Physician Ethics: How Billing Relates to Patient Care

Saba Fatima, PhD

On a beautiful autumn day, I received a call at work from a neighbor who had found my uncle confused and disoriented while he was on his walk. When I arrived, I learned that my uncle had suddenly become shaky and had fallen face forward on a concrete trail. His face was badly bruised, front teeth were loose, and he was still rattled. As I assessed his condition in a state of panic, I remember thinking: "do we *need* to go to the emergency room?" My uncle was uninsured and, having dealt with his previous medical bills, I had an idea of how expensive this visit could be. Precious moments later, I chastised myself for thinking about the costs, and rushed him to the nearest ER. I found myself informing the ER physician that my uncle was uninsured and to take that into consideration when ordering tests. After the initial evaluation, to our surprise, the ER physician conceded that my uncle's syncopal event was most likely from hypoglycemia and that she would spare us the full cardiac workup. Soon after, he was discharged for home.

What is the role of physicians in such a quandary? Are there situations where they should be aware of a patient's inability to pay, or would that inevitably harm the patient's interest to be treated without bias? Can doctors holistically treat a patient while purposely remaining unaware of the patient's financial situation and of the conditions of systemic inequality in healthcare access? I argue that they cannot.

Our present system is far from adequate in terms of making healthcare financially accessible to all. The brunt of the current White House's effort to dismantle the Affordable Care Act (ACA) will be borne by lower income families and negatively impact women's reproductive health.[1] But even before this administration took office, premiums were expected to rise by 25% in some areas, Aetna had already withdrawn from the ACA health insurance exchange, and Humana and UnitedHealth Group were reducing their participation in the exchange.[2] Now, with no initiatives on the part of the government to encourage enrollment or expand coverage, it has become clear that many more people will be priced out of affordable healthcare plans, or will be left with crippling premiums or inadequate coverage.

While this article is not about the ACA, the urgency of the current social and political circumstances do prompt the sort of moral inquires that ought to lead physicians to re-examine their relationship to billing. I argue that given our predicament, in which the number of uninsured Americans is only likely to go up drastically from the current 28 million,[3] it is imperative that physicians re-evaluate many of the ethical considerations about billing that are ultimately inseparable from patients' care. For the purposes of this article, *billing* refers to the act of coding patients' procedures on part of the physician, and my concerns herein only encompass any impact such coding

may have on patients' health. This thesis emerges from a commitment to the fundamental obligation that physicians have, namely to heal patients and/or manage their suffering.

ETHICAL CONSIDERATIONS

This article is not concerned about clear cases of fraud wherein a physician is willfully dishonest in billing. The focus of this article is on the structural aspects of billing that make the commitment to patients' care ethically problematic. Below, I consider three structural considerations that ought to prompt physicians to broaden their understanding of the ethical aspects of billing not to be merely about cases of fraud, but fundamentally about managing patients' health.

PHYSICIAN INCENTIVE

Medical billing serves an administrative purpose. It allows for documentation of a patient's visit and generates a charge. Whether related to an initial encounter or a follow up, medical billing can be separated into different levels of services, eg, I, II, or III, each successively worth more in revenue. Choosing which level can be based on time spent with the patient, the level of medical decision making required, or the patient's acuity. In order for the billing code to be accepted, the documentation of the encounter has to meet a minimum requirement. Electronic medical record (EMR) software often automatically populates a careprovider's note to reflect the highest level, leaving it to the physician's discretion to code the service down if need be. These codes are then used to reimburse careproviders for their services. However, often other significant financial incentives drive billing. Many large corporations and medical groups track physician employees' productivity through billing and incentivize the physicians to increase their volume and meet billing goals. A physician's livelihood can be tied closely with what is billed, whether it is in the fee-for-service model, wherein each service generates income for the physician, or a relative value unit (RVU) based model, wherein the doctor earns a base salary and receives additional compensation for productivity above a certain threshold. Although the task of billing may seem primarily administrative in nature, tying it to a physician's compensation may at least create an appearance of impropriety.

