window.

Management Focus:
For historical MIs, shift the documentation focus to secondary prevention and cardiovascular risk factor management.

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Time Frame of Myocardial Infarction & Best Practices

Acute myocardial infarction:

- Specified as acute or with a stated duration of 4 weeks (28 days) or less from onset.

Subsequent acute myocardial infarction:

- A new acute Myocardial Infarction occurring within 4 weeks (28 days) of a previous acute MI.

Old Myocardial Infarction:

- After 4 weeks (28 days), an MI is no longer considered acute. Documentation should reflect a past myocardial infarction confirmed by ECG or other investigation, with no current symptoms.

Best practice documentation for Acute Myocardial Infarction (AMI) includes:

Date of onset: Include the date of onset. If more than one infarction occurs within a 4-week (28-day) period, document each date clearly.

Type/Subtype: Specify whether the AMI is ST elevation myocardial infarction (STEMI) or non-ST elevation myocardial infarction (NSTEMI) and include Type 1-5 classification when applicable.

Episode of care: Indicate whether the encounter represents an Initial or subsequent episode of care.

Artery/Vessel Location/Site: Document the involved artery or site, such as left main, left anterior descending, right coronary artery, left circumflex, or anterior/interior wall.

Underlying cause (if known): Identify contributing factors such as atherosclerosis of the coronary arteries, blood clots, sudden severe stress.

Workup/treatment plan: Specify AMI-related interventions, including medications, oxygen therapy, referrals, or surgical intervention.

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Myocardial Infarction Documentation Examples

A patient had a STEMI of the LAD 9 days ago and comes for a follow-up visit. He does not have any chest pain and is compliant with his medications:

A: ICD-10-CM Code: I21.02 – STEMI involving left anterior descending coronary artery. Acute STEMI involving left anterior descending artery 9 days ago; stable with no recurrent symptoms.

P: Continue therapies, cardiac rehab referral, review precautions, follow-up in weeks.

A patient presents for a routine follow up three months after a non-ST elevation myocardial infarction (NSTEMI). The patient reports no chest pain, shortness of breath, or reduced exertional tolerance:

A: ICD-10-CM Code: I25.2 – Old myocardial infarction. History of NSTEMI 3 months ago; asymptomatic; no active MI care.

P: Continue chronic care, lifestyle counseling, routine follow-up.

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Incorrectly Submitted Embolism Diagnosis Codes

Humana incorrectly submitted embolism diagnosis codes for 28 of 30 enrollee-years.

14 cases: Medical records showed *history of embolism*, not an active condition.

11 cases: Documentation did NOT support an embolism diagnosis.

3 cases: Only radiology reports provided; not from acceptable provider types.

Result: Embolism HCCs not validated → $70,942 in overpayments

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Embolism

Specify

Acuity

- Acute embolism/thrombosis: New event, typically within 3–6 months, requiring active treatment (e.g., anticoagulation)
- Chronic embolism/thrombosis: Persistent clot or symptoms beyond acute phase, often confirmed by imaging.
- History of embolism: No current symptoms or treatment; use “personal history of” codes.

Document

Anatomic Location and Laterality

- Be precise: e.g., “left popliteal vein,” “right subsegmental pulmonary artery.”
- Use laterality (right, left, bilateral) when applicable.

Include

Treatment Details

- Start date of anticoagulation
- Duration of therapy
- Medication name and dose
- Monitoring plan (e.g., INR checks)
- If treatment exceeds typical duration (e.g., >3 months for PE), document rationale.

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Best Practices for Embolism

Specify

Acuity

- Acute embolism/thrombosis: New event, typically within 3–6 months, requiring active treatment (e.g., anticoagulation)
- Chronic embolism/thrombosis: Persistent clot or symptoms beyond acute phase, often confirmed by imaging.
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Document

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- Start date of anticoagulation
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Documentation Example for Embolism

Clarity Status

Active: Still under treatment (e.g., warfarin, DOACs).
Resolved: No longer treated, no symptoms.
Chronic: Persistent clot or symptoms confirmed by imaging.

