

## A GUIDE TO HEALTH INSURANCE & BILLING, 2E



*By Marie Moisis*

This text from Thomson Delmar Learning, together with other Thomson publications [1], are reviewed with a future eye fixed on exploring both the ever-worsening health care crisis and scandals involving non-profit hospitals [2] (institutions which presently provide the majority of health care services that are available in the United States).

However, some basic background is first necessary in order to educate the reader on these topics.

1-4180-2858-4  
(C) 2006  
576 pp, 8 1/2 x 11,  
Softcover, 2-Color

The Federal Medicare program was established in 1966 to provide basic form of supplementary health insurance to individuals 65 years or older (and to other qualifying individuals). (See 42 U.S.C. Sections 1395c, 1395j). Basically, Medicare gives retirement age individuals the ability to seek medical services under a program that is universally accepted among the nation's health care providers. Although convenient and easy for the consumer to use, the program itself has become a breeding ground for abuse, as doctors and their billing agents have gained control over a patient-base that has little ability to understand or monitor how services are being billed.

Yet, as Moisis's book reminds its readers, there are grave consequences to unscrupulous conduct on the part of health care providers. Specifically, it is a felony for a health care provider to intentionally make false statements of a material fact in order to obtain any payment. 42 U.S.C. Sections 1320a-7b(a); 42 C.F.R. Section 455.2.

Moreover, a health care provider found to have engaged in fraudulent billing is subject to a revocation of its right to treat Medicare beneficiaries. The scope of improper billing can be seen in statistics compiled by the Department of Justice which in 1996 estimated improper payments made by the Government amounted to 23.5 billion dollars: See: <http://www.usdoj.gov/dag/pubdoc/hipaa99ar21.htm>.

Given the magnitude of the problem and its impact on the quality of health care for every citizen, portions of Marie A. Moisis's text, specifically her chapter on the legal aspects of

ELECTRIC REVIEW BY:  
FRANK AIELLO

insurance billing, are especially relevant to life in 2006. Refreshingly, Moisio has not ignored the overriding issue of insurance fraud/abuse, noting in her chapter on the legal aspects of insurance billing that: "[i]nsurance billing fraud and abuse cost the federal government between 11 and 23 billion dollars per year. In 2002, about 7% of Medicare's total expenditures was paid inappropriately. The reasons for this error rate include fraud, abuse and lack of medical documentation related to insurance claims processing." [p. 33.]

Health care fraud is defined differently depending on the federal or state statute involved, but the term often means that "someone is illegally attempting to collect insurance payments from government health insurance programs...Most health insurance billing fraud is targeted at the Medicare program...Health insurance fraud activities fall under three main categories: fraudulent diagnoses, billing for services not rendered, and medical coding errors." [ p. 34.]

In illustration, Moisio provides well-defined examples relating to each category: Fraudulent diagnoses consist of either intentionally falsifying a diagnosis, misrepresenting the diagnosis, or selecting a diagnosis based on the amount of reimbursement. Billing for services not rendered can consist of scenarios where equipment is never provided to the patient; hospital visits which never occur; or laboratory/diagnostic tests which are never administered. Medical billing errors can include "upcoding" or selecting a diagnostic code based on a greater reimbursement; "leveling" or using the same billing/diagnostic code for all office visits; and "unbundling," or assigning individual medical or office-visit codes to services or diagnoses covered by a single code (note Moisio's excellent snapshots of such activity).

Unfortunately, identifying fraudulent activity in an ultra-complicated environment is not simple. For example, Medicare reimburses hospitals on a Progressive Payment System (PPS) that was adopted by Congress in 1986 (a system intended to reimburse hospitals for their "reasonable costs" according to PPS methodology which uses both a fee schedule and a cost-base method or a combination of both).

The primary components of this payment system are Medicare Part A, which covers institutional services, and Part B, which covers outpatient services provided by physicians and other professionals (with each segment or "part" financed differently and offering specific and distinct coverage). Part A provider claims for reimbursement are processed by "fiscal intermediaries," which are generally insurance companies operating under contract with the Secretary of Health and Human Services. Part B provider claims are processed by "carriers" who are also commercial insurance companies.

