

# Exchange Between Dr. Huntoon and former Medicare Medical Director, Dr. Gerald Rogan

Former Medicare Medical Director Gerald Rogan (California):  
Rogan's comments in [blue](#) regular print; Huntoon's comments in **bold** print.

Dr. Huntoon writes:

**Actually, the facts are in evidence. I did not accuse you of personally writing the EOMBs. "Medicare," however did put out highly inflammatory statements on EOMBs (printed by their computers and authorized by some Medicare bureaucrat) accusing hard-working physicians of providing "medically unnecessary" services to patients - millions of such messages over many many years. These messages caused undo tension and hostility between many patients and their doctors. The only thing I "accused" you of is being a "Medicare cheerleader," which evidence shows you to be. Unless I have completely misunderstood your previous comments, you highly favor the Medicare program, you "support the Medicare program," think that it is a good program that has "worked well." If this is not your position, please advise.**

**Physicians most certainly are routinely subjected to bureaucratic abuse by the Medicare bureaucracy.**

**I myself can testify to that.**

**The fact that Medicare has become the "best payor" in California is only testimony to the fact of how bad the others have become.**

**Further comments interspersed below.**

Dr. Huntoon, your remarks assume facts not in evidence. For example, I did not write the EOMB statements, nor does Medicare program routinely inflict horrendous abuses on physicians. The physicians who I worked with tell me in California Medicare is their best insurance program. Why are you making these statements? Do you recognize they are inflammatory and personal?

Your response suggests you hold strong (and perhaps emotional) beliefs about socialism and its safety net, versus its absence and no safety net. I am not interested in debating this with you. My point is that if the AAPS holds that Medicare should be repealed because of its socialistic aspects, and refuses to work with the Program to make it better, AAPS will become a reactionary fringe element with minimal effect on proactive change, and will disappoint me in the process.

**In view of your remarks above, I am somewhat shocked to see the personal and inflammatory comments you have made about those of us in the AAPS - i.e. "reactionary fringe elements." Since when is support of the U.S. Constitution and rejection of socialism, communism and fascism considered to be "reactionary?" Are we living in the same country?**

I support the Medicare program and think it should be expanded and improved. I support increased government activity in the health care arena for a variety of reasons. Socialism does work. Without the degree of socialism we have in the US, especially social security and Medicare, our middle class would be much smaller, the disparity between rich and poor much greater, and our political and economic way of life unstable. I believe President FD Roosevelt recognized this need, as did President LB Johnson. I believe repeal of the *Glass-Steagall* Act shows the

ongoing need for government regulation to keep greedy and self-righteous people who are in positions of economic power in check. Capitalism without government regulation will not work. Socialism without economic incentive is demoralizing. The proper balance is important. We experiment with this balance, and the fluctuations sometimes cause bad results, such as the stock market bubble□which was orchestrated by a few folks to make themselves rich, to the detriment of most of our people.

**I can see that there is really no point in arguing with someone, who despite what history has shown, thinks that "socialism works." It doesn't work, it never has worked, and it never will work. Trying to improve something that won't work is an exercise in futility. The Soviets learned this lesson quite well. "They pretend to pay us and we pretend to work" was the slogan of workers there in years past.**

**As for the bungling, waste, fraud and abuse such socialistic, health care systems bring, we need only look at your own state of California where "2.5 BILLION dollars in waste, fraud, abuse and mismanagement in the bloated Medi-Cal program alone" was reported recently by Citizens Against Government Waste ([www.cagw.org](http://www.cagw.org)). 2.5 BILLION dollars happens to represent about 10% of California's 25 billion dollar budget. These and other facts about how poorly the Medi-Cal system works can be found in the book 2003 California Piglet Book. It's a must read for those who believe such systems "work so well."**

If AAPS wishes to make changes in the Medicare program to move toward less economic control over physicians, the way to do it is to repeal the limiting charge rules. Those physicians who wish can then charge retail and see how many patients they get, vs those who accept assignment of the Medicare benefit from their patients. This small change will not eliminate the Medicare infrastructure and will not subject the beneficiaries to health care melt-down □which otherwise could be comparable to the melt-down of so many of our financial institutions and high capitalized companies.

**I think you have missed one of the salient features of socialism - it doesn't tolerate freedom. Socialism is about power, control and coercion, not about how they can give more freedom and options to those who don't like and who don't approve of the "system."**

The change will create two tiers of care which I view as two more tiers of a multi-tiered system based on ability to pay. I think that is OK. If the doctors who charge retail prove of no greater quality or significant access, the beneficiaries will not flock to them and the doctors will reduce their charges.

**Although the term "two tiers" is used in Canada in a derogatory sense by socialists to describe what would happen if they legalized the practice of private medicine, the remainder of your proposal sounds a lot like a small concession for the free market. By the way, did you know that the private practice of medicine in Canada is illegal? And, there is no escape for patients who need timely medical care for life-threatening conditions - i.e. they can't use their own money to purchase the health care that they need, when they need it? That's why they come across the border in droves to the good old USA where they can get the care that they need when they need it. That's one of the "costs" of a socialist health care system that socialists often don't like talk about. After all, it just affects a relatively few (compared to the healthy population). And, did you know that there are only three countries in the entire world where the private practice of medicine is illegal? Canada, North Korea and Cuba.**

I encourage the AAPS accept Medicare and get involved to make it better.

**As much as I would like to continue this futile debate, I do need to get back to more productive activities.**

Thanks for the lively debate. I have enjoyed it.

Dr. Huntoon, some of what you say rings true and some is a question of what our lawmakers decide and some is irrelevant and needlessly inflammatory in my view.

Now, that's a real twist. Medicare, the author of highly inflammatory statements on millions of Explanation of Benefits (which ultimately they admitted were highly inflammatory and changed them), who for years informed patients that their physicians were providing "medically unnecessary" services to them and now we find an affirmed Medicare cheerleader using the "inflammatory" word to describe those who complain about the horrendous abuses the Medicare program routinely inflicts on physicians.