Use Supporting Codes

Z79.01 - Long-term (current) use of anticoagulants
Z86.711 - Personal history of pulmonary embolism
Z86.718 - Personal history of other venous thrombosis and embolism

Example Documentation

A: Acute DVT of left popliteal vein, diagnosed 2 weeks ago. On Eliquis 5mg BID.
P: Continue anticoagulation, monitor for bleeding, follow up in 4 weeks.

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Incorrectly Submitted Sepsis Diagnosis Codes

Humana incorrectly submitted sepsis diagnosis codes for 17 of 30 enrollee-years.

14 cases: Medical records did NOT support a sepsis diagnosis. 11 cases: Documentation an embolism diagnosis.

2 cases: Documentation showed *history of sepsis*, not an active condition.

Result: Sepsis related HCC not validated → $59,625 in overpayments

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Sepsis

1. Determine Sepsis Status at the Visit

Sepsis is an acute condition

- Sepsis may only be coded when the patient is currently septic.
- If sepsis has resolved, it cannot be coded as active in the ambulatory setting.

2. If Sepsis Is Resolved

Document clearly:

- Prior hospitalization dates
- Resolution of sepsis
- Reason for today's visit

Example statement:

- "History of sepsis from pneumonia during hospitalization on [dates]. Sepsis fully resolved."

3. If Patient Is In Recovery/Aftercare Phase

Document

- Ongoing symptoms or organ dysfunction.
- Relationship to prior sepsis episode.
- Current management (labs, meds, follow-up plan)

Example statement:

- Follow-up after recent sepsis hospitalization. Sepsis resolved; persistent renal impairment due to sepsis.

4. If Sepsis is Still Active (rare in outpatient)

Document

- Clear clinical indicators (fever, tachycardia, hypotension, elevated lactate)

Example statement:

- Persistent signs of sepsis. Requires ED Evaluation.
- Active sepsis codes apply only when the condition is current.

5. Strong Documentation Should Include

- Timeline of recent hospitalization.
- Current status (resolved vs aftercare vs active).
- Organ dysfunction or complications
- Treatment, monitoring, and follow-up.
- Link conditions clearly ("… due to sepsis")

This aligns with CMS expectations for adequate outpatient documentation – records must support the reason for the encounter and conditions managed that day.

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Incorrectly Submitted Sepsis Diagnosis Codes

Incorrectly Submitted Lung Cancer Diagnosis Codes	Incorrectly Submitted Breast Cancer Diagnosis Codes	Incorrectly Submitted Colon Cancer Diagnosis Codes	Incorrectly Submitted Prostate Cancer Diagnosis Codes
Humana incorrectly submitted lung cancer diagnosis codes for 29 of 30 enrollee-years. • 17 cases: Records showed *history of lung cancer*, not active disease. • 8 cases: Documentation did NOT support lung cancer; lesser HCC-supported diagnoses existed. • 3 cases: Documentation showed suspected cancer only; outpatient rules prohibit coding unconfirmed diagnoses. • 1 case: No medical records located. • Result: Lung cancer HCC not validated → $194,396 in overpayments.	Humana incorrectly submitted breast cancer diagnosis codes for 29 of 30 enrollee-years. • 27 cases: Records showed *history of breast cancer*, not active disease. • 1 case: Only radiology report provided; not from acceptable provider type. • 1 case: No medical record located. • Result: Breast cancer HCC not validated → $37,643 in overpayments.	Humana incorrectly submitted colon cancer diagnosis codes for all 30 enrollee-years. • 27 cases: Records showed *history of colon cancer*, not active disease. • 2 cases: Documentation did NOT support colon cancer; lesser HCC-supported diagnoses existed. • 1 case: Documentation did NOT support colon cancer at all. • Result: Colon cancer HCC not validated → $66,411 in overpayments.	Humana incorrectly submitted prostate cancer diagnosis codes for 27 of 30 enrollee-years. • 25 cases: Records showed *history of prostate cancer*, not active disease. • 1 case: Documentation did NOT support a prostate cancer diagnosis. • 1 case: Only radiology report provided; not from acceptable provider type. • Result: Prostate cancer HCC not validated → $30,643 in overpayments.