It makes sense that a physician's compensation vary with the complexity of the service offered. On the other hand, it creates the sort of environment in which a physician may code *up* reflexively. For example, entering the billing code for a urinary tract infection when there is merely an abnormal urine test, billing for chronic obstructive pulmonary disease if a patient has shortness of breath and mentioned tobacco use, or billing for diabetes *with* kidney disease, when the patient just has diabetes. Such careless billing not only wastes taxpayers' dollars and raises premiums for insured patients, but also results in patients' medical histories being recorded falsely. Here, it is important to note that the frequency of such behavior is not the core issue; rather, it is that billing systems are often set up in ways that give at least the appearance of impropriety and can foster environments that are not optimum for patients' health. As such, physicians must examine financial conflict of interests and recognize coding as an ethically relevant activity, so that they can begin to take steps to remedy such an environment.

MEDICAL COSTS AND HEALTH

One of the main reasons that billing ought to be intertwined with ethical aspects of patients' care is that lifesaving medicine is financially out of reach for many patients. This situation generates anxiety in patients regarding their ability to cover medical expenses and becomes a direct obstacle for patients and their caregivers. The thought of having your wages taken by debt collectors can further exacerbate feelings of isolation and engender resentment towards the medical establishment. According to a study by the Consumer Financial Protection Bureau, medical debt is the most common type of debt for which debt collectors contact consumers.[4] In extreme cases, financial debt can contribute toward depression and suicide. A 2015 study reported that suicide rates for adults aged 40 and 64 had increased about 40% since 1999, with a sudden increase in 2007, when the United States dipped into a historical financial crisis.[5] Researchers found that external economic factors—job loss, bankruptcies, foreclosures, and other financial problems—were present in 37.5% of suicides in 2010, up from 33% in 2005. Moreover, this study focused only on cases of "successful" suicide that were correlated with economic factors, and did not consider cases in which financial trouble regarding the coverage of appropriate healthcare contributed to medical issues such as depression.

Patients can also face moral judgment for their inability to pay their medical expenses, leaving them feeling shamed and helpless. For example, in March 2017, U.S. Congressman Jason Chaffetz commented, "Americans have . . . got to make a

choice. And so maybe, rather than getting that new iPhone that they just love and they want to go spend hundreds of dollars on that, maybe they should invest in their own health care."[6] Suggesting that individuals are choosing luxury items over their own healthcare covertly aims to release the medical industry and the federal government from any responsibility for policies that sustain inequity in terms of access, and place blame squarely on the shoulders of the very people the policies are intended to serve.

Nonetheless, medical facilities often and genuinely pride themselves on practices that do not discriminate regarding patients' abilities to pay, especially in acute care settings. In emergencies treatment is neither delayed nor withheld, and is provided based on the standard of care. However, when this care results in an accumulation of insurmountable medical debt, it deters patients from following up on their care,[7] or causes them to ration their medications[8] so as to make them "last longer." Despite best intentions to disentangle the two, how billing systems are designed and managed becomes an inseparable part of what it means to care for and treat the patient.

ARBITRARY BILLING SYSTEMS

While healthcare operates within a free market in the United States, it does not seem to be driven primarily by consumers. Steven Brill writes about the business aspects of healthcare in his book *America's Bitter Pill*.[9] He documents how the determination of prices for medical procedures lacks transparency and consistency. For example, in some areas, insurance companies hold little bargaining power over hospitals that serve large portions of a local population. This is because insurance companies will be unable to sell policies if they do not include these hospitals in their coverage. In this way, hospitals hold most of the control in the negotiation of prices. Furthermore, according to Brill, the charge-description master (CDM) that lists the prices of all medical procedures, services, and goods that a hospital can provide to its patients, varies—often quite arbitrarily—across hospitals and regions. The same procedure can be billed quite differently between hospitals within the same region. Moreover, patients often have little to no knowledge of their procedural costs prior to being admitted. Even within the same facility, different insurance companies can negotiate different discounts. Besides the arbitrariness of differing insurance rates, negotiated rates are obtained by giving health insurance companies discounts off the full sticker price for that procedure. In order to demonstrate that the procedure would have cost the full sticker price, the hospital must to charge the full price to *someone*, and that someone is often the most financially vulnerable: the uninsured patient.[10] Some hospitals do offer self-pay patients discounts for full payments, but the charges are still not market driven, and are quite high for patients who pay out of pocket.