The fact of the matter is, Medicare and HCFA got their bad reputations the "old-fashioned way" - they earned them!

Changing the name of the skunk to "pretty little kitty with the white stripe," doesn't change the smell.

I suggest AAPS can be more effective by working to change some of the aspects of Medicare it considers most egregious, rather than taking a position against socialized medicine entirely. The CERT program is measured by an independent contractor, not by a carrier or other claims processor. The findings are reported to CMS. CMS will take the appropriate action related to its contractors based on the CERT findings. I will check out the book you recommend. I am listening to Master of the Senate about Lyndon Johnson and it is very interesting so far.

The "aspect of Medicare" that most find "most egregious" is its existence. Trying to "fix" something, like socialized medicine," that is inherently evil and harmful to patients would be a little like sending Saddam Hussein to a girl's finishing school in an attempt to "make him a better person." Adding 1 gram of arsenic to kool-aid as a "compromise," is no less evil than adding 2 grams.

As a neurologist, who is intimately concerned with the workings of the brain, I have always been fascinated how seemingly intelligent people continue to cling to the myth that somewhere, somehow socialism is the best and "most compassionate" system in the world for distributing resources. The cold war of Socialism/Communism vs. Capitalism is over - the latter won. Socialism doesn't work.

Here is the one incremental idea I have that may work for AAPS and may work to improve quality as well which is a CMS goal---

1. **Repeal the limiting charge restriction.** This would allow doctors to bill up to their retail price for all services. Those services that are not a Medicare benefit may be billed without an ABN and those that are a Medicare benefit but which the carrier considers not reasonable and necessary may be billed with an ABN. This will not change the Medicare tax, but will change physician behavior. The result may be that higher cost physicians are those who do a better job, or are better salespeople.
2. **CMS or NIH** could develop a consumers report on doctors, hospitals, and drugs --- to help consumers determine value. For example, consumers in far northern CA would be able to discover that a low cardiac surgery complication rate would be expected if normal patients are routinely operated. The consumers report could

be done by a private group. Maybe the AAPS could provide this service and charge for it? I first heard of this idea from former Governor Kitzhaber of Oregon. He might be available to consult with AAPS.

### **3. Organize a debate with AAPS regarding Medicare and the social safety net.**

**Perhaps you should conduct a "trial debate" with inmates in a prison of your choice and ask them how they feel about the "total security" and "social safety net" provided to them by the government. I suggest a one question questionnaire: If you had a choice between freedom and the "security" of a government-sponsored "safety net," which would you choose?**

Dr. Huntoon Writes:

**Dr. Rogan:**

**I think it is fairly clear from your comments, that there is quite a lot that you don't know about AAPS. I am, of course, happy to inform you about the many outstanding accomplishments of this one of a kind, national medical organization. Putting known Marxists in charge of committees to design a system of socialist medical care, is not a concept that most Americans embrace. We also note in her comments to a certain senator, that the author and director of the socialist health care task force commented that she felt the government would know better how to spend money on health care than individuals. We disagree - as do the majority of Americans who rejected the Clinton Totalitarian Health Plan.**

**My further comments are interspersed below in bold print.**

Dr. Huntoon--I did not know the AAPS sued Clinton under FACA. My compliments to AAPS. Clinton's health plan development process was illegal according to a CMS attorney FACA expert who explained to me how the Clinton process was illegal--and why it was stopped by a lawsuit.

The dead patient who was alive was a problem with the social security administration. The SSA signs up the patients for Medicare and tells CMS who is dead. Probably some computer glitch with the name or birthdate or some related screw-up. It obviously happens. So why is that important? Out of 35 million people, a problem now and then is not unreasonable. I diagnosed a pheochromocytoma once--that is rare too.

**I am sure that there are many dictators over the course of history who would fully agree with you. Adolph Hitler, Stalin, and more recently, Saddam Hussein, could make the same argument: They only killed a relative small percentage of the world population; A dead (fill in the blank) every now again "is not unreasonable." Moreover, using the same argument, some terrorists would likely argue that the World Trade Center was just a couple of buildings out of so many buildings in the world, and such a "rare" event; what's the problem?**

**My example highlights the egregious level of incompetence that exists in the Medicare system. Do you think it is "reasonable" for bureaucrats to argue with a patient and a licensed physician**

for nearly a year as to whether she was alive or dead? And, yes Medicare law is part of the Social Security Act, and they are essentially one big happy, bloated and bungling bureaucracy.

"works well" must be considered in the context of the overall error rate. Errors happen. The question is how many, how often, at what expense, and what can be done about it. This is why CMS' new Contractor error rate testing program (CERT) is so important --- to quantify the error rate and determine the additional resources that should be allocated to reduce the error rate.

The question is, what is the true "error rate" committed by Medicare carriers? I and many other physicians have good reason to believe that it is a lot higher than the carriers themselves have told us. It is clearly unreasonable and illogical to allow Medicare contractors to evaluate their own performance via ACERs. Would you allow a bank robber to decide if he is guilty or not? This is, however, the way the "system" has been designed and the way it has operated for many years. In the case of the Florida contractor which was deleting and throwing away hundreds of thousands of clean Medicare claims (as confirmed by the Medicare whistleblower who witnessed it first hand), the carrier continued to report stellar compliance and performance to HCFE via its ACERs. And, other evidence was presented to show that this is far from "rare." Throwing more money at the "problem," as Canada has seen, is clearly not the answer to "improving the system."

The alternative AAPS seems to propose is to get rid of Medicare--which I assume means that we will offer no social safety net underwritten by the government and taxpayers--go back to 1964--is that correct? I have heard this is the position of the AAPS--no social safety net for seniors? Is this true? If so, what alternative does AAPS recommend?