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Common Documentation Pitfalls in Neoplasm Coding

Most Common Errors

- [ ] Coding Active Cancer when it is resolved (Z85.x “history of”)
- [ ] Missing treatment status (e.g., no mention of chemo, remission, or surveillance)
- [ ] Using vague terms like “tumor” or “mass” “suspected” or “rule out”
- [ ] Lack of specificity (e.g., unspecified site, laterality, or histology)
- [ ] Copy-forward errors from outdated notes

Neoplasm Diagnosis Validation Checklist

- [ ] Active vs. History: Is the cancer currently being treated or monitored?
- [ ] Treatment Status: Chemotherapy, radiation, surgery, or surveillance noted?
- [ ] Confirmation: Diagnosis confirmed by pathology, imaging, or specialist?
- [ ] Specific Site: Laterality, organ, and histology if available
- [ ] MEAT Criteria: Evidence of Monitoring, Evaluation, Assessment, or Treatment

Best Practices

- [ ] Be Specific: “Patient with metastatic breast cancer to bone, receiving palliative chemo” is better than “breast cancer.”
- [ ] Avoid Ambiguity: Don’t use “history of cancer” if it’s still active.
- [ ] Use Clear Status Terms: “In remission,” “no evidence of disease,” “active treatment,” etc.
- [ ] Update Problem List: Remove resolved cancers or move to history.
- [ ] Link to Evidence: Reference labs, imaging, or oncology notes when possible.

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Currently malignancy versus personal history of malignancy

Active Cancer

When a primary malignancy has been excised but further treatment, such as additional surgery for the malignancy, radiation therapy or chemotherapy is directed to that site, the primary malignancy code should be used until treatment is completed.

Personal History of Malignancy

When a primary malignancy has been previously excised or eradicated from its site, there is no further treatment (of the malignancy) directed to that site, and there is no evidence of any existing primary malignancy at that site, a code from category Z85, Personal history of malignant neoplasm, should be used to indicate the former site of malignancy.

Example of using Z85

- Codes from subcategories Z85.0 – Z85.5 should only be assigned for the former site of a primary malignancy, not the site of a secondary malignancy.
- Code Z85.89 may be assigned for the former sites(s) of either a primary or secondary malignancy.

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ACTIVE CANCER VS PERSONAL HISTORY

ACTIVE CANCER OR PERSONAL HISTORY	MEAT CRITERIA	GUIDELINES/TIPS
ACTIVE CANCER Documentation supports at least one MEAT criteria	**Documentation must clearly state if:** ✓ Currently receiving chemo, radiation or on Adjuvant (list medication) therapy ✓ Receiving palliative care ✓ It is unresponsive to treatment ✓ Refused treatment ✓ Too frail for treatment ✓ Newly diagnosed/awaiting treatment	**As per ICD 10 CM and Coding Clinic Guidelines:** If **Leukemia** and **Multiple Myeloma** are **in REMISSION**, the appropriate code should be assigned from categories **C90-C95**. **As suggested by Coding Clinic (Q3, 2022):** For patients with **HISTORY** of non-Hodgkin **Lymphoma in REMISSION** "Assign code **Z85.72**, Personal history of non-Hodgkin lymphomas, for history of lymphoma in remission" **Avoid using a "history of" statement if cancer active** **It is EXTREMELY IMPORTANT that the provider clearly document the cancer status accurately** **(As per CMS guidelines an active treatment must be specifically documented):** ▪ **If there is no active treatment a personal history code must be assigned** ▪ **If the cancer is suspected but not confirmed, document the clinical evidence. Do not assign a cancer diagnosis until confirmation is obtained.**
PERSONAL HISTORY Documentation supports at least one MEAT criteria	✓ Cancer removed, no active treatment ✓ Status post (S/P) no active treatment ✓ In remission (except for Leukemia and Multiple Myeloma) ✓ "Resolved" ✓ NED (No Evidence of Disease) ✓ Routine annual follow up with oncologist/urologist/gynecologist	