While there are many products within the general marketplace that might seem arbitrarily priced, or have high mark ups (such as the aforementioned iPhone), these products are generally not essential to one's life in the same way that access to medical care is, and consumers can choose not to buy these non-essential items. It is also true that hospitals must provide care in cases of emergency, but that care does not extend to a continuity of care for financially strapped individuals. Thus, these individuals may not have access to healthcare until their condition becomes acute. These emergent care cases act as a temporary dressing on gaping wounds, in terms of the financial cost incurred by the healthcare system and, more importantly, in terms of patients' long-term health. It should not be the case that for something as vital as true access to healthcare, we retain a "free market" framework that does not include a serious restructuring of billing practices from an ethical lens.

AN ETHICAL COMMITMENT

Critics may worry that conceptualizing billing practices as an ethical aspect of patients' care may make patients' care more consumerist. It is certainly possible that knowing the financial status of patients could certainly bias physicians to treat them differently. From the physician's perspective, although it is considered a good standard practice to be aware of which services a patient is able to access (eg, in discharge planning), being blind to a patient's billing source may seem better since the physician is providing the necessary care without discriminating on the basis of the patient's socioeconomic status. However, what a physician may not realize is that the discrimination has already occurred in the patient's selection—ie, in who comes in to seek medical care—and further social discrimination can occur in relation to a patient's subsequent inability to pay.

In an ideal world, it would seem morally intuitive for physicians to divorce themselves from such concerns in order to provide unbiased and nondiscriminatory care. However, deriving a billing system from an ideal model of the world fails

to solve the very problems the system is supposed to solve. Philosopher Charles Mills[11] distinguished between two different conceptions of the ideal: ideal-as-model: these are descriptive models that represent crucial aspect of something; and ideal-as-idealized-model: these are a representation of what something *should* be like. Mills expresses that the latter conception of the ideal is problematic when it abstracts away from actual injustices. That is to say, ethical prescriptions that arise from an idealized view of the world end up not remedying the social injustices in society because their starting point abstracts away from those very inequities. However, our world is not an ideal one; social inequities do exist, many of which are institutionalized and systemic. Thus, any effort to remedy those inequities cannot begin by imagining that we live in an ideal world. Rather, we must take these inequities actively into account *while* aiming for the normative ideal. In this particular case of the healthcare system in the United States, one's access to healthcare *is* dependent on economic inequities. We can aspire for an ideal world in which physicians do not have to be concerned with issues of billing, *provided* that we are realistic about how things actually are. So any attempt to think pragmatically about what it means to treat patients ethically must consider the very reality of economic inequities in healthcare access, and not shy away from those realities under the guise of providing "impartial" care.

Some critics might also say that physicians do not have much control over the bureaucratic medical billing system. It is indeed true that physicians are quite disconnected from day-to-day feedback on how billing systems should work, and one might say that it is not their job to become actively involved in fixing this complex system. However, there have been instances when what may have seemed like bureaucratic policy changes were linked explicitly to physicians' ability to provide care to patients. One example is the general effort by physicians to advocate for gun violence research. On the surface, it may appear outside of the professional purview of a physician's obligations to get involved in the national debate on gun violence. However, in 2016, following one of the deadliest mass shootings in Orlando Florida, the American Medical Association joined the American College of Physicians and the American College of Surgeons[12] to declare gun violence a public health crisis and to push for renewed research. On a more individual basis, a 2014 *New England Journal of Medicine* editorial[13] by two pediatricians argued that doctors and other healthcare providers should act as patients' advocates and support broader policies related to family leave. They argued that such policies are linked intricately to caring for children. This is all to say that it is not odd or unprecedented to understand the bureaucracy of billing in terms of a physician's telos, especially when it directly corresponds to the health concerns of patients at large.

Any attempt to think pragmatically about what it means to treat patients ethically must consider the very reality of economic inequities in healthcare access.

It is imperative that further research be conducted on what it would mean for physicians to broaden their moral scope of practice as it relates to billing. A possible route might be that we teach this as a part of medical resident training. That would allow physicians to rethink patients' care in more holistic and comprehensive ways. It may also push physicians to be more involved collectively and individually to change our billing practices to better patients' care. This can be done through either advocacy for mandates and penalties to increase coverage[14] or advocacy for some form of single-payer system.[15] While the path forward needs an empirically based solution, it is clear that physicians cannot fully care for their patients without taking into account their patients' accessibility to care. If we stick with the current outlook on billing as not located within the purview of the ethics of patients' care, then physicians will inevitably remain enablers of, and complicit within, a broken and unethical system.