AAPS is opposed to socialism in any form. We are also opposed to fascism, communism and totalitarian forms of government in general. What some so "compassionately" refer to as the security of a "social safety net," is anything but compassionate. There are many people in these United States who currently enjoy 100% security, compliments of our government. All of their meals, clothing and health care needs are "covered" by beneficent government. Unfortunately, these individuals have had their freedom curtailed rather severely as they reside in various prisons throughout the nation. Their "safety net" largely consists of bars, high walls and razor wire. Likewise, those who are under a government health care program, have had their freedom curtailed. They are the "beneficiaries" of government-rationed health care (since everyone can't have everything they demand), and for most there is no escape from the "system." If a physician is unable to provide a "covered benefit" under the Medicare program, because Medicare has set the price so low that it is impossible, most people are shocked to find out that they cannot spend their own money on their own healthcare to receive that "covered benefit" - it would be illegal for the physician to accept the payment. And, if the physician cannot provide it, the patient may have to go without.

I would also encourage you to read the book entitled "Medicare" by Sue Blevins (recently published by the Cato Institute). It dispels many myths people have about Medicare - like seniors were in dire need of it at the time it was passed, for instance (most seniors had perfectly good health care coverage at the time) and didn't need the "social safety net"). Her book is extremely well-documented. The pamphlet which I wrote for AAPS entitled "Medicare Myths and Facts: What the Government Doesn't Want You to Know," summarizes many of these Medicare myths. It is available online at [aapsonline.org](http://aapsonline.org) under "brochures."

I agree with you that a system that does not reward excellence can degenerate to rewarding--or at least tolerating--incompetence. I think the carriers and CMS could do a lot more to reward competence, if not excellence. I do not know how to fix this, or how it could be fixed. I did not know how to fix this when at Medicare, and on some days I feel a victim of this problem personally.

**The "system" clearly not only tolerates, but by ignoring incompetence that is brought to their attention many many times over many years (as I have the documentation - 10 bankers boxes full - to prove), clearly "values" incompetence. If they didn't value it, they would actually do something substantial to eliminate it. And, throwing more money down the rat hole, is clearly not the solution.**

But overall, from my experience and the feedback of the doctors who could always call me, Medicare works very well. 99% of the claims are processed on time. We will see what the error rate shows and what corrections are required. I fixed lots of screw-ups when at Medicare. What impressed me is that improvements can be made. My point is the system can and will improve and need not be abandoned---it much be changed--but not discarded--unless you have a better solution. I do not think the free market will work--but maybe your vision is wiser than mine.

**Allowing doctors to call you and discuss problems is indeed a very rare occurrence in my experience and the experience of many other physicians with whom I communicate. I contacted our carrier many times and asked to speak with the medical director so as to clear up problems that could be easily cleared up, but was routinely informed that it "wasn't their policy" to allow physicians to talk to the medical director. They refused to provide his number to me.**

So, I invite the AAPS to debate me to discuss problems and consider solutions. Solutions could include raising the limiting charge, or removing any limiting charge. If our seniors and/or our society would do better without Medicare, an experiment to see what happens without a limiting charge would be interesting and not require repealing the entire Medicare law. The change would be incremental--which is usually more acceptable to lawmakers and the general population. Eliminating the limiting charge rule is an option AAPS could consider--it is less radical than eliminating Medicare and may show everyone whether a "free market" will work better. What do you think of the idea? Do you understand what it means? If not, I will give you more detail.

**AAPS has opposed limiting charges in the past when they were implemented, to no avail. Government price controls are always part and parcel of any socialist health care system, such as Medicare. The socialists recognize that this is the only way their system can "work." When government interferes in the free market system, where sellers and buyers interact directly with one another, the economic results are predictable. When a "third party" (government) pays the bill, neither physician nor patient have any incentive to control costs. Cost inflation and rationing of whatever is price-controlled is always the end result. Always, no exceptions! Patients who have been repeatedly told by politicians that they have a "right to free health care," have come to view government as their "protector" from the "high prices" of medical care via price controls. What most fail to recognize is the overt and covert rationing that occurs as a result - clearly not a "benefit" for the sick patient. Elected officials who attempt to actually uphold the U.S. Constitution, as they have sworn to do, by rejecting socialism (socialized medicine), clearly recognize that they will be touching the "third rail." People clearly**

do not want to hear that it can't be provided for "free." Government does not produce anything of any value. Government can only provide to people what first it takes from people (via taxation). Alas, "From Each According to His Ability, (a "progressive tax system") and To Each According to his Need (the "social safety net") has become part of the American "system." You, of course, recognize the origin of this infamous phrase.

BTW--you are correct, once the doctor's claim is denied for lack of medical necessity, the doctor is informed and can no longer deny, for future claims, lack of knowledge that Medicare will not pay. So for each service, arguing lack of knowledge as a defense only works once.

As for so many rules--well--we retired over 100 LMRPs in CA and many other carriers did the same. But, there are still lots of rules-- and the doctors who bill under those rules are responsible to know them--or take chances of repayment and an educational experience--so, I may have lots of work consulting.

Yes, I would consider 132,000 pages of rules and regulations with which doctors must comply to be "a lot of rules." So much so, that the government could easily target any physician in this country and find some violation. The Soviet KGB has a phrase for this sort of situation: they said "Show me the man and I will show you his crime." Is this a fair and "reasonable" system. Clearly not.

Tomorrow I will send you my analysis of the stock market bubble. See how it compares. Best wishes.

Dr. Huntoon writes:

As a matter of fact, I have contacted my Congressman many times concerning the widespread bungling that occurs in the Medicare bureaucracy. And, I have the letters (i.e. ample documentation) to prove it.

