ISSA Proceedings 2002 – Using An Activity System Model For Analyzing Effective Arguments

This presentation analyzes the arguments of three business managers who worked in privately owned medical practices. Their jobs were to pursue payments for claims that had been billed yet denied by health insurance companies. Their claims for payment were in effect arguments for which they gathered data, offered proof, and stated their claims. I use an activity system model to examine the interrelations between the elements of their workplaces and to highlight their roles as agents of workplaces.

Activity System Theory

Activity systems theory, based heavily on theories by Vygotsky and Leontev, studies groups of people who come together to work for common goals through dialogic, tool-mediated means. According to Beach (1998), activity systems researchers pay close attention to the subjects (the people involved in the activity system) and their (sometimes conflicting) identities, the objective/motive (as Engestrom defines it, "the problem space at which the activity is directed" [Engestrom, 1993, p. 67]), tools (usually genres or texts), rules, community, and division of labor. In simple form, an activity system includes the whole context in which people come together with discursive means to achieve certain outcomes – hence workplaces, classrooms, boardrooms, homes, civic groups, hobbies, even conferences can be theorized as activity systems.

Russell (1997) argues for this model that allows a researcher to understand the relationship between text, context, and writer, and to explore the power, stability, and change in that relationship. He uses activity system theory to combine both genre and community in an "expanded theory of dialectic that embraces objective and motives of collectives and their participants to explain reciprocal interactions among people through texts" (p. 505).

Simply put, Russell proposes a model for systematic, "principled and concrete analysis" (p. 524) of the dynamic, powerful, and complex context of activity systems through the textual practice of agents. His theory offers many benefits: it

understands that activity systems have many motives, subjects, and tools; reveals that individual subjects also have many motives and tools; highlights the contradictions and double binds which rise through the various motives and tools; shows activity systems and genres as dynamic in space and time; makes necessary the interrelation between the genres and their contexts; and it underscores the overlapping nature of multiple activity systems and of genre systems.

Russell identifies these tensions as "contradictions" or "double binds;" they are "the dialectical pulls within and among systems" (1997, p. 519). Identifying these areas of "contradictions" can help us understand the ways in which genres can both "stabilize systems… as well as mediate collective change" (Winsor, 1999, p. 202). And this theory gives scholars an avenue for analyzing more fully discourse and contexts. As Winsor theorizes,

Activity theory has the potential to help us stop thinking of context as a container in which text is subsequently produced. Rather, an activity system and the elements making it up (tools, actors, objectives) can be seen as mutually constitutive and always in flux. (p. 201)

I use activity theory because it helps to heighten the inter-relatedness of all the elements of the activity system – objective, tool, and agent – as I examine the workplace writing of three different medical practices. In doing so, I look at how the agents, in this case, the three business managers of the three medical practices, interact with the objectives and tools of communication in their practices. Of these three activity systems, the objectives for these practices were the same – to collect payments form health insurers on previously filed and rejected claims – and the job descriptions of the agents were similar – they were all business managers in charge of billing and collections for their respective medical practices. However, their choices and actions in how they used communicative tools to achieve those objectives show marked variances and help to highlight the tension between the role of an agent in an activity system and the will of the individual.

Agency Theory

One of the key terms of activity system theory is that of the agent or the individual person who works purposefully toward the objective or motive of the system. Yet the individual agent of an activity system may also have commitments, sometimes competing commitments, to other systems or to

personal loyalties, an issue that continues to complicate composition theory and philosophy. As Jones (1995) states in his essay, the impasse between traditional foundationalist philosophy and post-modern anti-foundationalist philosophy continues to "bedevil contemporary compositionists" who question the issue of agency. In other words, compositionists question the writer's ability to formulate and communicate through language thoughts that are at once neither controlled by the foundationalist belief in absolute knowledge, nor controlled by the anti-foundationalist theory of powerful language communities. As Porter (1986) explains,

The poststructuralist view challenges the classical assumption that writing is simple linear, one-way movement: […]A poststructuralist rhetoric examines how audience (in the form of community expectations and standards) influences textual production and, in so doing, guides the development of the writer. This view of course is open to criticism for its apparent determinism, for devaluing the contribution of the individual writers and making then appear merely tools of the discourse community (p. 40).

