# Medical Billing Fraud and Abuse

## Specific issue and background

Healthcare in the USA is a serious issue of concern with the population spending more than 17 percent of the total gross domestic product (Collier, 2015). There is need for healthcare reform in the United States because it is a crucial sector of the economy and at the same time insurance has become very expensive. To understand the reason for the high cost of insurance one must look at the underlying factors and issues of concern. One of the major ethical concern that have been identified is the neglect to inform patients on their financial responsibility in regards to medical insurance payments.

Many health care facilities are utilizing a manual claiming management process which is an administrative challenge on the medical facilities. In the past reimbursement in the healthcare facilities has been done through fee for service model where there is a flat sum for a service model regardless of the procedure the customer has benefited from (Spithoven, 2010). This flat sum model has been in use for the past twenty years in the US and has been criticized for lack of accountability as the model rewards volume over value therefore creating a bloated system. The end result of the high cost in healthcare one would expect that the life expectancy in the US would be higher than in Europe but this is not the cases far. An MRI in the US is four times expensive compared to an MRI done in France despite the costs in the USA (Webster, 2014). Most of these problems are attributed to the manual claim management process as well as the lack of information on financial responsibility which spells collection issues.

## Relevance of the topic to the senior management

Thereis an increase in the financial responsibility through insurance premiums by the patients for the services rendered in a health facility, it is therefore important for the billing department to have a clear responsibility on the collections made (Webster, 2014). In this regard it is the responsibility of the senior management to ensure smooth running of a health facility and more so the collections and billing. The CMS report in 2016 indicated that about 90% of more than 12.7million individuals that participated in that survey chose a high deductible plan as opposed to low deductible plan, this has a danger on the patients financial obligation because the high deductible plan shift the healthcare payment responsibility from the buyer to the consumer (Spithoven, 2010). It is the duty of senior management of the organization to give correct information on these individuals and more the worrying trend has to be stopped, this is why the issue is very important and need to be addressed urgently.

The ethical issue of collection also touches on reimbursement and most claims in the healthcare facilities do not just involve a touch of the button only there must be a clear explanation as to why a denial has been made and the senior management must be fully involved in the procedure and consider the reasons of a case to case basis as opposed to a blanket reason which can be used by the clinical staff. Claims management is a complex process in any healthcare and if not addressed fully will dent the organization image as the non-deserving cases will be considered while the deserving cases will be denied. This process is more of data driven procedure but there is need for senior management to put a human touch to the claims through adding a value based care model.

## **Potential consequences if the issue is not addressed by the organization**

The collection and financial management issues on the services rendered in a healthcare facility has had adverse effects on organizations where it has been ignored. For instance there was an insta med report that was conducted in June which stated that there was an increase in patient financial responsivity in 2015 by almost three quarters, this was according to a report done by McKinsey and company (Collier, 2015). What this means is that the medical facilities expected to collect fifty to seventy percent of the patient’s balance after a visit to the health facility. On the other hand, more than seventy percent of the service provider expected to receive payments from patients not longer than a month. This is a problem of the healthcare not informing customers on their financial responsibility and healthcare payments, in turn they struggled with payments due to high deductible insurance. On the issue of billing especially on claims there were major problems too in that organizations were unable to monitor on the key performance indicators (Collier, 2015). There were issues such as discharged patients but not yet billed and days in accounts receivables. All this mix up was occasioned due to lack of automation on the billing department who were stuck on manual claim management system.

## **Recommended course of action**

I would recommend automation of the medical claims billing system and the issues related to managing denials. Automation has more benefits to both the management and to the patients when it comes to billing and reimbursements, data is retrieved in a timely manner and if there is an issue of concern the management can be able to intervene and give a way forward as fast as possible. Manual claim process has a lot of discrepancies owning to human errors and this goes throughout the system, it is these inaccuracies that automation will eliminate a lot of claim and follow up will be done. The healthcare facility need to simplify patient bills to create understanding through eliminating jargon, there is need for innovation in the billing system to patients.

## **Federal statute**

The federal statue is very clear on healthcare fraud to whoever willingly executes a scheme to defraud a program beneficially wither through wrong information given or lack of any information at all will be deemed to have caused a violation of the act the punishment is a jail term of not more than twenty years or a fine or both (Webster, 2014). The statute continues to note that any money obtained and retained in the program which ought not to have been on their custody is also criminal and will attract a fine. Therefore, discrepancies due to manual claim management cannot be excused under the federal statute. The department of health and human services has a mandate of overseeing the programs of protecting the health of all Americans.

### Ethical concern

There is increase in technology which is equally expensive and this will further stretch the financial responsibilities of patients. Some of the expensive drugs are only partially covered by the insurance and there is widespread lack of coverage on the elderly. This lack of full coverage has led to most pharmaceutical companies finding this area of developing products unattractive financially though clinically beneficial*.*

### Future concerns

There is growing agitation on the Obamacare with 62% of Americans saying they don’t favor it nor the proposal in the congress by the republicans (Spithoven, 2010). All the Americans want federal government to ensure healthcare for all, there is high exclusion in children and the elderly. One of the main problem with the healthcare as through the federal state has been exclusion and more than 37% of Americans feel the government should ensure everybody has access to health insurance (Collier, 2015). There is a gap in information delivery from the health facilities and the patients as well as manual billing system that are tedious and inaccurate which creates dissatisfaction among patients.

There is a projected increase of the elderly and this will require more healthcare which the government may not meet therefore there is need to have restructured healthcare with more private players coming on board. Decision makers have been unable to agree on the way forward on the major healthcare problems facing the country and this need more focus.

## References

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