On one occasion, I wrote multiple letters to the local Medicare contractor, the HCFA Region II

Office and to the main HCFA office concerning one of my patients whom the bureaucracy that "works so well" in your estimation, wrongfully and prematurely "killed off" in their computer database "system." Medicare kept writing to my patient (an 80 some year old woman) with official letters addressed "To the Estate of....lady's name." In other words, the "wonderful Medicare system," literally tormented this poor woman by making her read what amounted to her own obituary. My letters to the carrier, to the HCFA Region II Office and to central HCFA headquarters in Baltimore were of no avail – they "couldn't do anything about it." The lady called up the Medicare contractor and the HCFA Region II Office (Mr. Preston Lowen) and informed them that she was still alive. She also went down, in person, to the local Social Security office and presented her picture ID to prove that she was still living - but none of the Medicare bureaucrats would budge. Over the course of many months, I wrote to my Congressman, and he too got the bureaucratic run around from the Medicare bureaucracy that "works so well." Finally, the Medicare bureaucrats reluctantly agreed to resurrect the poor woman - but there was just one catch. Apparently because there was no real protocol or mechanism for re-instating someone who had been "declared dead" by the bureaucracy, they assigned the woman a new name and a new Medicare number to go with it. They actually named her after a name brand enema! (and I have

the documentation to prove it). This required that I and the patient write further letters to the Congressman to protest. And, finally, after nearly a year of arguing with the bureaucracy that "works so well," they gave the woman her own name and Medicare number back. All of this letter writing, of course, cost me hundreds of dollars, not to mention the total aggravation of having to deal with the "system" that is so full of totally incompetent people!

**Further comments to your misimpressions are interspersed below in [blue] print:**

Dr. Huntoon, thanks for replying. I hope you will take some of your energy and speak to your congressman about improving Medicare.

Some people in the carrier understand little or nothing about medical care because they are computer experts and secretary types. Customer service understands almost nothing about medical care because they are entry workers with minimal training. Their training is several weeks. Their answers are supported by a software system that shows them the claim and the relevant rule. The rules are explained to them in plain English and are made available on their computer screen for the relevant call. The screens are created by behind the scenes support people usually nurses and sometimes the medical director write these instructions.

**The above is merely an excuse to "explain" why Medicare contractors are not very competent at what they do.**

**It simply sustains the findings of the GAO study - 85% of the time, Medicare personnel get it wrong. If a company hires incompetent people to perform a job, what else would we expect to get but incompetence?**

Most of the customer service people work at the carrier where I worked for a short time while going to college. So, variability with customer service does not surprise me. The customer service job typically is not used as a way to move up in the organization□at least in our shop. That's not the "system" ---that is the way one customer service shops I know about works. The importance of customer service to Medicare is similar to the importance of credit card customer service.

**As you have explained, however, hiring incompetent individuals to work for Medicare is really part of the "system" - it is the way it has been designed to work.... or rather not work. And, there's a huge difference between customer service at a credit card company and at Medicare - one has a choice whether or not to do business with the former. Past age 65, most really have no choice but to deal with the Medicare "system." And, non-participating physicians who don't participate because they disagree with the "system," also have no choice but to deal with the "system," unless they choose to opt out under Sec 4507.**

In my experience, most of the ALJ's in northern California are very sympathetic to the appellant. Some I would call biased, based on my experience. Some do not try to understand the science of Medicine when two doctors disagree but find for the appellant. For example, when I argued before the ALJ that a certain treatment was worthless and that the evidence was uncontrolled level 5 and that the experts in the field did not support the treatment the ALJ found for the appellant. The doctor was paid for a medical service for diabetes which is not supported in the literature.

You are correct, that the "system" is set up so that physicians are hassled to get paid if the carrier AND the hearing officer denies payment. However, this is not a common problem. When it does happen, sometimes it is because the doctor did not pay attention to the rules and had consultants that did not pay attention as well. Remember, if the doctor cannot be expected to know the rule, the doctor can keep the money.

**Surely you jest! Physician payment hassles and denials by carriers and hearing officers not a common problem???**

**Who are you kidding?**

**And, the little "loophole" regulation that you cite where doctors who did not and could not reasonably be expected to know the rule or regulation rarely works - because, the carrier will routinely offer as proof of "advisement" the thousands of patients of fine print in the Medicare Bulletins sent to physicians or the thousands of pages posted on the website. In my experience, and I have used this regulation on one occasion, it works only once - i.e. after that, Medicare considers that you have been duly "notified" of the rule or regulation.**

So, in my view the "system," is not set up to promote theft of services—at least compared to other systems, such as the stock market based on the repeal of the Glass Stagal Act. But some doctors do miss out on some money to which they are entitled, or have to spend a lot of energy to get it. But, overall, considering the \$50 billion paid out, the dollars involved are not much taken as a whole. Medicare has implemented a CERT process to measure the claims payment and denial errors to quantify the problem so recommendations may be made.

**The very nature of third party transactions, where the physician need not ask the patient directly for money (except of small copayments etc), is clearly an open invitation for fraud. And, yes, doctors "miss out on a lot of money" to which they are entitled, because Medicare cheats them out of it! Physicians routinely have to spend a lot of money just to collect the paltry, and ever decreasing amounts, "allowed" by Medicare. For those of us who do not live off of government or government contractor paychecks, that's a very big deal. There is such a thing called profit and loss. If you have to spend \$20 to collect \$10, guess what?**

*You state---And, in my experience, and in the experience of many other physicians I have talked with, hearing officers will frequently manipulate this process so that the doctor cannot proceed up the appeals ladder - by allowing just enough claims so that the amount in dispute doesn't reach the necessary threshold. ---My response is when that happens call me and I will offer consulting services to the doctor for a fee and help.*

**If it's for the "betterment" of the system that "works so very well," why wouldn't you simply offer your services free of charge? If it "works so well," and this type of thing happens so rarely as you say, it seems that your services likely wouldn't be needed very often if at all. And, if it's "for the good of society," and the Medicare system that you so love, why wouldn't you simply help the system "work better" for free? In fact, maybe we could even refer to your services under a "correct paycheck initiative," as simply "included in" service you performed for Medicare in the past. That would at least be consistent with "the system."**

I agree with you that *Due Process* assumes that there is an inherent fairness of the "system" such that "differences of opinion," as you put it, can be resolved by those who are **competent** to resolve them. When the "system" allows an incompetent person to make medical necessity decisions about services provided, the system is necessarily depriving physicians of substantive *Due Process*.

