

# Free research paper on medical billing fraud

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## **Introduction**

The US healthcare system is currently at the state where undoubtedly, it needs to be reformed. According to Dewar (2010), " The concern over the future of health care revolves around three broad issues: cost, quality, and access. As private health insurance declines and the number of uninsured people steadily rise, emerging public consensus is that the system is in need of reform. Gaps in coverage, combined with the upward trend in medical care spending over the past several decades, add to the commonly-held belief that the U. S. healthcare system is in crisis. Many are concerned over access to care for the uninsured and the prospects for continued access for those currently with insurance." In addition, Chris Connover of Forbes wrote that " the U. S. health system needed reform was never in doubt. However, that government-run health care was the answer was never in doubt only in the minds of progressives. And there is no doubt that Obamacare puts us firmly on the path towards government-run health care"(Connover, 2012). According to the Congressional Budget Office, the enactment of Obamacare will bring the cost of healthcare spending down for the federal government. In fact, it's a very little known fact that private companies benefit from the law also. Under Obamacare, families with group income that fall between the 100% and 400% of the poverty line can avail of tax credits that they can utilize in paying for insurance premiums (Obamacare Facts, 2013). Such tax credit may be availed in advance or refunded. These families have no enough money to buy insurance but are considered to have more not to be qualified in the Medicaid. With Medicaid Expansion they can be covered. The federal government offers state government that will have Medicaid

Expansion funding of 100% on the first three years and 90% on the succeeding years. Thus the dependence on programs such as Medicaid is critical for the continued growth of the US economy. This growth is threatened however, by medical billing fraud.

### **The Problem: Medical Billing Fraud in Illinois**

In May 2013, the Federal Bureau of Investigation (FBI) reported that two physicians and three health-clinic owners are among those that were accused of health care fraud schemes in the state of Illinois. These individuals were charged with schemes designed to abuse the Medicare program (2013). This incident in the Chicago area is not an isolated case of fraud and the crackdown by the authorities are part of the concentrated effort to address the problem of medical billing fraud which according to the Department of Justice and Health and Human Services amounts to about \$233 million in false billing.

Any attempt to obtain payment from insurance providers in a fraudulent manner is called Medical Billing Fraud. In the United States, both Medicare and Medicaid are susceptible to medical billing fraud chiefly due to how payments are arranged. To illustrate, consider how Medicare is operationally structured. Medicare's regulations handbook for example, is a 45, 000-page document. The processes prescribed therein have been abused repeatedly because of the many loopholes and technicalities that disable both Medicare and its supposed beneficiaries, the proper delivery of such service.

In the United States, five common types of medical billing fraud are committed. An article by Swanson (2012) describes these common medical billing fraud types and present day examples. The first type is called “

Upcoding” and happens when medical bills are improperly coded thus overlooking higher-than-required payments for rendered treatments. For example, a person who goes to the hospital for treatment of a simple procedure such as an ankle sprain receives treatment for such a condition but the incident is recorded and reported as a broken ankle, which is a more serious condition that dictates a higher payment. Incidents of uploading are common and dangerous; consider for example the recent payments made by the University of Texas Southwestern Medical Center. Kaiser Health News reports that the university agreed to pay a total of US\$ 1. 4 million to find a resolution on claims made by Medicare and Medicaid that physicians practicing in UT’s Parkland Health and Hospital System in Dallas are committing medical billing fraud by way of “ upcoding” from 2004 until 2007.

The second type of medical billing fraud is known as “ Phantom Billing” and happens when billing charges are imagined. Phantom billing is a criminal offense, as described in an article in Business Ethics. Phantom billing is so common that it is considered a “ science” in the field of fraud. In the US, phantom billing

Hospitals are at times at fault in committing “ Inflated Hospital Bills” or excessively charging patients with surcharges and exorbitant fees. Often patients are unaware of the components of their medical bill, thinking that their health insurance covers the entire amount. They are shocked to find that insurance does not cover everything but winds up paying for the balance because of their own failures at examining the components of their medical bills. Many cases have been documented of hospitals overcharging

patients thus committing medical billing fraud. Sometimes hospitals and other health care institutions “unbundle” their services such that repetitive charges are made over another thus making the medical bill larger than what is normally expected.

Lastly, a physician that order tests on patients and then “refers” himself to conduct the prescribed test is called “self-referral” and is considered fraudulent. In these instances, the medical practitioner profits unlawfully, thus driving the cost of healthcare up.