ICD10 Code	Description (Personal History)
Z85.0/Z85.85-	Personal history of malignant neoplasm (primary sites)
Z85.89	Personal history of malignant neoplasm (primary or secondary)
Z85.0-	Personal history of malignant neoplasm of digestive organs (by site)
Z85.1-/Z85.2-	Personal history of other malignant neoplasm respiratory system (by site)
Z85.3	Personal history of malignant neoplasm of breast
Z85.41	Personal history of malignant neoplasm of cervix uteri
Z85.42	Personal history of malignant neoplasm of other parts of uterus
Z85.44	Personal history of malignant neoplasm of other female genital organs
Z85.45	Personal history of malignant neoplasm of unspecified male genital organ
Z85.46	Personal history of malignant neoplasm of prostate
Z85.72	Personal history of non-Hodgkin lymphomas

Clinical Documentation Guide
Active vs Sequela/History Diagnosis

Condition	When to document as ACTIVE (outpatient/CMS)	ICD-10-CM (ACTIVE)	When to document as HISTORY/SEQUELA	ICD-10-CM (HISTORY/SEQUELA)	Documentation tips
Myocardial Infarction (MI)	Confirmed acute MI — within 4 weeks (≤28 days) from onset; document type (STEMI/NSTEMI) and site.	I21.0–I21.4, I21.9, I21.A1/A9 (specify type/site)	>4 weeks from event; no ongoing acute MI treatment. Use 'old MI'.	I25.2 (Old myocardial infarction)	Capture onset date, type, artery; if >28 days, code as old MI.
Stroke (CVA)	Rarely coded as acute in ambulatory settings unless event is occurring/witnessed → send to ED/EMS.	Acute I63.* typically assigned in hospital setting (not outpatient without confirmation)	After acute phase: code sequelae (residual deficits) or personal history when no deficits.	I69.* (sequelae by deficit); Z86.73 (personal history without residual deficits)	Link deficits to prior stroke (e.g., hemiparesis side/dominance, aphasia).
Cancer (any primary site)	Active malignancy present OR patient is receiving active or adjuvant treatment, palliative care, or on active surveillance/watchful waiting.	C00–C96 by site/type (use specific code)	Primary malignancy excised/eradicated; no active treatment to that site; no evidence of disease.	Z85.xx by former primary site	State status (active, in remission, NED), treatment intent, and site/laterality.
Sepsis	Only when the patient is currently septic with clinical indicators and active management.	A40–A41 (by organism), R65.2* if applicable (per inpatient rules; outpatient rarely appropriate)	Past resolved sepsis or aftercare with no current sepsis; document any ongoing organ dysfunction due to sepsis.	Z86.19 (personal history of other infectious & parasitic diseases); code residual organ dysfunctions as applicable	Document timeline, resolution, and any residual organ dysfunction due to sepsis.
Embolism/Thrombosis (e.g., PE/DVT)	Active acute embolism/thrombosis with current signs/symptoms and treatment (e.g., anticoagulation).	I26.* (PE), I82.* (venous thrombosis) by site/side	Condition resolved (no current acute event); on prophylaxis only; being monitored for prior event.	Z86.718 (personal history of other venous thrombosis and embolism)	Specify acuity (acute/chronic), anatomic site, laterality, treatment start date and plan.

Summary of Incorrectly Submitted Diagnosis Codes

Humana received $553,049 in overpayments for 218 sampled enrollee-years.

Total overpayments for 2017: $280,578.

Total overpayments for 2018: $272,471.

These findings span all eight high-risk diagnosis groups reviewed in the audit.

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Humana’s Policy and Procedures Need Improvement

Audit findings showed that Humana’s processes to prevent, detect, and correct noncompliance with CMS requirements need improvement.

Humana had some preventive efforts:

- Provider education on accurate coding
- Guidance on proper coding for 6 of 8 high-risk diagnosis groups

Humana had some preventive efforts:

- Routine internal medical reviews comparing claims to medical records
- Coder guidance for 7 of 8 high-risk diagnosis groups

However, internal reviews did not focus on the highest-risk diagnoses, contributing to ongoing miscoding issues.

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Audit Recommendations & Humana's Response Summary

Three recommendations were made to Humana:

Refund $5.5 million in estimated overpayments to the Federal Government.

Identify and refund any additional overpayments from similar issues after the audit period.