**ELECTRIC REVIEW BY:  
FRANK AIELLO**

In actuality, the PPS payment method is a labyrinth of rules and regulations virtually incomprehensible to all but the most determined student, and deep understanding of this material requires access to a two-volume "Provider Reimbursement Manual" which is basically the "bible" of the industry.

Medical reimbursements have created a complicated system with layered rules that benefit hospitals in myriad ways. Some examples of instances which mandate special attention: payment adjustments may be made to providers who are sole community hospitals or Medicare-dependent small rural hospitals; adjustments may be made if a provider serves a disproportionate share of low-income patients; teaching hospitals can receive additional payments through a variety of indirect medical education adjustments. In addition, there are also different cost-reporting requirements for proprietary facilities, teaching hospitals, doctors providing inpatient medical services, skilled nursing facilities, and home health care facilities (among others).

As a means to illuminate her readers on how health care billing is done, Moisio provides crisp descriptions of the coding systems and the terms commonly used in those systems:

*"CPT "Evaluation and Management" section (E/M) (99201-99499) codes are divided into three broad categories of provider services: office visits, hospital visits, and consultations. E/M codes capture information about medical services, as opposed to surgical services. As the name implies, evaluation and management codes are used to report physician or provider activities associated with evaluating an individual's health status and managing or implementing a plan of care related to that status." [ p184.]*

And taking the subject still further:

*"Selecting the appropriate evaluation and management CPT code that is the responsibility of the physician or provider. Many providers document the E/M code by circling or checking one of the E/M codes that are preprinted on the encounter form or route slip. Figure 6-7 is a sample encounter form with the E/M and diagnosis codes printed . . . It is important to emphasize that the billing specialist and medical coder do not challenge the clinical judgment of the physician. Rather, the record review is a method to ensure that the documentation in the patient record supports the physician-or provider-selected code. . .Insurance carriers and regulatory agencies monitor E/M codes for upcoding or downcoding . . .Some providers downcode under the mistaken assumption that this prevents insurance carrier or regulatory agency audits. In fact, both upcoding and downcoding can be categorized as insurance fraud or abuse." [pp. 196-197.]*

Even though the system itself seems to create paths of abuse, fraudulent manipulation of a patient's Medicare benefits are not tolerated, with severe administrative, civil and

ELECTRIC REVIEW BY:  
FRANK AIELLO

criminal penalties in place should a health care provider be proven to have engaged in insurance fraud. To evince how serious it takes the issue, the Government encourages citizens to come forward to report suspicious patterns of activity. And Moisio writes: "The Federal False Claims Act provides financial incentives when suspected fraudulent activities are proven true. Any individual who reports the fraud may receive 15%-25% of any judgment." [p.36.]

Although written as a learning aid, *A Guide To Health Insurance Billing* is one of the few readily obtainable resources which provides a clear understanding of this subject area, including a guide to key terms and abbreviations, descriptions of medical coding, and sample copies of the appropriate forms. Accordingly, it not only serves the goals of the student, but also can assist administrative agencies, auditors and attorneys involved in the examination and prosecution of insurance fraud. We found the short but informative chapter on the intricacies of Medicare billing worth the price of the book alone.

Recommended as a primary classroom text in courses focused on the technical aspects of billing procedures for the health care industry. Further recommended as a research tool for individuals charged with overseeing this industry and enforcing procedural compliance. Finally, recommended to all Health Science libraries as a general reference text.

[1] Future columns in The Electric Review's Reference section will review several of Thomson/RIA's manuals on tax requirements for not-for-profit entities.

[2] Mississippi attorney Richard Scruggs, noted for litigating cases against the tobacco industry, recently filed several lawsuits against non-profit hospitals alleging that they were illegally acting as non-profit entities and not meeting the IRS' strict standards to maintain this status. Consequently, the evidence Scruggs is presenting in his cases has opened up the entire concept of the not-for-profit hospital to closer scrutiny -- by both the Internal Revenue Service and the American public. ~**The Editor**

**ELECTRIC REVIEW BY:  
FRANK AIELLO**