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# Is Upcoding Anesthesia Time the Tip of the Iceberg in Insurance Fraud?

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The Centers for Medicare & Medicaid Services (CMS) defines fraud as making false statements to obtain benefit or payment for which no entitlement would otherwise exist. Medicare and Medicaid fraud was estimated in 2014 to range from \$82 billion to \$272 billion and involved spending \$1.4 billion to combat it.<sup>1</sup> Examples of Medicare fraud include but are not limited to billing for services not furnished, billing for services not necessary, misrepresenting the diagnosis to justify payment, and upcoding.<sup>2</sup> An unknown number of health care professionals, hospitals, and other health care organizations have probably upcoded for many years. For example, it has been reported that 10 000 of 60 000 annual paid claims for infections that were present at admission were actually hospital-acquired infections that were upcoded to present at admission to avoid financial penalties and claim compensation.<sup>3</sup> Examples of Medicare fraud that involves physicians have included cardiologists knowingly submitting claims for consultation services that were not supported by patient medical records and did not meet the criteria for a consultation and endocrinologists who billed routine blood sample collection as critical care blood sample collection.<sup>4</sup>

The question of whether there is anomalous billing in anesthesia care is beginning to be asked by operating room managers, health care administrators, policy makers, and regulators. This question may arise when an anesthesia case seems to take more time to complete than it should.<sup>5</sup> Audits, when conducted, have found that an unusual number of claims end with the digits 0 or 5 as if large numbers of cases start or end on the 5-minute mark. Such a finding serves as a red flag for that practice to undergo an audit.<sup>6</sup> Questions may also be raised because the percentage of patients coded as having a higher anesthesia risk, using the American Society of Anesthesiologists Physical Status Classification System, has increased from 2.9% in 2005 to 13.2% in 2013, mainly because coding a patient's physical status at a higher classification or anesthesia risk in a claim ensures better payment of the claim.<sup>7</sup>

The study by Sun et al<sup>8</sup> provides insight into insurance reimbursement fraud, which is facing the health care industry in general. The problem of rounding time using the digit 5 is addressed explicitly in this study, in which the authors estimated the unusually large numbers of cases with durations that were a perfect multiple of 5 minutes for the recorded anesthesia time in several different types of health care settings with functioning operating rooms.<sup>8</sup> Of a final sample of 6 261 955 anesthesia cases (from 4221 anesthesia practitioners at 931 facilities in the National Anesthesia Clinical Outcomes Registry), 5% of practitioners reported anesthesia times greater in total than what would be expected across university, community, and specialty hospitals. Furthermore, it was found that the greatest differences in expected anesthesia times were in specialty hospitals compared with university hospitals.<sup>8</sup> However, the authors have stressed that their findings should not be interpreted to indicate fraud because fraud involves intent, which could not be determined. Because this study was a retrospective study, the authors could not rule out the alternative but unlikely explanation that the practitioners could be rounding down. The reason for caution by the authors is that the CMS has differentiated fraud from abuse by emphasizing that fraud is intentional, whereas abuse is the result of poor medical practices.<sup>2</sup> This differentiation is important because sometimes the rounding in digits ending in 0 or 5 minutes in anesthesia time is part of the organization culture of operating rooms in which rounding is performed systematically by the operation room circulating nurse along with the anesthesia practitioner. Sun et al<sup>8</sup> recognized this issue as being related to

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institutional factors, which was one of the reasons they performed a 2-step regression analysis; long anomalous times were not sufficient to establish inappropriate discretion.<sup>8</sup>

The uniqueness of the research conducted by Sun et al<sup>8</sup> is that most of the literature in Medicare fraud and health insurance fraud has focused on hospitals, insurers, and other health care settings, but fewer investigations have examined physicians and even fewer analyses have reviewed anesthesia practitioners and their anesthesia billing time. In the scope of overall Medicare fraud, 5% of anesthesia practitioners reporting longer anesthesia time can be considered to be a small rate. However, the intensity of fraud is as important as the incidence of fraud. As health care costs continue to rise, anesthesia practitioners must be good stewards of the time they report and the dollars they seek to collect. Although reporting of inaccurate times may only amount to a few extra minutes per day, the time that accumulates and ultimately the funds associated with this time could result in significant losses to patients, facilities, and insurance carriers, including Medicare and Medicaid. Many of the challenges facing health care today are complex; however, the billing issues discussed in the article by Sun et al<sup>8</sup> could be corrected easily by raising awareness and encouraging more accurate reporting of times.

The US Government Accountability Office roadmap for physicians released in November 2012 has renewed a focus on physician understanding that it is their responsibility to submit accurate claims because they are now being held more accountable with more stringent laws and penalties.<sup>4</sup> In addition, increased auditing of health care professionals by payers and Medicare is now being performed using big data and more complex computer-assisted audit techniques, such as predictive modeling.<sup>9</sup> In the end, the ideal solution is educating and engaging physicians and health care organizations about policies and laws designed to prevent fraud, which would help them to become partners in the mission to protect the funds that are lost because of Medicare fraud.<sup>10</sup> As long as payment drives the practitioner's behavior, it is unlikely that Medicare fraud will decrease. However, with more complex auditing technologies, it will become easier to assess the real breadth of the problem—the iceberg—in anesthesia and other specialties and across the health care industry.

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## ARTICLE INFORMATION

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