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IMPLICATIONS OF UPCODING ON MEDICARE

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ABSTRACT

The complexity of and amount of funds involved in Medicare has led to a significant increase in the incidence of Medicare fraud. A type of Medicare fraud, upcoding, has contributed to excessive and unnecessary health care spending. Upcoding has been an illegal strategy that some providers have used to increase their Medicare reimbursement for certain conditions. This is accomplished by coding a provided service as a more expensive service than what was actually performed. With the proliferation of upcoding, there has been an astonishing \$12.5 billion in fraudulent Medicare charges since 2007. The fraudulent strategy of upcoding to increase Medicare reimbursement for organizational financial gain has been a common occurrence and has resulted in substantial Medicare overpayments. While solving the problem of upcoding will not eliminate the myriad contributing factors to this enormous healthcare expenditure, it certainly would be a start.

Key Words: Claims, expenditures, Medicare fraud, physician upcoding

INTRODUCTION

Medicare Fraud as defined by Centers for Medicare and Medicaid Services (CMS) has included the following: the submission of false claims or misrepresenting facts to obtain a payment that would not have been paid in any other circumstance, soliciting or receiving payments for inducing rewards for referral of Medicare patients, or generating referrals to certain health services (CMS, 2017). There are four types of Medicare: Part A, B, C, and D. Part A covers the hospitalization of members and Part B covers the outpatient care. Part C has become a little more complicated in that it falls under the Medicare Advantage plan, and it has commonly been a Health Management Organization that contracted to providers for health care needs (Lankford, 2018). There have been many ways that Medicare fraud has been initiated, which can include billing for services or supplies never provided, billing for missed appointments, altering the claim form to receive a larger payment, using a recipient's information for insurance coverage, offering Medicare Part D drug plan not approved, and giving deceptive information on a health care plan so they have participate in it (Berwick, 2015). Medicare Advantage Plans have formulated risk adjustment processes to help to place these patients in a certain class of health risk depending on each patient (William, 2017).

The Prospective Payment System's providers have been reimbursed a fixed payment for each Medicare patient for a particular Diagnosis Related Group (DRG) regardless of how much the hospital actually has spent to treat the patient. The fixed payment, however, has varied by medical diagnosis/DRG, and sometimes CMS has raised the price for certain DRGs. Since the process of assigning codes to patients with the DRG's has become the hospital's responsibility, there could be room for fraud when hospitals can benefit from upcoding (Evbayiro, 2011).

CMS has been established to create and implement Medicare and Medicaid guidelines, and all commercial insurance plans have to follow the guidelines that have been set up for reimbursement of Medicare claims (Boulton, 2006). Medicare claims have been set up and processed based mainly on a fee-for-service basis with the provider offering the service (Daily Herald, 2013). Depending on the severity of policy holder condition, services provided and geographic market have been the factors that determine the amount paid to the provider (Health and Beauty, 2010). Due to the fact that there have been so many Medicare claims going through the processing center, Medicare has 30

days to make a decision on these claims and payments processed to providers. This has led to an increase in the incidence of Medicare fraud and abuse in this payment system (Daily Herald, 2013). It has been estimated that approximately 3% of \$1.7 trillion of health care spending has been fraudulently obtained (Boulton, 2006). In 2008, the federal government stated that improper payments racked up an overwhelming cost of the U.S. Treasury of approximately \$72 billion (Iglehart, 2009).

The Health Care Fraud Prevention Enforcement Action Team (HEAT), formed by the Department of Health and Human Services (DHHS) Secretary, and the US Attorney General have been cracking down on finding solutions to prevent fraudulent billing activities with the use of specialized technology (Health and Beauty, 2010). Also, the Department of Justice and the HHS created a team called the Medicare Fraud Strike Force that began in 2007. This team alone has detected an astonishing \$12.5 billion in fraudulent Medicare charges (United States Department of Justice, 2018).

The purpose of this paper was to assess Medicare fraud and abuse, and determine if strategic upcoding by organizations and physicians would lead to increased Medicare reimbursements, as well as its financial impact of upcoding on the Medicare system.

METHODOLOGY

The methodology of this study consisted of a qualitative literature review. Appropriate research articles and peer-reviewed literatures were located through Marshall University's Ebscohost, CINAHL, PubMed, ProQuest and Google Scholar research databases. The Google search engine was also used to research government and private associate websites such as CMS, HEAT, United States Department of Justice and DHHS.

Key words used in this study for research purposes included 'Medicare fraud' OR 'upcoding' OR 'fraud' AND 'claims' OR 'physician upcoding' OR 'HEAT' OR 'expenditures'. Research articles were searched of articles published between the year(s) of 2005 through 2018. A total of 22 research articles and sources pertaining to Medicare fraud was utilized thus far in the English language for this study. The primary research was completed by JO, KC, SM, and CN and was reviewed by AC who acted as the second reviewer and verified that references met inclusion criteria.

