Medicare claims wrongly denied

by Linda Everett

Testimony presented at the House Select Committee on Aging Subcommittee on Health and Long-term Care on Sept. 23, charged that the Bush administration has implemented hundreds of millions of dollars in "backdoor budget cuts to the Medicare program" by wrongly denying millions of legitimate Medicare claims for services to elderly and disabled beneficiaries.

The hearing was organized by Rep. Edward Roybal (D-Calif.), chairman of the Committee on Aging, after the committee was flooded with complaints about practices of private insurance companies, such as Blue Cross-Blue Shield and Travelers, that contract with the federal government to process Medicare claims. Roybal said complaints of wrongful denial or underpayment of Medicare claims have risen almost 300% since 1980, while the number of Medicare beneficiaries rose 23%. *EIR* has reported on many abuses perpetrated by Medicare processors. This hearing, however, focused on how the insurers' systematic and illegal denial of Medicare benefits causes physical and fiscal crises for patients, forcing some into bankruptcy to cover costs, and others, too poor to pay, deeper into illness.

The Department of Health and Human Services' Health Care Financing Administration (HCFA) oversees the Medicare program. It contracts with 34 private insurance companies as carriers to process and issue payment for about 500 million claims submitted annually to Medicare Part B which covers doctor visits, tests, and medical equipment. HCFA allows the insurer-carriers to develop their own criteria for determining what is medically necessary, what services Medicare will cover, and Medicare's allowable charge for services or supply. Some 20% of all the Medicare claims for health services filed last year, about 92 million claims, were denied outright by these insurer-carriers. Another 75% had payments *reduced*. HCFA's own statistics show that 60% of these claims, when appealed, resulted in additional payments—a 67% error rate.

Thus, the General Accounting Office (GAO) was asked to assess the methods HCFA uses to monitor the quality of carriers' processing of claims. They found what Rep. Ron Wyden (D-Ore.) called "gigantic holes" in the government's oversight of the insurance companies. HCFA's standard operating procedure is to have insurers randomly chose a tiny sample of claims and report to HCFA on how well they performed the documentation on those claims. There is no way of knowing when claims are erroneously denied. Nor is there any measure of the *extent of underpayment*. An insurer may refuse coverage for two foot-care treatments in a six-month period, which may seem appropriate to a HCFA reviewer—unless two visits were, indeed, warranted.

Diane Archer, director of the New York-based not-for-profit Medicare Beneficiaries Defense Fund, told the committee: "Indeed, there is no reason to believe that if all denied claims were appealed, two out of three would be reversed." Only 2% of patients appeal claims, millions of others are too sick to or don't know how. For beneficiaries and health care providers, Archer said, the Medicare administration is a "never-ending nightmare," with no way to correct misinformation quickly. She told of two clients all of whose claims were repeatedly denied for over a year. The insurer insisted the patients had died—despite countless calls and evidence by doctors.

Keeping payments low

Insurers have every reason to keep Medicare payments low, and to deny or reduce the benefits approved. The carriers are often the same private insurers providing Medicare supplemental insurance. Medicare covers 80% of the charge of an approved service, leaving the elderly to purchase secondary insurance for the remaining 20%. When an insurer-carrier denies a legitimate $100 Medicare claim, it saves the government $80, and the carrier $20 in co-insurance. Archer charged that HCFA "looks the other way when carriers implement policies that are illegal but save the government money." Said Archer, one computer mistake could take a patient's lifetime to correct. But, some patients aren't even that lucky.

Camilla Bourque, of Waterville, Maine, told the committee that her late husband was denied coverage of a seatlift wheelchair because the Medicare carrier, Blue Cross, said he did not have a disease of the legs. In fact, Mr. Bourque had no legs: He was a double amputee. But, despite his doctors' pleas and interventions by an attorney, Blue Cross denied payment. Blue Cross also refused Medicare coverage of Bourque's $11,000 hospital bill (after he died of kidney failure with an enlarged liver), because it was "medically unnecessary."

Roybal reported the case of Gale Swiech, a 42-year-old Connecticut woman with spina bifida who was forced to depend on her elderly father's fixed income for $400-a-month worth of dressings needed for twice daily changes of an infectious wound on her hip which her doctors say is necessary, but for which Travelers Insurance Co. still denies her Medicare payment. Dr. Leon Bernstein of Washington, D.C., who also testified at the hearing, told *EIR* that even with his decades of experience as a medical research scientist and a government health policy and systems researcher, he was confounded by Medicare's repeated denials of routine claims and procedures necessary for chemotherapy for prostate disease. What they were promoting, Bernstein said, was the kind of medical care that would have caused serious injury and grounds for malpractice.

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