This impasse is at the heart of this study. If language controls and constructs identities, cultures, and communities, then language users are at the mercy of that language; they can neither control their own language use, nor construct new thoughts and ideas beyond the control of the language-bound culture. Influence would pass only one-way, from context to text. Yet reminded by Bakhtin, scholars recognize that different people can resist the dominant discourse, that they can control language use, and that they can develop resistant or novel thoughts and knowledge. Compositionists recognize that influence can pass both from language to context and from context to language, and that subjects or individuals are not simply language conduits. Jones "resoundingly" proclaims "the dominant discourse is never so stable and uniform so as to render the individual a subject completely subordinate to discursive practices. The instability and heteroglossia of language create the discursive space for individual agency" (p. 94).

Other scholars (Dias et al, 1999; Schryer, 2000) echo this uneasy balance of competing ideologies between the structuralist theories and individualistic theories, arising from scholars who promote discursive freedom of marginalized groups, like African-Americans and women. To solve this conflict between agent and system, Schryer redefines her notion of genres (and hence the writer's agency) as "the constellations of regulated, improvisational strategies triggered

by the interaction between individual socialization and an organization" (p. 9). By defining genres as both regulated by the community and improvised by the individual, Schryer opens up a space for individual agency to flourish in a tight, systemic community, like a medical workplace.

Medical Workplaces

I chose to conduct my case studies at three medical practices in a mid-western state. One practice was very small with the business manager, Mona, conducting the billing and collections in addition to her duties as a x-ray technician. In the larger second practice, the business manager, Cathy, conducted the billing and collections as well as oversaw the work of the receptionists and filling clerks. In the third practice, the business manager, Terry, supervised the billing and collections completed by three other billing clerks while he worked on difficult billing cases. Although there were differences in the medical practices and in the full job duties of the business managers, their responsibilities for supervising the billing of claim forms and analyzing and solving the problems for rejected claims were the same. It was their jobs to see that as many insurance claims as possible were paid, and if the claims were not being paid, it was their jobs to correct the problems. In all the problematic billing cases, these business managers formed and participated in some kind of argument to receive better payments. Given these similar objectives – to collect and resolve insurance claim problems – and the similar roles that defined their work and positions as agents within their respective activity systems, the differences in the way these agents chose to use their available communicative tools highlight the extent to which these agents could make decisions and act as individuals. Further, we can then see the choices involved in forming and pursuing arguments.

Mona

Mona followed a set pattern of dealing with billing: once a week she filed all the billing accumulated during that week, usually on Friday; on Tuesdays, she tackled the job of figuring out claim problems. On her desk, Mona kept a neat stack of claims and cases that had been problematic – slow to pay, denied, or minimal payments. On the computer, she then sorted and printed a list of claims according to the lateness of payment, like 30 days, or 60 days, or later. From this information, she called (her preferred method) insurance companies for claims over 30 days late to get an explanation of the delay. Usually she spoke to an automated operator on the phone, to which she entered that patient's id and

group numbers and the date of service. The most frequent responses that she heard were problems with the date of birth of the patient or client, the social security number, that the case was under review, or that there was a problem recognizing the claim as a primary or secondary insurance obligation.

For example, she called one insurance company to see if Dr. Rick were a participating provider for a certain patient who needed an x-ray. Four times, Mona explained to the person at the insurance company what she needed to know, yet she still couldn't find out from the lady on the other end of the phone whether or not Dr. Rick was signed as a participating provider. The lady kept saying that she didn't know what Mona wanted. Finally Mona hung up the phone, and checked back through her earlier files. Previously they had billed a claim to this insurance company who then rejected it. So, Mona decided from that earlier rejected claim, that Dr. Rick was not a participating provider.

On another day, Mona dealt with several late and denied claims. She used the speakerphone so that I could here both ends of the conversation. On the first call, an automated operator (female voice) listed the various menus. The next voice (male) stated that due to damage caused by Hurricane Floyd, their office was closed temporarily. On the second call, an automated female voice directed callers to enter information of claims less than eleven months, provider number, employee SS#, date of service, patient date of birth. After Mona entered that information, the voice responded with "We have no record of that claim." Mona told me that she would refile. On the third call, Mona entered the provider number, the employee SS#, and couldn't get any file to match. So she got an operator on the line. She gave her name and the employee's name, and asked to check the status of a claim with a date of service of 10-7-98. The company representative said that they hadn't received it. Mona replied that she had filed it four times, and asked if there were a fax number where she could send it. She wrote down the fax number, and finished the call. While she made two other calls, one of which was to a real and human insurance company representative (a non-automated operator), she checked on the claim which she planned to fax and found out that she had already faxed that claim a month earlier. Mona said that she would follow it up later, but she thought "the company [was] giving her the run-around."