RESULTS

A study by Bastani and colleagues demonstrated that 10,000 out of 60,000 annual reimbursed claims for infections that were Present On Admission (POA) were actually hospital acquired infections that were upcoded to POA in order to avoid financial penalties and actually claim reimbursement (Bastani, Goh, & Bayati, 2015). These researchers reported that this upcoding costed Medicare \$200 million, and concluded that weakly-regulated providers upcode and over-report POAs, leading to a reimbursement burden for Medicare.

Dafny (2005) explored hospital reaction to price increases for a particular DRG; specifically, would hospitals abuse the Medicare system by giving patients higher-paying diagnoses without altering treatment plans (Dafny, 2005). The study confirmed that coding responded to changes in code reimbursement by Medicare for inpatient hospital stays. The author uncovered that hospitals gained an extra \$330 to \$425 million in reimbursement when responded to price changes in the DRG classification system by upcoding patients to DRG codes associated with large reimbursement increases (Dafny, 2005). This study also revealed that while all of the hospitals within the study upcoded in response to the changes in the DRG system, for-profit organizations took advantage of the perceived opportunity to the greatest extent (Dafny, 2005).

Nie, Mattke, Predmore and Hangsheng (2016) conducted a study to ascertain if there was a trend showing an increased use of anesthesia services for outpatient gastrointestinal procedures, and if so, was it truly based on higher patient risk, or was it fraudulent upcoding. The researchers also examined fixed effects into the model using data from 2010 to 2013 to test changes with time in coding practices of the same physicians. It was concluded that coding practices for anesthesia services changed with time, and there was evidence of potential upcoding of patient anesthesia risk. It was found that the proportion of cases with ASA coding increased from 2.9% in 2005 to 13.2% in 2013 (Nie et al., 2016). The proportion of patients coded as having a high risk increased from 11.6% in 2005 to 18.9% in 2013. Their results indicated the potential for upcoding after demonstrating that the predicted probability of being coded as

having a high risk of anesthesia more than doubled for all conditions from 2005 to 2013. The researchers found patterns that revealed the probability for patients with certain medical conditions increased over the specified time frame with no supporting evidence as to why other than monetary gain through upcoding. It was also demonstrated that the odds of patients with similar characteristics being coded as high risk in 2011 were double those in 2010. Further, the changes in coding for anesthesia risk became more evident when the same physicians were examined over time leading the authors to conclude that the physicians used their clinical discretion to systematically change coding practices (Nie et al., 2016).

Geruso and Layton (2015) conducted a research study in which they constructed a model to assess the effects of upcoding in a setting where private health plans compete for enrollees against a public option, and to determine if one individual could generate a different risk score under two insurers, ultimately changing the amount of reimbursement. The number 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 enrollees in Medicare (Geruso & Layton, 2015). It was determined that diagnosis coding has led to billions in annual overpayments by the federal government (Geruso & Layton, 2015). The researchers found that their estimates implied excess payments of around \$10.2 billion to Medicare Advantage plans annually, or about \$650 per Medicare enrollee per year (Geruso & Layton, 2015).

A study done by Brunt and Bowblis (2011) suggested that Skilled Nursing Facilities (SNFs) upcode by using more therapy minutes to increase their Medicare reimbursement. The authors estimated that this upcoding tactic created \$8.6 to \$63.2 million in fraudulent Medicare costs, and ultimately wasteful spending by Medicare (Brunt & Bowblis, 2011). This was equated with \$32.22 to \$237.88 per admission at 266,000 admissions in 2005 (Brunt & Bowblis, 2011). It was also determined that SNFs in higher wage index areas had a greater incentive to upcode.

Goates (2010) studied the relationship between upcoding and types of diseases in the hospital, as well as upcoding and the insurance type. This study included higher or lower reimbursing diseases, and Medicare's PPS or non-Medicare patients. The findings indicated that there was a higher probability in being diagnosed into a higher DRG when the patient was enrolled in Medicare's PPS (Goates, 2010). The evidence proved that a 10% increase in Medicare patients at a hospital escalated the probability of being diagnosed into a higher reimbursing diagnosis by 1.1% (Goates, 2010).

A study by Hebert and colleagues (2005) used the Medicare Provider Analysis and Review (MedPar) files, where each file contained a hospital stay by a Medicare beneficiary. These files were then analyzed for upcoding due to the primary diagnosis of pneumonia or influenza, versus receiving a primary diagnosis with a lower DRG code (Hebert, McBean, & Kane, 2005). It was found that there was a five percent increase in pneumonia and influenza hospitalizations due to upcoding, and that physicians were upcoding to a staphylococcus aureus or pseudomonas pneumonia code rather than an unspecified bacterial pneumonia code to receive the higher DRG (Hebert et al., 2005). Further, the authors revealed that physicians were even going as far as to code aspiration pneumonia when there was only pneumonia listed in the patient's chart (Hebert et al., 2005).

