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Implications of Upcoding on Medicare Fraud

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IMPLICATIONS OF UPCODING ON MEDICARE

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Introduction
Medicare and Medicare Fraud

- Breadth of the problem
  - *Medicare constitute about 20% of health care spending at $572.5 billion (2012)*
  - *National health spending expected $5.0 trillion in 2022, accounting for nearly 20% of GDP*
    - A projected spending growth of 7.4% through 2022
    - Medicare could reasonably cost $1.0 trillion or greater by 2022 ($100 billion in fraud & abuse alone)
- Fraud and abuse account for 3% to 10% of Medicare spending or $70 to $234 billion dollars annually

Introduction

- No measure available to evaluate the precise scope of healthcare fraud
- Efforts have increased detection and prevention of Medicare fraud
- Fraud is often identified through billing and retrospective investigation (audits mostly by red flags given by whist blowers)
- There are many enticing weaknesses within the Medicare system that attracts criminals – lesser penalties than selling illegal drugs

Introduction
Insurance and Medicare Fraud

- The Centers for Medicare and Medicaid Services (CMS) have defined fraud as making false statements to obtain benefit or payment for which no entitlement would otherwise exist.
- CMS has differentiated fraud from abuse by emphasizing that fraud is intentional whereas abuse is the result of poor medical practices (i.e. rounding up 5 minutes in Anesthesia time)
- Medicare/Medicaid Fraud was estimated in 2014 to range from $82 billion to $272 billion, and involved spending of $1.4 billion to combat it

Introduction

- Methods Medicare Fraud and Abuse
  - *Submission of false claims*
  - *Misrepresenting fact to obtain a payment*
  - *Soliciting or receiving payments for referral of Medicare patients*
  - *Billing for supplies or services not received*
  - *Billing for missed appointments*
  - *Altering claim forms*
  - *Falsely using a patients information to receive Medicare services*

Introduction

Methods of Medicare Fraud

- *Kickbacks*
  - Kickbacks in the medical industry have prompted legislatures to enact laws such as the Anti-Kickback Statute and the Physician's Self-Referral Law or "Stark Law" to prevent this occurrence.
  - Kickbacks have included physicians and healthcare providers, medical suppliers, pharmaceutical companies, and even patients.
  - Kickbacks may include:
    - *Physicians receiving payments for referring patients to specific dialysis centers.*
    - *Medical companies providing grants or free medical equipment to physicians that utilize their products.*
    - *Pharmaceutical companies providing incentives or hosting seminars at luxurious resorts for physician that agree to prescribe their drugs.*

Introduction

Types of Medicare Fraud

- *Upcoding*
  - Providers increasing reimbursement by billing for a more complex service or procedure than was rendered and/or diagnosing the patient with a costlier condition than was present.
  - Medicare payments increased by an estimated $10.8 million or 48% between 2001-2010 as a result of upcoding.
  - Attributed reasons for the increase in upcoding:
    - *Electronic health records*
    - *Point and clink boxes to satisfy coding complexity requirements*
    - *Templates to ensure billing is at the highest reimbursement level*

Introduction
Medicare and Medicare Fraud

- Prospective payment system
- Provides reimbursed fixed payment for each Medicare patient for DRG/ RUGS
- Varies based on medical diagnosis/DRG
- Codes are assigned by hospitals and providers.
  - *Increased incidences of upcoding*
  - *Increases Fraud*
- System is set up to pay fast rather than for auditing purposes.

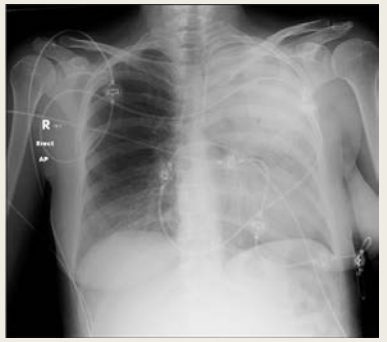
Purpose

- The purpose of this research was assess Medicare fraud and abuse, to determine the financial impact of upcoding on the Medicare system.

Methodology

- Methodology: Qualitative research combining : Literature review complemented with semi structured interview (in IRB process).
- Databases searched: PubMed, EbscoHost, CINAHL, ProQuest, and Google Scholar
- Reputable websites utilized: U.S. Department of Health and Human Services (DHHS), Centers for Medicare and Medicaid Services (CMS), U.S. Government Accountability Office (GAO), Office of Inspector General (OIG), and U.S. Department of Justice (DOJ).
- Articles selected (43) were selected for this study 2005 – 2018

Results: Hospitals



- Herbert and colleagues (2005) found that physicians were upcoding to a staphylococcus aureus or pseudomonas pneumonia code rather than an unspecified bacterial pneumonia code to receive a higher DRG.
- It was also found a 5% increase in pneumonia and influenza hospitalizations due to upcoding.
- In addition, it was reported that physicians were even going as far as to code aspiration pneumonia instead of only pneumonia listed in the patient's chart

Results: Hospitals

Bastani et al., 2015

- Found Medicare reimbursement fraud/ abuse was approximately $200 million per year
- This overpayment was performed from upcoding in two ways
  - Providers over-reporting Present-on-Admission infections (POA). It was reported that 10,000 out of 60,000 annual paid claims for infections that were POA were actually hospital-acquired infections that were upcoded to POA
  - Providers under-reporting Hospital-Acquired Infections (to avoid penalties).