From Mona's case we learn that the process of filing and pursuing payment for a claim is much like constructing an argument. Mona had a claim, she had warrants and backing for the claim in the guise of treatment codes, dates of service, patient

identification numbers, and contractual agreements between the patient and the insurer, and sometimes between her physician and the insurance company. However, in many ways, Mona's pursuit of her differed from traditional styles of argumentation, and left Mona frequently feeling frustrated and without a conclusion to her "argument." By conducting her arguments through automated telephone operating systems, she was limited by the menu choices as to which kinds of data she could use. Further, she was limited in the kinds of answered she could receive. More importantly, even with human representatives on the phone, Mona often could not make the other party understand or pay attention to the claims she was trying to make. In a sense, she had no audience or participant for her arguments. On the other hand, Mona claimed that she preferred to use the telephone to get information from the insurance companies and to refile claims because she had no experience with formal writing and telephone calls were faster. For her phone calls were a highly efficient way of conserving her time. While she made calls, she frequently conducted another task on the computer, kept notes of her calls on the printouts, made notations on the computerized patient accounts, and prepared for the next phone call. She was fast and efficient in her pursuit of claims, but she frequently ended up frustrated and without and sense of closure to many claims.

Cathy

At medical practice #2, the business manager, Cathy, opened a letter from Health Care Payment Administration, a carrier for CareMed, requesting a refund. As she read it, Cathy reported to me:

When they [that specific insurer] want a refund, we're supposed to send back the refund and then try to prove them wrong, (regardless of whether or not the medical practice agrees with the refund request). Then they're [the insurer] supposed to re-pay. If we don't send back the refund right away, before we prove that it was a correct payment, they'll fine us.

Despite length and numerous referrals (at least nine times) to the overpaid amount, the letter does not sufficiently explain in detail why CareMed will not pay for the service, does not specify the medical service, and does not mention the diagnosis for treatment. The letter only states once that "This overpayment occurred because CareMed does not pay separately for this service," without specifying what the service was or what the service was separate from. The letter, without sufficient explanations or reasons, caused Cathy much consternation.

Like Mona, Cathy began her pursuit of her claim with telephone calls. The insurance company claimed that the place of service code was wrong. And somewhere in the middle of this conversation, Cathy said, “I’m confused. This is a service that can’t be paid for this procedure?” She pulled out her codebook to quote the correct code. “What CPT code are you showing? Hmm. That doesn’t fit.” At that point, she was disconnected. When the phone call was re-established, she said that the CareMed code did not match her procedure. She continually asked the same questions, trying to find out if another doctor had seen the patient that same day, but she did not get any information from the CareMed representative (Jim) because he claimed that he could not break patient confidentiality. She was very dogged and made Jim pin down a day for a response.

When she hung up, she told me, “They’re saying that she had another procedure done; they won’t tell me what it was or by whom; they keep saying patient confidentiality. My doctor shouldn’t be penalized because he was called in by mistake for someone else’s mistake.” She could neither refile this claim, nor appeal the refund, without more information.

On the third day, Jim from CareMed called back on the patient claim refund remittance. The patient’s kidney doctor had signed a claim stating that he would accept once a month payment and sole responsibility and care for the patient, a contract called a MCP, or Major Contracted Physician. But Cathy said that her physician was the only physician to do regular rounds at that patient’s nursing home, thus the other kidney doctor could not be seeing that patient. Jim had no response for that fact. Cathy asked Jim in which bulletin was this rule about the sole-care contract listed, to which he replied that the rule was not listed in a bulletin. Cathy said, “Then how are we supposed to know about this? How are we supposed to be educated about it?” He replied that her best bet would be to call the education department, which she did but their answering machine stated that they were out of the office for another two weeks. Cathy said that she would have to refund the claim but she planned to re-bill the claim with a letter of appeal.

On the fourth day, an education representative from CareMed called about the patient. Cathy asked for a fax of this rule, which prevented her doctor from being paid while another doctor was listed as the MCP physician. The fax contained two sheets, copied straight from the CareMed handbook; a copy of this handbook containing several thousand pages and in several volumes resided in the back corner of Cathy’s office. It became evident here that Cathy had access to the rule and should have known the rule, although given the enormous amount of information in the handbook (several thick and unorganized volumes), I can

understand how Cathy would have missed or forgotten it.