In 2007, it was found that 3.6% of total Medicare part B spending on physician's services was due to unnecessary upcoding by physicians (Brunt, 2011). The author analyzed the outcomes of Medicare part B fee differentials on the upcoding of office visits. It was found that the Medicare part B fee differentials made a largely persuaded physician's Current Procedural Terminology (CPT) coding, and that Medicare's expenses caused by upcoding amounted to 15% of total expenditures for general office visits (Brunt, 2011). In addition, the author determined that the greater the marginal revenue, the higher the probability that a physician chose to use a higher payment code (Brunt, 2011).

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). Ultimately, 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 et al., 2016).

Seiber (2007) investigated South Carolina's Medicare and its state employee's health plan and claimed that its physician office visit expenses had been increasing annually due to upcoding. It was found that upcoding increased billing at a rate of 2.2% each year for both of the programs (Seiber, 2007). In addition, the author determined that the methods of physician billing altered between the two programs, where Medicare visits averaged 1.3% less costly than per visit than the state employee's health plan (Seiber, 2007).

DISCUSSION

The primary purpose of this paper was to assess Medicare fraud and abuse, and determine if strategic upcoding by organizations and physicians would lead to increased Medicare reimbursements, as well as its financial impact on the Medicare system. After reviewing the literature and research studies, the authors of this review conclude that this hypothesis was indeed proven true. Upcoding in the health care field has drastically increased the amount of Medicare reimbursement for those health care organizations and providers that take part in it.

One form of fraud by upcoding occurs when a healthcare organization reports a patient condition as Present On Admission (POA) rather than a hospital acquired complication. CMS has instructed hospitals to self-report these conditions as one or the other, making it possible for them to misreport (Bastani, Goh, & Bayati, 2015). The incentive for hospitals to misreport has been based on the premise that POA conditions have been considered comorbidities, and eligible for reimbursement through Medicare. However, if a hospital would report a condition as hospital acquired, the facility would not be reimbursed for the cost of treatment, and would actually face penalties.

Likewise, from a public relations standpoint, losing money from hospital acquired infections could potentially be detrimental to a hospital's status and reputation. Not only would a hospital or provider risk their reputation by reporting the hospital acquired infection as they should, but they would also lose money in return by Medicare withholding their reimbursement. Many times, hospitals and providers obtain clients from word of mouth, so repute holds extreme importance in the health care field. Therefore, there would be a great deal at stake for correctly reporting events and illnesses as they occur, which would give hospitals or providers incentive to commit fraudulent upcoding.

In addition to upcoding to avoid penalties, results have shown that it has been up to the physician to classify the patients' status within the coding system. This has led to an increase of upcoding a patient's status to high risk in order to receive more money from Medicare, and has proved to be true when dealing with anesthesia providers (Nie et al., 2016). Within this particular study, it was indeed suggested that upcoding tendencies tend to fall within the same physicians who practice anesthesia (Nie et al., 2016). One could speculate that this has held true to all provider specialties including the Emergency Department (Pitts, 2012). Harsher punishments and increased scrutinization for physicians had been suggested as a result of inappropriate billing and upcoding in the Emergency Department (Pitts, 2012).

Furthermore, the motivation to upcode has seemed to spread amongst all areas of the health care field. The CMS system was put in place to help improve quality and value of care, however, with the large sums of money riding on one simple selection of a code, the temptations have proven too great for many providers to unquestionably become greedy. In one study, physicians have gone so far as to code a patient as having staphylococcus aureus or pseudomonas pneumonia rather than simply coding as pneumonia (Hebert et al., 2005). Also, the study found that there was a five percent increase in pneumonia and influenza admission rates due to the act of upcoding (Hebert et al., 2005). Additionally, in another study it was found that the use of diagnosis coding has led to billions of dollars in annual overpayments by the federal government (Geruso & Layton, 2015).

With these implications, there would be no wonder as to why the U.S. has a national health care debt of more than \$3 trillion dollars. With the utilization of the PPS and the use of DRGs, there has been a decrease of HIPPA violations, and the organization increased drastically in the health care industry. However, flaws such as upcoding have been able to fall through the cracks and spread like wildfire within the system creating billions of dollars' worth of debt. Although HEAT and other Medicare justice services are in place to catch Medicare fraud, the importance of staying vigilant in the fight against upcoding remains paramount. Appropriate education for proper billing and coding should be implemented within the health care industry and offered to providers and hospitals in order to stay up-to-date with the evolving health care industry (Pitts, 2012). Limitations of this study included a lack of access to credible databases and only the utilization of eight total databases. Also, with upcoding being a more recent discovery of

Medicare fraud, there continues to be a lack of information on upcoding in the health care field. There were also researchers and publication biases within the studies obtained for this particular analysis.

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