Strengthen compliance procedures to ensure high-risk diagnosis codes submitted to CMS meet Federal requirements.

Humana's Response:

Humana did not agree with the audit findings or recommendations.

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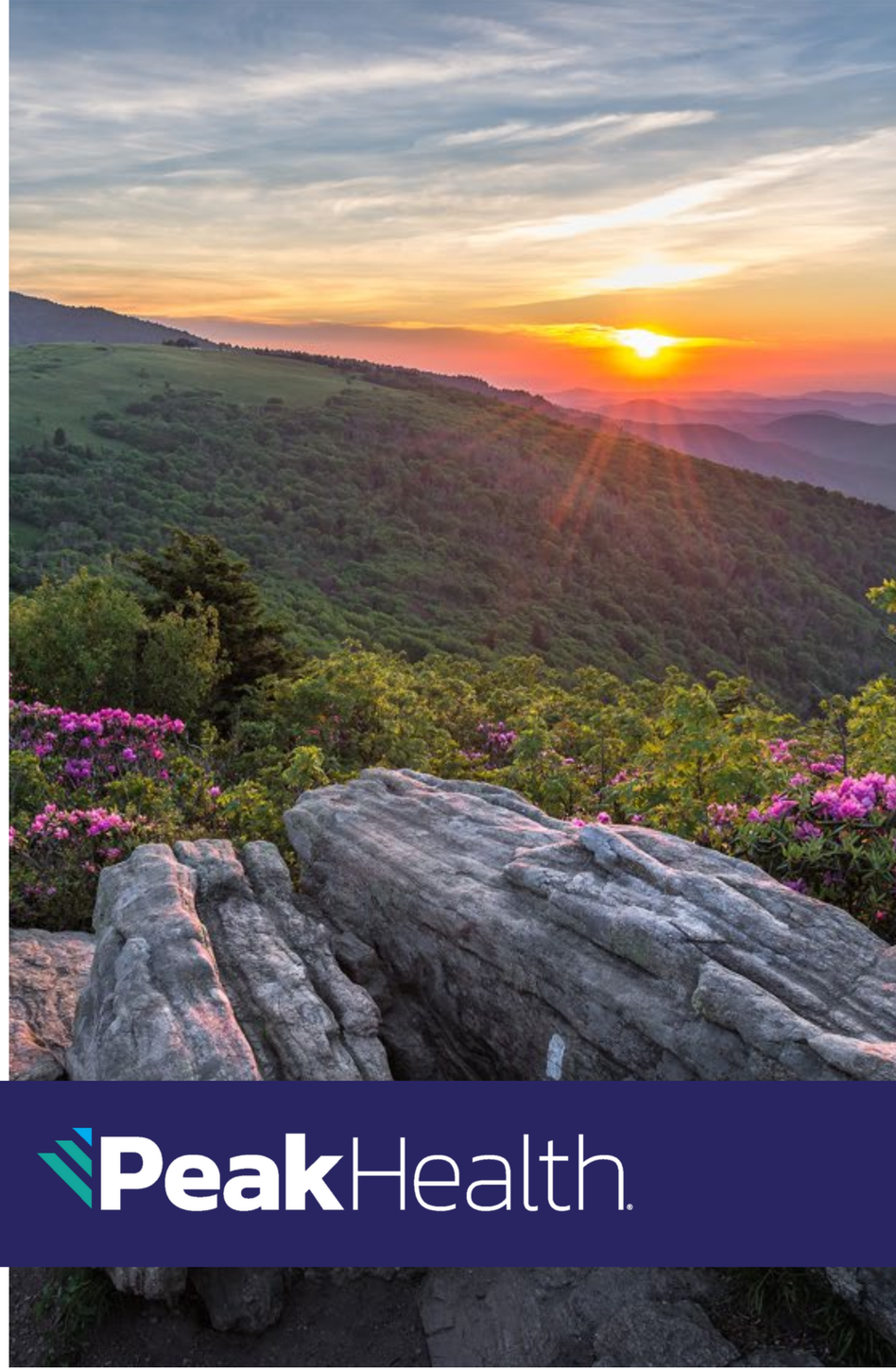
Thank you for your time today. For any questions, please feel free to reach out to:

For inquires/questions please email at:

riskadjustmenthelp@peakhealth.org



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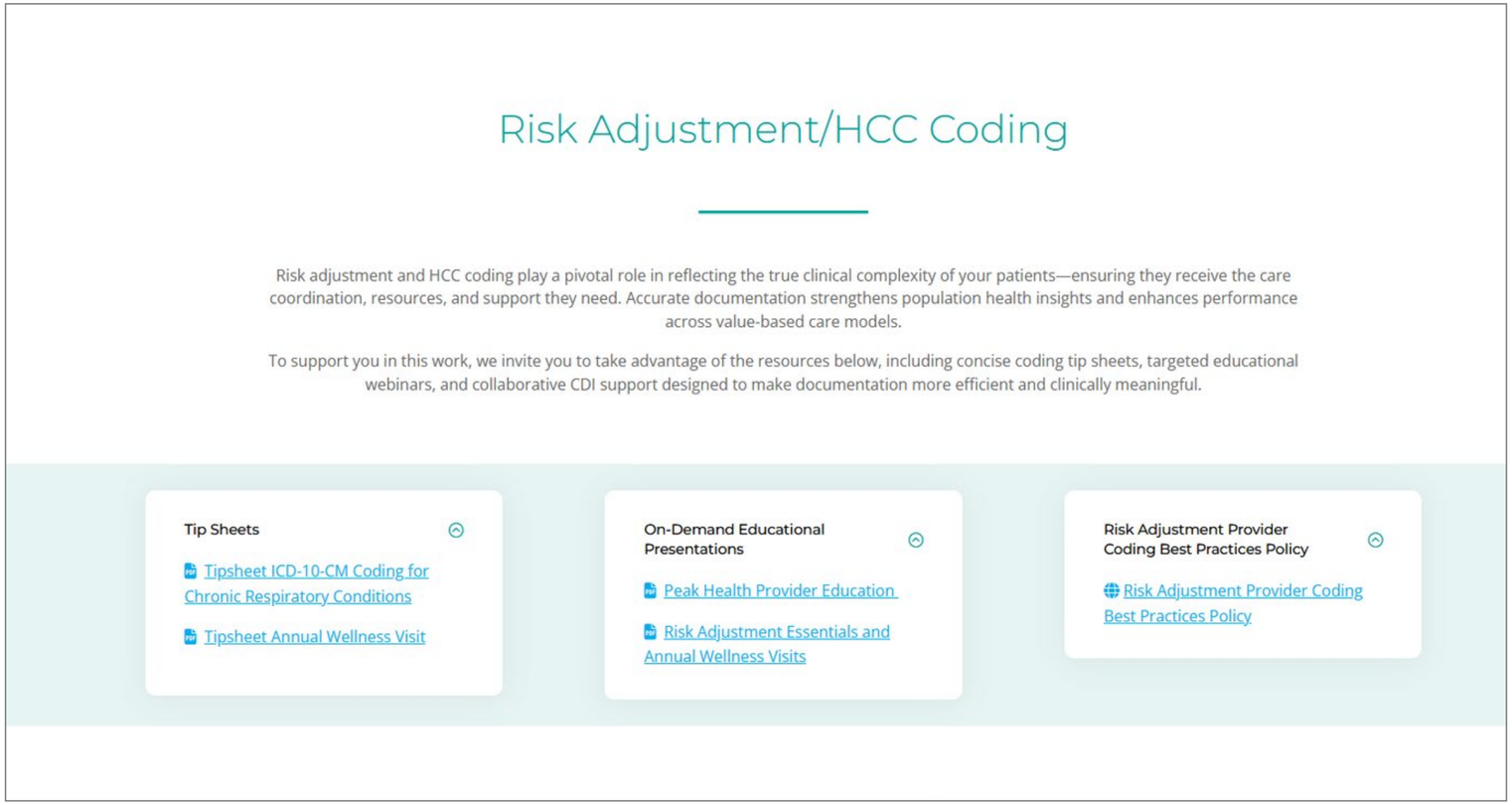
Where to Find the Webinars and Tipsheets

QR Code



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