Later on the next day, Cathy told her doctor, “we’ll have to refund these two earlier claims. It’s our fault.” Here, she seemed to accept her responsibility for not having remembered the rule about billing separately from the MCP doctor. However, it remained unclear how Cathy was supposed to have known about the existence of this patient’s MCP physician, because her doctor was not notified by the nursing home (who may also not have known) that this patient had a previously contracted MCP physician.

At this point Cathy changed her plan of refiling the claim with a written letter of appeal. Instead she accepted the insurance company’s proof in the form of the fax and accepted that statement of her responsibility or fault. Notably Cathy did not exercise her own agency to file an appeal on the refund request, as she had originally planned. She reasoned that the insurance company was not liable for the mistake because she already had access to the rule. Rather the nursing home or the MCP would more than likely be liable for not having notified the patient’s new nursing home physician that another physician was already contracted. However, as Cathy pointed, she did not hold the MCP physician personally responsible, because “he may not have had any choice” in signing his MCP contract and may not have known that the patient was being admitted to the nursing home on that day. Instead, she accepted, rather passively, the responsibility for the loss of payment because of a mistake, maintaining her doctor’s current role as the caregiver in this system of nursing home care, even though filing an appeal might not have changed his role.

Terry

At medical practice #2, the large, pediatric-specialty clinic, I learned about an earlier claim problem between the practice and a health insurer. Terry, the business manager, told me that the claim had taken almost a year to clear, during which time he had put in a great deal of effort on this case. He narrated the case to me and showed me the copies of the letters, which he had written to solve this case. In the letters Terry had asked the insurance company to pay for treating a patient who was covered under the insurer’s policies. The costs of treating the patient were tremendous, and the insurance company had gotten so far behind in making payments, by denying or stalling payments, that the bill was well into the tens of thousands of dollars.

There was very little disagreement between the medical practice and the

insurance company about what kinds of treatments would be paid and what kinds were excluded. But the medical practice and the insurance company disagreed about who should pay. The patient had two insurance companies, one listed as the primary insurer and one as the secondary. Both companies refused to pay until the other paid first, although the legal responsibility of that payment rested with the primary insurer first. Terry made several earlier attempts to receive significant payment from the primary insurer; many of these earlier attempts were not made in printed form, but rather they were filed electronically and then refused by the insurance company. The practice then made queries by phone and was notified of further denials, before the negotiation between them turned to the rhetorical tactic of writing letters.

According to Terry, these letters were well written and well reasoned, and followed the format of their practice's letters in other cases. Terry reported that they had used an appeal to logic by stating the insurance company's legal and contractual responsibility to pay the bill. In the final letter, he went so far as to threaten the insurance company with legal action if they refused to pay, a very strongly worded statement taking a stance of strength. However, through various media like phone calls, electronic filing and written genres, with a variety of rhetorical stances in a long series of genres, nothing worked.

So Terry tried a different tactic: he wrote to his State Department of Insurance, asking that agency to force the primary insurance to uphold their legal obligation to pay the bill. By writing to the state health insurance commission, he "marshalled" his forces by increasing the number of people and offices supporting the claim. Further, this letter referred to having the claimant's permission to seek further means of collection. Terry abandoned the normal rhetorical tactics of the practice to persuade the insurer directly; instead he, through this letter, moved to strength in outside forces, what Corbett (1969) calls the difference between the rhetoric of the open hand and the rhetoric of the closed fist:

The open hand might be said to characterize the kind of persuasive discourse that seeks to carry its point by reasoned, sustained, conciliatory discussion of the issues. The closed fist might signify the kind of persuasive activity that seeks to carry its point by non-rational, non-sequential, often non-verbal, frequently provocative means. (p. 288)

The claim was turned over to the state commission who did indeed force the health insurance company, Healthsearch, to pay the claim.

This case was highlights the question of agency as each insurance company refused responsibility for the payment. Further, Terry also took on the role of the patient's agent, with the patient's permission to seek further measures for payment. The claim problem became a question of whose responsibility was the payment, and who had the choices and power to avoid paying or to pursue other means of receiving payment. In addition, Terry exercised his own agency by choosing to pursue these other avenues. By his own admission, most of his time was spent on researching and analyzing EOB's for details for appeals. This normal activity took "a lot of patience and an eye for small details," and the most important attribute for this job was having a "good reputation, making contacts, and above all, networking." He elaborated in an interview that pursuing insurance companies for legally required payments was one of his great strengths. This pursuit was a skill and technique that he developed through 15 years of experience, networking, and knowledge of the field. This cache of knowledge served him well as he struggled with the specific billing problems of this medical practice.