### **Legal Issues with Medical Billing Fraud**

Medical billing fraud is an obvious abuse and has legal implications. This kind of crime undermines the national (federal) policies of the US and its states and therefore is a concern that reaches to the top of the policy making bodies of the country. Medical billing fraud potentially cripples the US economy by making its workforce less productive while syphoning the very limited resources of the country.

### **Ethical Issues with Medical Billing Fraud**

The ethical implications of medical fraud are very pronounced. The medical profession seeks to provide honest services and yet the practice of what seems to be innocuous acts by medical professionals is a serious ethical issue that stains the medical profession.

### **Financial Issues with Medical Billing Fraud**

The financial implications of medical fraud, according to various government and non-government sources amount to more than a quarter of a billion

dollars each year. This amount of money could be spent on further improving the delivery of health care systems but is lost due to this crime.

## **Societal Issues with Medical Billing Fraud**

Society pays dearly for medical fraud. The most affected sectors are those that cannot receive medical assistance due to the shortage of funds that were diverted due to fraudulent activities. When these people become less productive, the economy of the country suffers as well.

## **Overall Risks**

The overall risk of medical fraud being a rampant, country-wide criminal activity undermines the economic viability of the United States. The risks are too numerous and far reaching that policy makers have put on an effort to curb the medical fraud committed in the same manner and intensity that the government has tried to control drug trafficking.

What is more alarming is the fact that medical billing fraud is widespread but the damage to society has yet to be accurately quantified. Nancy Aldrich of Health Benefits ABCs writes that the US does not have an accurate handle on the cost of healthcare fraud, simply because private sector fraud is not reported. She says an estimated 3 to 10% of the US budget for the healthcare approximates the losses due to billing fraud. In 2011, the US budget for health care is US\$ 2. 6 trillion making the losses due to fraud as much as US\$260 billion.

Such a serious problem will rarely go unaddressed. The primary stakeholder responsible for mitigating the problems of medical billing fraud is the government itself. The US Federal Government, through the Health

Insurance Portability and Accountability Act (HIPAA) in 1996 established what is known as the Health Care Fraud and Abuse Control Program. This purpose of this program is to combat medical billing fraud by providing the framework for cooperation between the federal, state, and local efforts designed to address the issue. The Office of the Inspector General (OIG) issues reports on health care fraud periodically, designed for helping the Federal Government to legally combat medical billing fraud. Lastly, the government also established the Medicare Task Force for the purpose of investigating and prosecuting proponents of fraudulent transactions. This task force was responsible for the significant decrease in medical billing-related fraud incidents in 2007.

## **Solution to Medical Billing Fraud**

Patient empowerment however, is still the most effective way of negating the harmful effects of medical billing fraud. A healthy dose of vigilance is required for addressing fraudulent transactions and can be done through some intuitively common actions, as prescribed by Trisha Torrey in About.com's article on Patient Empowerment.

It is always wise to review medical records especially medical billings for errors. Errors may either be on the charges made for services provided or insurance estimates, both of which will over-burden the patient with uncalled for expenses. If and when errors are located, it is important that corrections are made immediately. Any discrepancy should be reported immediately to the insurance provider. Medicare provides a procedure for filing a report on inconsistencies. Medicaid has launched a similar procedure for reporting erroneous medical billing and insurance estimates as well.

Many patients have taken up the mantle of correcting medical billing fraud formally. The Medical Billing Advocates of America (MBAA) was established to “to train, educate, and provide services to advocates, businesses, and consumers by promoting true and accurate billing and fair and reasonable pricing.” This organization provides advocacy education, provide expert resources for matters concerning medical billing fraud, provide consumer education for anyone interested in learning about it, and provide cost containment program training aimed at providing corporate and government healthcare subscribers the necessary tools to fight fraudulent medical billing.

## **Proposed Solution**

The involvement of the customer in the quest for finding a solution for medical billing fraud is the most critical yet under developed approach both by government agencies and private advocacy groups. Patients, if educated enough to understand their rights and responsibilities, would be better suited to address medical fraud, after all the effect of this criminal activity impacts the patient on both the personal level (through excessive payments) and through indirect levels (such as depletion of funds for other services from the government). For readers of medical billing fraud news reports, it is best to understand how the fraudulent transaction was committed in the first place, because people may unknowingly be committing the same fraudulent transactions without their knowledge. Being informed is always winning half of the battle already.



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