**Thank you for your agreement. Medicare does, in fact, routinely deprive physicians of *Due Process*.**

However, my response is that competency cannot be defined by the appellant who disagrees with the medical expert representing the carrier. If the carrier medical director, or the medical expert used by the carrier is incompetent, in time that individual is no longer used. For example, I removed from our panel a specialist who demonstrated lack of knowledge in his specialty area, and overruled his denial of the claim and paid the doctor. However, this does not happen very often. In that case, the specialist was with the company for many years and had retired. But, that can happen in any system.

**What about competency as defined by a State Licensing board? Would you accept that? If so please review my comments as previously stated below regarding the "incompetent medical director" (your term). "In time that individual is no longer use." What a joke! In time, we all die too. Doesn't happen very often? Give me a break!**

**The "system" encourages such incompetence and routinely keeps Medicare medical directors who have made incompetent decisions as defined by a neutral third party - such as a State Licensing Board.**

Medical necessity decisions at Medicare are made by medical staff, most of the time. Sometimes non-medical staff made medical decisions and when I found out about, heads rolled. Medical necessity decisions are supposed to be made by medical staff. However, once the decision is made such as an ECG is not needed for an ingrown toenail non-medical people can deny the claim when that type of claim is reviewed.

**Yes, "medical necessity decisions are supposed to be made by medical staff," but the facts as documented by the 1993 GAO study found otherwise. The world is "supposed to be" fair too, but that doesn't make it so. As far as "heads rolling" is concerned, in my experience, it was more like heads were promoted. The more incompetent the worker was, the higher he or she rose. The one who denied that the woman was still alive, for instance, was promoted forthwith to a managerial/supervisory position at the carrier.**

As far as I know, hearing officers can provide as much false information as they like but eventually they are fired for it I saw this happen. Moreover, the contract they have with the carrier is that of a regular employee and the wages are certainly not what I would call lucrative. I paid my office manager more money in some cases. The carrier gets no credit for improperly denying claims under the CERT program a denial error is a demerit. The CERT program is just getting started, so improvement is likely. Improvement could mean finding a way to make the system work better by being sure more of the people working in the system are accurate and accountable.

**Show me the proof that hearing officers are held accountable and "fired" for providing false information. The ones that I know have been working for years and are doing quite well, thank you.**

*You state We also note that when people in the business community commit fraud, they frequently go to jail. When individuals working for Medicare contractors commit fraud, they rarely go to jail. The "system," you see is such that it tolerates a great deal of fraud by Medicare contractors.*

Well, I am not sure how you know this but I disagree. The best way to get away with fraud is to steal a lot of money just look to some bank/brokerage houses as an example. Incompetent individuals are not necessarily fraudsters. The fraud word is overused especially by doctors who use it to justify their anger by claiming they are being accused of fraud when Medicare does not pay for a service supplied. That is complete hogwash and is promoted by consultants and organizations who want to scare you to get your money.

**Actually, the way that we "know this" is by first hand reports by a Medicare Whistleblower by the name of Theresa Burr, who worked for the second largest Medicare contractor in the nation. The lawsuit is a matter of public record. And, although the OIG was firmly convinced of fraud, no one ever went to jail for it. The carrier was allowed to quietly settle - for a relatively small monetary fine. And, incompetent individuals who deprive physicians of due process and proper compensation for services provided are, indeed, committing fraud. They have a contract with the government to process claims in a competent fashion, and when they deliberately place incompetent people in positions that they should not be in, they are surely committing fraud on a grand scale. And, when Medicare arranges for seniors to receive services without paying for them (via a whole host of hidden, secret screens, "correct" coding initiatives and ambiguous LMRPs, they are most certainly committing fraud against the physician.**

*You stated: Your comments that the Medicare "system works well," are quite typical of comments I have heard from other medical directors who work for Medicare. A secure pay check is a rather reliable incentive not to bite the hand that feeds or fed you.*

**You will note that I used the word "fed" in the past tense.**

My response is that I no longer work for Medicare and have nothing to do with CMS or my former company in any way. I can say anything I want without any financial consequences, so long as it is not slander. I have no conflict of interest or hidden agenda.

The incredible 132,000 pages of Medicare laws, rules and regulations, sometimes are vague but rarely are contradictory. When I found problems, I got clarity and explained it to the doctors. Most of the (LMRP) policies at [www.medicarenhic.com](http://www.medicarenhic.com) I wrote. See if you can understand them. The "correct coding initiative" is required because doctors try to overbill all the time such as billing an arteriotomy repair for placement of a vasoseal device following a cardiac cath or billing an office visit with every PT visit done in a FP office. CCI saves about \$10 billion a year in duplicate payments. The CPT system cannot work without CCI because some services are a-la-carte, and some services are a full dinner. Without CCI, the full dinner would always be billed a la carte and the payment would exceed that with the RUC committee of the AMA thinks is reasonable relative to other services. For example, without CCI, an appendectomy would be paid and a separate payment would be made to close the wound.

Well, I must be the unluckiest physician who ever was, because I found contradictory Medicare regulations to be quite common. I can recall one so-called "correct" coding initiative having to do with 93880 and 93875, for instance. Medicare totally improperly "bundled" (a kind word for "theft") these two together - a fact which they ultimately agreed with, after I spent thousands of dollars pointing out their incompetence and proving it to them. And, when I contacted the carrier that creates the CCI in Indiana, they provided me with totally contradictory and false information - a fact which I can document as they responded in writing, and the Region II Office agreed, finally, that they were wrong. The problem with the Medicare system is that everything is increasingly "included in" something else (often times not an "ala carte" component). What Medicare has done is a little like declaring that for a \$3.89 "value meal" at McDonalds, the consumer is "entitled to" a 16 ounce steak, vegetables, salad, dinner roll, and a five star dessert because it's all "included in" the price of the value meal. That's called government "devaluation" of physician services. Some would also call it theft.

LMRPs differ substantially from carrier to carrier for a variety of reasons the most important of which is that some areas have waste and abuse that other areas do not have. For example, IVIG is abused in LA but not in Mass. See the LMRP on IVIG at [www.medicarenhic.com](http://www.medicarenhic.com). I wrote it to help stop payment for probably \$10 million paid for IVIG for conditions for which it is ineffective. The mark-up profit is \$2 for each \$3 Medicare pays.