Author

Saba Fatima is associate professor of philosophy at Southern Illinois University, Edwardsville. Her research interests include non-ideal theory; social and political theory within prescriptive Islam; Muslim/Muslim-American issues within a framework of feminist and race theory; and medical humanities. She has recently published on how aspects of hospital settings, such as standards of professionalism, influence of external monitors, and emphasis on adherence to guidelines, can adversely affect the character of physicians.

References

1. Himmelstein DU, Woolhandler S. Trumpcare or Transformation. *Am J Pub Health*. 2017;107(5):660-661.

2. Johnson CY. Aetna will leave most Obamacare exchanges, projecting losses. *Washington Post.* August 16, 2016. http://wpo.st/tlJ42.

3. Clarke TC, Ward BW, Norris T, Schiller JS. Early Release of Selected Estimates Based on Data From the January–September 2016 National Health Interview Survey. *National Center for Health Statistics*. 2017. https://www.cdc.gov/nchs/data/nhis/earlyrelease/earlyrelease201702.pdf.

4. Consumer Experiences with Debt Collection: Findings from the CFPB's Survey of Consumer Views on Debt. *Consumer Financial Protection Bureau*. 2017. https://s3.amazonaws.com/files.consumerfinance.gov/f/documents/201701_cfpb_Debt-Collection-Survey-Report.pdf.

5. Hempstead KA, Phillips JA. Rising Suicide Among Adults Aged 40-64 Years. *Am J Prev Med.* 2015;48(5):491-500. doi: 10.1016/j.amepre.2014.11.006.

6. Bump P. Jason Chaffetz's iPhone comment revives the "poverty is a choice" argument. *Washington Post,* March 7, 2017. https://www.washingtonpost.com/news/politics/wp/2017/03/07/jason-chaffetzs-iphone-comment-revives-the-poverty-is-a-choice-argument/?utm_term=.f803397976a8.

7. For eg, see: Study: High Deductibles Cause Patients to Delay Care. *Robert Graham Center Research*. 2016. https://www.aafp.org/news/practice-professional-issues/20161122highdeductible.html. Or see: Steve Kukulka S. New Carepayment Research shows Americans can't afford their medical bills. *CarePayment*. February 14, 2018. https://www.carepayment.com/new-carepayment-research-shows-americans-cant-afford-medical-bills/ that reported "64% say that have avoided or delayed medical care in the last year due to expected costs."

8. For eg, see: Ricks D. Rising cost of insulin leads LI diabetics to take dangerous risks. *Newsday.* September 18, 2017. https://www.newsday.com/news/health/rising-cost-of-insulin-leads-li-diabetics-to-take-dangerous-risks-1.14196973. Or see patients' stories in Thomas K, Ornstein C. The Price They Pay, *New York Times.* March 5, 2018. https://www.nytimes.com/2018/03/05/health/drug-prices.html.

9. Brill S. *America's Bitter Pill: Money, Politics, Backroom Deals, and the Fight to Fix Our Broken Healthcare System*. New York: Random House, 2015.

10. Reinhardt, U.E. The pricing of US hospital services: Chaos behind the veil of secrecy. *Health Aff*. 2006;25(1):57-69.

11. Mills C. "Ideal Theory" as Ideology. *Hypatia.* 2015;20(3):165-184. 166-167.

12. AMA Endorses Important Framework to Promote Firearm Safety, November 16, 2016. https://www.ama-assn.org/ama-endorses-important-framework-promote-firearm-safety.

13. Schuster MA, Chung PJ. Time off to care for a sick child—Why family-leave policies matter. *New Eng Med J.* 2014;371(6):493-5.

14. Herzlinger RE, Richman BD, Boxer RJ. Achieving Universal Coverage Without Turning to a Single Payer Lessons From 3 Other Countries. *JAMA*. 2017;317:1409-1410. doi:10.1001/jama.2017.1475.

15. See the work done by *Physicians for a National Health Program.* Available at http://www.pnhp.org/.