Terry claimed that making personal contact with assigned representatives in insurance companies was the most effective way of getting claims paid quickly and correctly. He made these contacts by attending seminars or workshops that insurance companies hosted or attended, by "schmoozing them," getting to know them, keeping in close contact with them, calling them every so often, and sending some claims to them personally. Terry reported that usually after winning an appeal, billing with company would go smoothly for a while; he attributed that to name recognition. Speaking hypothetically, Terry explained,

when the insurance representative gets the next letter from me, I would think he would recognize the name and know our company, especially if there were some phone conversations also. And that goes back to the development of great relationships with provider reps; they call you back. They are more apt to go out of their way to help out.

Finally, of course, in this case Terry eventually pursued the state department agency to ask them for help. He involved them by using their strength as the governing body for any insurance company conducting business in that state. This agency's strength lay in legality; as a result it was able to force effective and quick changes in the insurance companies' positions, sometimes within a matter of days. In this case, then, Terry requested this department to exercise its right to enforce legal guidelines and supervise non-compliant insurance companies. He

asked that the department step into the claim problem as a stronger, more effective agent than he had been.

Agents And Agency In Systems: Constraint And Choice

Theories of agency have frequently focused on roles or identities accepted by individual members of a collective or community. Beach (1998) concludes, "participants define their identities with the context of an activity. Participants constitute their identities as members of an activity system who have expertise in the use of certain tools or genres" (p. 5). Thus, agents are defined, constituted, by the work that they do; in Beach's definitions, agents are as much the conduits of the work performed as the tools used. However, other activity system theorists, like Russell (1997), Winsor (1999), and Schryer (2000) suggest that the members of an activity system are also agents of change and choice. Russell emphasizes this choice: "When an individual, […] takes some goal-directed action […], the subject might choose from a range of tools (p. 515). He further elaborates:

The first time one or more persons in an activity system (or between activity systems) are confronted with a need to carry out a specific action, to achieve a specific goal, the person(s) must choose some means of action, using some tool(s). If the person(s) perceives that the choice of tools and their use in a certain way has accomplished the goal, the person(s) might choose it again. (p. 517)

Schryer (2000), too, has focused on the role of individual choice in "structured and structuring" environments, theorizing about genres that it is "the concept of strategies and a related concept of strategies as networks of regulated improvisations that [defines] the limited kind of agency that seems possible with genres in workplace environments" (p. 9). And she notes that with this theory of workplace genre, "we can address issues of agency especially if we look for constellations of strategies. But we might have to admit that the kinds of agency we will find will be limited, especially in situations of power and hegemony" (p. 14). For Schryer and Russell, the issues of agency circle around the choices that an individual can make and the constrictions of the workplace goals and rules that limit those choices. In all, the idea of agency combines in dialectical tension all these ideas: worker in the system, constraint, and choice.

For these agents – Mona, Cathy, and Terry – the tensions and questions of agency reside between their roles as agents and representatives of their workplaces and the individual choices and experiences, which they bring with them to the workplace.

Choices

A variety of communicative tools (written genres, telephones, faxes, etc.) exist through which agents can pursue claims.

Some communicative tools lead to limited choices of responses from the other party.

Extensive experience and knowledge can help agents recognize the choices available to them.

A variety of types of claims can be used to pursue objectives: claims for more information, requests for the other party's stance, requests for proof, formal appeals to logic.

Exploring the agency of other people both directly and indirectly involved may lead to a greater recognition of arguments available.

Constraints

By choosing to file her claims only through one medium, Mona sub-consciously limited the type and number of claims she could construct.

By accepting the "proof" of the fax from the health insurance without considering all the circumstances of the other party's claim, Cathy removed her option to file an appeal.

Preconstructed strategies of one party – the health insurance company using automated telephone systems – can significantly constrain the opportunities for claims from another party – Mona.

Repeated (and obstinate) commitment to one claim may deter the other party for a while, but may not entirely prevent them form seeking other avenues for their own success.

By comparing their actions in pursuing problematic billing claims, we can recognize the choices available to them, choices that sometimes they do not even recognize. Further, we can explore and examine the constraints around which these agents work. In so doing, we can develop a finer understanding of the choices and constraints through which most writers work as they pursue and participate in arguments of their own.

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