So, if you still think the Medicare system does not work well compare it to the alternative.

Yes, in fact, I have considered the "alternative," and frankly I like it! The free market seems to work rather well for every other business enterprise, why not medicine? We don't have government price controls on essential foods (fruits, vegetables, bread etc) or on cars or on clothing. And, retailers don't have to incur the expense of dealing with 132,000 pages of incomprehensible government regulations every time they sell an orange. Just think what an orange would cost if it was subject to the Medicare "system."

With respect to Medicare financing that is another issue. You may believe we should not have a medical care social safety net for our seniors, that the financing of Part A is outrageous that society should support young families more than elderly etc. etc. You may oppose government price fixing which is part of Medicare now, but need not be. Did you know that Medicare contractors make no profit and a lot of companies have quit being contractors because of no profit?

Actually, I believe in supporting our U.S. Constitution. I have searched diligently in that document, but am unable to find the passage that requires "society" to provide health care, food care, car care, clothing care, and which would make everyone dependent on government. In fact the way that I read it, the authors designed the government to have only a very limited role in our lives, protecting us from invasive government that meddles with nearly every aspect of everything that we do in our lives. It's a little concept called freedom. And, please don't insult me by telling me that those poor "non-profit" carriers don't make any profit from the Medicare system. Just because "non-profit" is in their name, doesn't make it so. If they didn't make a profit, they wouldn't do it. They don't do it as a public service out of the goodness of their hearts.

Medicare A is financed by workers, some of whom are poor with small children, and have no health insurance, --for the benefit of retirees and disabled some of whom are rich and can afford to buy private health insurance. Is this a huge Ponzi scheme across generations? I think it is. I think this type of financing must change. It is not illegal it is just outmoded. Part B is financed by taxes on all earnings, not just wages, and is fairer. It still represents a shift of wealth from the younger ages to the older ages. In my opinion, I do not mind because the people who get Medicare now saved me from speaking German or Japanese as a first language. In my view, they earned it, even if they did not pay enough for it when they were working. But that is just another value statement not a factual analysis of the system.

**Thank you for pointing out the reverse Robin Hood concept which is part and parcel of the Medicare "system" - i.e. taking from the poor and re-distributing to the better off. I couldn't have said it better myself. And, thank you for acknowledging that Medicare is, in fact, nothing more than a huge Ponzi scheme. I am sure you recognize that all Ponzi schemes eventually collapse - there have never been any exceptions. And, you are correct that the Medicare Ponzi scheme "isn't illegal," because Congress has passed legislation, but it does represent, nonetheless, "legalized plunder" as defined by F. Bastiat (The Law). Bastiat said look and see if government does what an individual cannot do without committing a crime, and that is the definition of legalized plunder. Neither you nor I could legally run a Ponzi scheme. Government, however, has declared their own scheme to be "legal." Sort of diminishes the term "legal," don't you think? Theft, after all, is theft irrespective of what you call it. I also feel that those who fought in WWII etc deserve better treatment than that provided by a "no escape" Medicare system that rations their medical care and forbids them to spend their own money on their own health as they see fit. And, although I am sure you haven't read the AAPS pamphlet I wrote on Medicare Myths and Facts, you really should (its available on aapsonline.org). I dispel many common myths such as that you state when you say "they earned it." Actually Medicare "beneficiaries" today receive much more than they ever paid into the "system" (in constant dollars) - and that's a fact!**

From what I can tell the AAPS has taken a reactionary stand on Medicare. The AAPS makes unsubstantiated and misleading inflammatory statements resulting in upsetting people for no good reason other than to make it look important. I am very disappointed because Medicare could use a national organization that is a trade group to help doctors. Currently the AMA is the only organization that represents doctors and it does not consider itself a trade group although it really is in many respects. In my view, the approach of the AAPS will assure that it remains a fringe organization whose information is considered unreliable and misleading. I invited the AAPS to attend my CAC meeting, but no one ever came.

**AAPS supports the U.S. Constitution and our free market system - as opposed to socialism (socialized medicine), communism, fascism etc, which some misinformed people think are "more compassionate" systems. The documented facts and history clearly show that socialized systems are anything but compassionate.**

**We believe that patients are smart enough to choose their own medical care and those who provide it - unlike others who believe that patients are "too stupid," and government must make all of those important health care decisions for them. It is no doubt "upsetting" for some to hear the term "socialized medicine" in reference to Medicare, but the fact is the Medicare system does represent socialized medicine for those over age 65. The truth is sometimes unpleasant to hear, but it's still the truth. And, as far as the AMA is concerned, we note that according to its published membership numbers, it doesn't represent the majority of physicians in this country. The AMA no longer depends on physician dues to sustain its financial survival (does this impact**

accountability to the membership?). And, most physicians are unaware of the little known agreement which the AMA made with the government back in 1983 that granted the AMA a monopoly on the coding system required in all government programs. Care to guess what the revenue stream is from selling CPT coding books and related items? - off the backs of U.S. physicians. If an organization is granted a highly lucrative monopoly by the government, do you think they would be more favorable or less favorable toward government-run medical programs?

I am also unclear on what AAPS information you find to be unreliable or misleading? Do you have any documented, concrete examples of false information at all, or are you merely spouting a biased opinion?

Had it not been for the AAPS (AAPS v. Clinton), we would all be living under a socialist system of medical care right now. Thankfully, AAPS took the stand that the public's business should be conducted in public instead of in secret, behind closed doors (FOIA Law). Once the grand socialist plan was exposed, people were rightfully frightened and rejected it. AAPS would thus appear to be in agreement with the majority of the American public who value their freedom and don't take it lightly.

Best wishes.

