The New Upcoding
Risk Adjustment as a False Claim

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Just like the rest of us, fraudsters will adjust to changes wrought by the Affordable Care Act. There is simply too much money in healthcare to keep the fraudsters from trying to get at it. This article describes one method that fraudsters will use to bilk money from the healthcare system in the future and how the government and compliance officers will try to stop them.

The Change to a Wellness Model

Previously, healthcare providers were paid for each activity they performed as identified by a Current Procedural Terminology (CPT) code. The more CPT codes, and particularly the more complex a CPT code, the more money paid to the provider. For example, office visits with an established patient can be coded at four different levels ranging from the least complex of CPT 99211 to the most complex of 99214. Distinctions among the codes can be judgment calls, although there is a suggested time component. CPT 99213 requires an "expanded problem focused history" with medical decision making of "low complexity" typically lasting 15 minutes with the patient, whereas 99214 requires a "detailed history" with medical decision making of "moderate complexity" typically lasting 25 minutes with the patient. Each level pays $20 or more than the lower level. Fraudulent providers saw the direct relationship – the higher the code, the more the money – and they claimed they performed procedures with higher codes. They defended the higher code by pointing out the allegedly subtle differences between a code of 99214 and a code of 99213. Who's to say that 99214 was not justified and really should have been 99213? Although the difference per patient may not seem like much, the volume of patients makes the money add up. The shorthand for this type of fraud is upcoding. Furthermore, the greater the levels of upcoding, the greater the increase in payment.

Healthcare is now moving away from paying for procedures in favor of rewarding a wellness outcome for the patient. In addition to seeking better patient outcomes, this approach would seem to prevent fraud because it undermines the incentive for traditional upcoding. Using the example above, the complexity of the office visit does not produce more income under a wellness model because payment is based on overall treatment outcomes rather than particular procedures performed. What's a fraudster to do in this brave new world? The answer is: change the kind of upcoding.

The New Upcoding

Although the wellness approach focuses on the outcome to the patient, it also recognizes that the conditions of some patients are more difficult to treat than others. In recognition of these differences, the wellness approach assigns a risk adjustment to the payment made for treating certain medical conditions. Medicare instituted this process for the Medicare Advantage program in 2004. Using actuarial models, the nearly 3,000 diagnosis codes in the International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9) have been linked to 70 groups in the Hierarchical Condition Category (HCC) model. Each group in the HCC model is assigned a different risk adjustment based upon actuarial studies.

This change in payment priorities has prompted medical providers, like physician groups and hospitals, to double check the diagnoses of their patients. When payment was based on procedures performed, the precise diagnosis was not as important. Under the HCC model, selecting an incorrect ICD-9 code can cost the providers increased payments to which they are entitled. For example, assume treatment of an elderly patient suffering from Diabetes Mellitus and a Urinary Tract Infection when the base payment is $800. Under the HCC model, the risk adjustment increases both because it is riskier to treat an elderly patient as well as

CHART 1

Condition/ICD Diagnosis Code	HCC Risk Adjustment (RA)	Demographic RA	Total RA Score	Base	Payment = RA x Base
Diabetes Mellitus ICD 9 – 250.00 Urinary Tract Infection ICD 9 – 599.0	+0.162 +0.0	+0.44	= 0.602	x $800.00	= $481.60

CHART 2

Condition/ICD Diagnosis Code	HCC Risk Adjustment (RA)	Demographic RA	Total RA Score	Base	Payment = RA x Base
Diabetes Mellitus w/Renal Manifestations ICD 9 – 250.40 Urinary Tract Infection ICD 9 – 599.0	+0.508 +0.0	+0.44	= 0.948	X $800.00	= $758.40

because it is treating a patient diagnosed with Diabetes Mellitus. There is no risk adjustment for treating a simple urinary tract infection. Thus as shown in Chart 1, the payment would be $481.60.

If, however, the patient should have been diagnosed with Diabetes Mellitus with Renal Manifestations, that change would produce a payment of $758.40 as shown in Chart 2.

By adding other appropriate complications, the reimbursement amounts could continue to increase for legitimate providers.

The fraudulent path is clear: upcode the patient instead of the procedure. Fraudsters will follow the lead of legitimate providers by double checking their patients to ensure a greater payment because a patient is suffering from chronic conditions. After all, who's to say that the patient in this hypothetical is not showing renal manifestations? Not only that, but ICD-9 will soon be changed to ICD-10, which has even more codes and differentiations that will affect the HCC model. This means the opportunities for upcoding will only increase.

The Federal Response

The federal government will attack this kind of fraud through data mining, that is, by using computers to identify a provider, known as an "outlier," who treats an unusually large number of patients with high risk adjustments. Focusing on an outlier, investigators will collect documentation from medical files by, for instance, using a subpoena or Civil Investigative Demand, or, in more extreme situations, by execution of a search warrant. The government also will examine how patients have been diagnosed by other providers, and what subsequent providers report about the patients' condition. The government will interview nurses, office staff and patients in its attempt to evaluate the diagnoses made by the outlier. These interviews generally begin informally, with agents meeting at the homes of those being interviewed. If the investigation reveals potential fraud, the interviews can become formal, including depositions or even testimony before a grand jury.

When satisfied that upcoding has occurred, the government can bring a civil lawsuit under the False Claims Act (31 U.S.C. § 3729) that provides for penalties up to $11,000 for each violation of the Act, that is for each false claim submitted. In addition, the violator is required to pay three times the amount of damages sustained by the government, known as treble damages. A variety of criminal charges, such as Health Care Fraud (18 U.S.C. § 1347), also are available.

The Compliance Response

Compliance needs to anticipate the threat posed by the new upcoding under the wellness model and prepare for it. Compliance officers must have unfettered access to the Board, and be provided with the tools to assess the medical necessity decisions on a patient-by-patient and institution-wide basis. Key ingredients to effective compliance in an environment, like healthcare, subject to heavy government regulation are: (a) careful, informed listening, (b) detailed data and chart analysis, and (c) proactive compliance.

Compliance programs need to encourage reporting. Anonymous hot lines and complaint/suggestion boxes provide an opportunity to view the organization from every perspective. Once a complaint or information is collected, it needs to be investigated and evaluated thoroughly. Complaints from any source, whether from patients, nurses or staff, cannot be explained away or, even worse, simply ignored. The complaint evaluation process must be separated from medical decision-making and institutional financial pressures that look for mere billing errors. While not every complaint has merit, those with merit need to be addressed.

Like the government, compliance programs should analyze charts and data. Routine audits of medical charts will provide an objective review of a patient's diagnosis. Just as important, routine chart audits will ensure that the documentation is sufficient to justify the given diagnosis in the event of a challenge by the government. Statistics of the provider should be compared to accepted national data such as National and Local Coverage Determinations (NCD/LCD) from the Centers for Medicare & Medicaid Services.

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