Results: Skilled Nursing Facilities

Brunt & Bowblis, 2011

- Aimed to determine if skilled nursing facilities payment differentials across Resource Utilization Groups (RUGs) affected the probability of which RUG was selected
- The reimbursement associated with each RUG varies positively in accordance with several factors, including the amount of rehab therapy time
- Skilled nursing facilities upcoded by using more therapy minutes to increase their Medicare reimbursement
- This upcoding created $8.6 to $63.2 million in fraudulent Medicare costs, and ultimately wasteful spending by Medicare ~ $32 to $238 per admission at 266,000 admissions.

Results: Payers

Geruso & Layton, 2015

- Aimed to determine if providers manipulate diagnosis codes based on the patient's insurance plan
- Evaluated if patients could generate a different risk score under two insurers, ultimately changing the amount of reimbursement
- Enrollees in private Medicare plans generate 6-16% higher diagnosis-based risk scores than they would under FFS Medicare
- The # of consumers enrolled in a diagnosis-based market where an insurer's payment is based on diagnoses and risk scores increased from none to 50 million from 2003 to 2014, including Medicare
- $10.2 billion in excess payments to Medicare Advantage plans annually ~ $650 per Medicare enrollee per year

Results: Anesthesia Providers

Nie et al., 2016

- Aimed to determine if increased use of anesthesia services for outpatient GI procedures was due to upcoding
- The # of cases with ASA coding increased from 2.9% (23,345 of 812,513 cases) in 2005 to 13.2% (223,852 of 1,697,928 cases) in 2013
- The # of patients coded as high risk increased from 11.6% in 2005 to 18.9% in 2013
- Results indicated upcoding after demonstrating high risk codes more than doubled for all conditions from 2005 to 2013
- Physicians used their clinical discretion to systematically change coding practices because coding a patient as being at high risk in a claim ensures payment of the claim
- Changes in coding for anesthesia risk become more marked when the same physicians were examined over time

Results

- Schonberger and colleagues (2016) studied the relationship between American Society of Anesthesiologists (ASA) physical status scores with age to determine if patients received a higher ASA physical status score when age 65 or greater when having hip, femur, or lower leg fracture repair (Schonberger, Dutton, & Dai, 2016).
- It was determined that there was not a notable increase in ASA physical status score, only a 2% increase, with being 65 or older (Schonberger, Dutton, & Dai, 2016).

Discussion: Summary Results

- Upcoding occurs in many areas of health care
- Physicians or providers seem to be consistent in their upcoding characteristics
- Upcoding had drastically increased the amount of Medicare reimbursement for those health care organizations and providers who commit the crime
- Studies have shown that diagnostic fraudulent upcoding has led to billions of dollars in annual overpayments by the federal government and increased admission rates with certain illnesses
- Hospitals or providers must report hospital acquired infections, so many providers are changing their diagnosis to present on arrival to avoid penalties and ensure they receive federal reimbursement

Discussion

Legislation Against Medicare Fraud

- In 2011 a total of 1,430 individuals were charges with healthcare fraud, a 75% increase from 2008.
- Billing privileges of 4,850 Medicare suppliers and providers have been revoked.
- During fiscal year 2011, combined efforts lead to 977 new investigations of civil health care fraud, 743 criminal convictions, and the largest monetary recovery in a single year totaling $4.1 billion.
- Whistleblower cases increased from 300-400 cases between 2000 and 2009 to more than 700 during 2014.
- Nearly 86% of the $3.5 billion recovered by the department of justice in fiscal year 2015 was attributed to cases filed under the *qui tam* provision.

Discussion: Practical Implications

- Teams created to combat fraud and abuse
- Health Care Fraud Prevention Enforcement Action Team (HEAT)
- DHHS Secretary & US Attorney General
  - *Use specialized technology to crack down on fraud*
  - *2007 $12.5 billion in fraudulent Medicare charges found*
- Estimated out of $1.7 trillion spend on health care spending 3% is fraudulent

Discussion: Practical Implications

Information Technology and Data Sharing used Against Medicare Fraud

- The Healthcare Fraud Prevention Partnership
  - *Created by the Obama administration to combat all categories of insurance fraud.*
  - *Has allowed data to be shared between both private and public insurance sectors that have been used to identify unknown fraudulent schemes and possible prevention strategies.*
- *Predictive Modeling*
  - Relatively new technology incorporated into Medicare claims processing as a tool for fraud prevention.
  - Uses advanced methods to evaluate claims by assigning a score based on sets of characteristics frequently associated with inappropriate claims and fraud (like rounding in 0 and 5 in anesthesia).
  - High scoring claims are manually evaluated for validity.

Discussion

- Predictive Modeling
  - *Fraud detection algorithm made up of multiple variables, or 'predictors' to determine the likelihood of an event, represented by a score of high (likely) to low (unlikely)*
  - *Used widely in credit card fraud detection*
  - *Changes the paradigm from pay & chase to preventative detection*
  - *Estimate $20billion savings in Medicare parts A & B annually*

Questions?