Dr. Huntoon Writes:

Dear Dr. Rogan:

The "system," unfortunately is administered by a horde of bureaucrats who, for the most part, understand little or nothing about medical care. In my experience, and as reported to me by many other physicians, the people who work for Medicare are, in general, not very competent at what they do. The recent GAO study confirmed this conclusion. When individuals working for the GAO called up various Medicare carriers and asked very simple questions, the answers to which had been clearly published in their own Medicare bulletins and on their own website, they found that 85% of the time carrier personnel gave an answer, which if followed, would result in claim denial. 85% of the time they got it wrong! That's the "system."

Your advice that if the physician isn't happy with the so-called "fair" hearing (which is usually anything but fair and unbiased), he or she can appeal to the ALJ ignores the reality that many of the ALJ's at least in this region of the country are highly biased in favor of the carrier. Experience as related by the League of Physicians and Surgeons confirms this - i.e. it is fairly common knowledge. And, your advice is pertinent only if the amount in dispute reaches a certain threshold to proceed up the ladder of appeals. The "system" is set up so that physicians are expected to accept some loss by default since it doesn't reach the threshold for ALJ or District Court appeals. The "system," thus, is set up to promote theft of services. And, in my experience, and in the experience of many other physicians I have talked with, hearing officers will frequently manipulate this process so that the doctor cannot proceed up the appeals ladder - by allowing just enough claims so that the amount in dispute doesn't reach the necessary threshold.

The example I provided of the "incompetent medical director" (your term) is indeed an example of lack of due process. Due Process assumes that there is an inherent fairness of the "system" such that "differences of opinion," as you put it, can be resolved by those who are competent to resolve them. When the "system" allows an incompetent person to make medical necessity decisions about services provided, the system is necessarily depriving physicians of substantive Due Process. Moreover, I would point out to you the GAO study published in 1993 which found

that over 90% of medical necessity decisions at Medicare were made by those who have only a high school education. Where, we must ask, is the substantive Due Process in a system that is set up to allow high school graduates to sit in judgement over highly trained physicians in making medical necessity decisions?

The other example I provided where the Medicare hearing officer deliberately provided false information about Medicare laws and regulations and used that false information to deprive me of my Due Process rights of appeal (he claimed I had no standing to appeal, and there was no further appeal, therefore, to his decision). The Medicare hearing officer was an attorney who had been conducting so-called Medicare "fair" hearings for years. As an attorney, who was serving as a Medicare hearing officer, he clearly knew or should have known the Medicare law. In my discussions with the League of Physicians and Surgeons (who defend many physicians with wrongful Medicare claim denials), they confirm that this type of tactic to deprive physicians of Due Process is frequent and typical. And, we note that they "system" does not provide any means to hold such hearing officers accountable when they commit these wrongful acts. Unlike physicians, who may be accused of providing false information and risk going to jail, hearing officers can provide as much false information as they like with impunity while maintaining their lucrative contracts with the carrier for a "job well done" (denying claims). This is the "system."

We also note that when people in the business community commit fraud, they frequently go to jail. When individuals working for Medicare contractors commit fraud, they rarely go to jail. The "system," you see is such that it tolerates a great deal of fraud by Medicare contractors.

Your comments that the Medicare "system works well," are quite typical of comments I have heard from other medical directors who work for Medicare. A secure pay check is a rather reliable incentive not to bite the hand that feeds or fed you.

The incredible 132,000 pages of Medicare laws, rules and regulations, which are extremely vague and often contradictory, the incredible complexity of so-called "correct coding initiatives," which in my experience are anything but correct (they represent simply another scheme to cheat physicians out of actual services performed), the constantly changing LMRPs, which frequently differ substantially from carrier to carrier, do, indeed, represent the Medicare system. And, it is clearly a system, when viewed from the perspective of those who must contend with its abuse and incompetence on a daily basis does not work well! ...unless you view routinely cheating physicians out of proper compensation as "working well."

Medicare is a system which clearly promotes fraud. Assignment status, "participating status," is an open invitation for fraud. It is very hard for a physician to commit fraud when he is paid directly by the patient. It is very tempting and easy for a physician to commit fraud when the money comes "directly from the government," and the patient could care less about what it costs because it "isn't coming directly out of his or her pocket." It's viewed as "free." This situation clearly leads to cost inflation - that's a direct result of the "system." Neither party, physician or patient, has any incentive to control costs. It's a system that clearly does not work well - i.e. government price fixing as opposed to the inherent mechanism of price control in the free market where consumers and sellers interact directly. Likewise, fraud committed by Medicare contractors is rampant - 25% of carriers, by some estimates. It is a "system" that allows Medicare contractors to largely evaluate themselves in terms of their performance (ACER). Does that "system" work well? Clearly not! And, why shouldn't the Medicare carriers commit fraud. Even if they are caught, they are likely never going to go to jail and the company will merely pay the fine for them. We have shown this time and time again in AAPS (Association of American Physicians and Surgeons). It's the perfect crime - no risk.... and a lot to gain.

And last but not least, let's look at the way that Medicare is financed. Is it a "system that works well" and is financed on a sound basis? Clearly not. It is in fact nothing but a huge Ponzi

**scheme. If any private business were to implement this "financing mechanism," as Mr. Ponzi himself found out, they would clearly be prosecuted and go to jail. It is, therefore, a highly fraudulent financing mechanism. And, when demographics change, many people will suffer when the Ponzi system begins to crumble - both those who have come to depend on it and those who will pay the increased taxes to support it.**

**How does one conclude that such a system "works well?"**

**L. Huntoon, M.D., Ph.D., F.A.A.N.**

Dear Dr. Huntoon

It is important to distinguish the system from the variety of the people who work within it. A system may be relatively properly set up with appropriate checks and balances and a valued deliverable product, yet not always work optimally. We have examples of this all the time, most recently within our financial institutions, and, perhaps with the current scandals elsewhere. If the Medicare program is not working properly, the dysfunction could be related to its level of administrative funding, the manner in which medical directors are credentialed or how their service is valued by those in a position of authority to make change. Your complaints do not necessarily support an allegation the Program is improper but may support the need for improvement.

With respect to your comments and mine, I had six years working as a CMD within the largest carrier in the US California. I worked with hearing officers on a regular basis. I wrote LMRPs and oversaw carrier review which hearing officers also reviewed.

You are correct that the hearing officers are not completely independent of the carrier, because they share the same boss up the line. However, the carrier where I worked responds to hearing officer overturns of doctors claims by reviewing the LMRP, rule, regulation, or the reliability of the reviewers rather than compelling the hearing officer to improperly uphold a carrier denial. It is possible other carriers handle hearing officers differently. Congress has passed a law to remove hearing officers from the carrier control. But when the hearing officers uphold a denial, the doctor can appeal to an ALJ.

The behavior you see may not be explained by the motivation you postulate. That is where I can shed some insight.

Your response did not validate my statement was incorrect---

"...individuals, who most of the time act in good faith completely independent of everyone else"

My response to you is although people are not homogeneous and improper interpretation of regulations can happen. The hearing officers at my shop overturned the carrier on many occasions, particularly for ambulance claims. The major problem was lack of sufficient documentation with the initial claim.

In your example of an incompetent medical director the problem you explain was a difference of opinion not a lack of due process. You thought the CMD opinion was so improper that the CMD was incompetent. A difference of opinion is not the same as a lack of due process. This is an important difference. Due process is important, even if the appellant disagrees with the result. When due process is denied, we all suffer. Medicare has remarkably accessible due process when doctors understand how it works and use it. This is

one reason I am exploring consulting services for physicians to help them work with the system.

As far your the comment I have not lived in the real world, I should point out I practiced for 23 years during which I signed my own paycheck. I was audited by Medicare twice and paid back some money. My billing company made a mistake and listed the wrong doctor as the supervising physician for incident to services performed by a NP. I could have appealed the recoupement to an ALJ stating the single line entry in a Medicare Bulletin (explaining the rule) 7 years earlier was not sufficient noticeso I could not have reasonably have been expected to have known of the error. With this argument to an ALJ, the ALJ could have ruled that I could keep the money. Instead I just wrote a check because I was working for Medicare by that time and did not want to embarrass anyone.

My point is that Medicare works pretty well for the 900 million claims it processes and the \$50 billion it pays out. Nothing is perfect but it works pretty well overall. It could work better, its administration could be funded better, and it could be administered with incentives that promote excellence instead of mediocrity. But overall, Medicare works better than most organizations responsible for so much money. Compared to the SEC ---well- there it is.

Dr. Huntoon Writes:

**I must respectfully disagree with some of the statements made below.**

**Surely the author was joking when he said that Medicare hearing officers are "...individuals, who most of the time act in good faith completely independent of everyone else." In my experience, nothing could be further from the truth - as I document in the article Abuse, Lies and Audio Tape, published in the *Medical Sentinel* (i.e. I clearly caught a lawyer-hearing officer misrepresenting Medicare regulations on tape, in an apparent attempt to deprive me of due process). And, he would have gotten away with it had I not decided to vigorously fight back.**

**As has been well-documented by the League of Physicians and Surgeons in New York City, Medicare hearing officers are usually anything but impartial. If they value their continuing independent contract with the Medicare carrier, there is strong incentive to find in favor of the carrier as much as possible. And, do they use dirty tricks so that appeals can't be further pursued because of threshold limits? You bet they do!**

**The author below also needs to be disabused of the notion that if Medicare denies something as not reasonable and necessary that it is just a simple difference of opinion and that if doctors would only document properly, there wouldn't be such problems. I certainly know of a very typical case where the physician had excellent documentation, performed a service that was clearly "medically necessary," (even by Medicare's own, written, local review policy), yet the elderly, general practitioner, Medicare medical director, over-ruled the specialty physician's position that the service was both reasonable and necessary. The Medicare medical director had absolutely no competence, no experience and no training to support his medically unsupportable decision - yet hearing officers were quick to agree with him. A complaint against that Medicare medical director was subsequently filed with the state licensing agency (something which more physicians should do when they are subject to clearly incompetent decisions made by Medicare medical directors, clearly outside their expertise of practice). **The state licensing board investigated and agreed with the specialty physician - the elderly, "party-line," "deny whenever you think you can get away with it," medical director was practicing medicine outside of his scope and training.****

The author's assertion that "CMS oversees the carrier to be sure the contract requirements are met," is also a complete joke! As Theresa Burr (Medicare Whistleblower) pointed out in her talk at the annual AAPS meeting recently, ACER (annual contractor evaluation reports) are self-evaluations and are often complete fiction. Even when there is clear and convincing evidence that the Medicare carrier is committing fraud, the government is loathe to take any criminal action against most carriers - most settle for relative small amounts (in comparison to the dollar amount of fraud). We are also quite aware of the "revolving door" where CMS employees go to work for the carrier and vice versa - just one big happy family. Do Medicare contractors get away with deleting or throwing away perfectly clean claims en masse? You bet they do!.... as pointed out by Theresa Burr, someone who was there and saw it first hand. Do other Medicare carriers do the same thing? You bet they do - as pointed out by the defense attorney's letter which Ms. Burr presented where the attorney's main defense was essentially everybody else is doing it!

Do Medicare contractors have their own "experts" who strangely enough find in favor of the carrier the vast majority of the time? You bet they do! Just ask the League of Physicians and Surgeons.

There is nothing simple about the 132,000 pages of vague and often incomprehensible and sometimes contradictory Medicare regulations, LMRPs, so-called "correct" coding initiatives that are "updated" quarterly etc etc. The author of the comments below clearly has not lived in the real world that the rest of us live in where we have to contend with this tyrannical and abusive Medicare bureaucracy.

**L. Huntoon, M.D., Ph.D., F.A.A.N.**

Rogan:

I was the Carrier Medical Director for Medicare B, NHIC for 6 years, and just left the job. I am now consulting and practicing a little. I am responding to your inquiry of the AAPS web site. I am not a member of AAPS and do not agree with several of its positions, but I do support organized medicine, including the AAPS.