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Who Gets Health Care? Rationing in an Age of Rising Costs --- Health Club: Behind Medicare's Decisions, An Invisible Web of Gatekeepers --- Shot in the Spine, Mr. Erringer Suddenly Lost Coverage For Some Pain Medicine --- A Fateful Letter From Fargo

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[Second in a Series]

TUCSON, Ariz. -- One evening in 1986, while Chris Erringer was sitting in his Toyota Land Cruiser, a stranger approached him and shot him under the right eye.

Mr. Erringer jumped out of the truck, lunged at his assailant and collapsed. The gunman shot him in the back, stole his money and fled, Mr. Erringer says. When he came to, "nothing worked."

The attack left Mr. Erringer a quadriplegic, with painfully knotted back and neck muscles. His only relief: shots of a mild anesthetic, which his doctors administered twice a month. Mr. Erringer, who was left unable to work and lived on Social Security disability benefits, depended on Medicare to pay for the treatments.

Then, in September 1999, came a letter that would change his life again. Medicare would no longer cover the injections. "It didn't really explain why," he says. "It just said no."

Mr. Erringer continued to get the trigger-point injections, as they're known, but only once a month, or sometimes less. He cut down on the shots in case Medicare rejected his doctors' appeal and he ended up getting stuck with the whole bill.

Because of the pain, he mostly sat in his wheelchair "like a rag doll," says Larry Shepherd, a friend and Mr. Erringer's legal guardian. Mr. Erringer's headaches and depression worsened. The rare dinner or movie out became even rarer. "I kept wondering," says Mr. Erringer, now 44 years old and gray-haired, "Why did Medicare do this out of the blue?"

Finding the answer took Mr. Erringer more than a year of frustrating arguments and appeals, a legal crusade that turned into a class-action suit against Medicare's bosses. The decision-makers, it turned out, weren't in the massive Baltimore headquarters of the federal Centers for Medicare and Medicaid Services, which runs the Medicare program for nearly 40 million elderly and disabled Americans. The real authority lay in the hands of a North Dakota insurance company -- one of the hidden gatekeepers of American medicine who ration health care.

About two dozen of these government-contracted insurers handle the claims for doctor visits and hospital outpatient procedures submitted to the \$250 billion-a-year federal program. The Medicare agency, commonly known as "CMS," sets national policies on coverage for some items, including expensive new technical advances. But the agency gives the insurers -- whose territories cover multiple states or even whole regions -- broad authority to fill in the blanks, laying down local rules on what Medicare will cover and what it won't. The result: Decisions on everything from trigger-point injections to psychiatric services to the use of ultrasound and CT scans are in the hands of the insurers and their little-known medical directors.

Those decisions can vary widely from region to region, creating a patchwork of rules that sometimes angers doctors and patients. In the late 1990s, dermatologists howled as medical directors in Florida and elsewhere restricted the treatment of certain skin lesions that can be precursors to skin cancer. In 2001, CMS issued a national ruling lifting the restrictions.

In a recent report, the General Accounting Office, Congress's watchdog agency, found that in the past few years there was widespread variation in coverage for a new treatment, called bilateral deep-brain stimulation, for debilitating tremors caused by Parkinson's disease. For example, insurers covered the treatment for certain patients treated in Kansas but not in Florida. The inconsistencies ended in April when CMS, responding to the request of a Texas patient, approved the treatment nationally.

Meanwhile, when meetings are called to consider these local policies, they're attended mostly by doctors and manufacturers pushing for approval of services and devices. A Medicare spokesman notes that insurers announce the meetings on the Internet

and elsewhere, but "the general public doesn't show up for these things."

Mr. Erringer's fight for answers offers a window into how these insurers regulate and sometimes restrict medical care -- often with policy rulings that most patients and many doctors weren't aware of until a claim is denied.

"It's rationing. It's a way to limit things," says Grant Bagley, a former top Medicare coverage official who now represents manufacturers, providers and beneficiaries as a partner at the Arnold & Porter law firm in Washington.

Tom Scully, the administrator of CMS, sharply disputes that notion, as does the insurer that cut back on coverage for Mr. Erringer. The medical directors, Mr. Scully says, "have no economic incentive to deny coverage for anything. They are trying to do the right thing."

Indeed, the issue here isn't "greedy" insurers limiting health care to pocket extra profit. The insurers are paid by the number of claims they process, regardless of whether the claims are accepted or rejected, and Medicare covers about 99% of the procedures and items submitted for claims, according to the GAO report. While the insurers write the reimbursement checks for Medicare patients, the money comes from a government-funded bank account. Last year, Medicare paid the insurers \$1.08 billion to handle 970 million claims from doctors, hospitals and other health-care providers.

The local policies are one of the few brakes in a program that costs more every year, and will cost even more when the baby-boom generation retires, especially if Congress adds prescription-drug coverage. Without local rules on coverage, says Mr. Scully, "spending would be higher because nobody would ever say no, and it would be ludicrous." He argues, moreover, that the local policies provide needed flexibility for regional variations in medical practice and that the decision-making process is "faster, less politicized and less controversial" than on the national level, especially for new technology. At the same time, he's encouraging medical directors across the country to work together more to make their policies more consistent.

Back in September 1986, Mr. Erringer, then 27, was estranged from his adoptive parents and trying to figure out what to do with his life. He had been laid off from a job moving mobile homes and was pursuing passions for music, hiking and motorcycles. When he was attacked, he was four-wheeling in a dried-up riverbed in northern Tucson.

He was rescued by hikers and spent more than five months in the hospital, leaving with a grim trophy: a bullet that severed his spinal cord. The surgeon carved Mr. Erringer's initials on the bottom. The bullet that went in under his eye fragmented; one piece got infected and was removed, but others, including one in his ear canal, remain. "If I stick a Q-tip in my ear, I have to be careful" not to bump it, he says.

Mr. Erringer faces a lifetime of limits and loneliness. He is plagued by bladder infections, has no use of his legs and only very limited use of his arms, which are too weak to move his wheelchair backward through the carpets in his house. "This brown carpeting is like quicksand," he says. He passes time listening to ZZ Top, Mozart and Michelle Branch and playing Tomb Raider video games, using partially numb hands that he says "are like two dog paws."

Like many people who are paralyzed, Mr. Erringer has intractable chronic pain called myofascial or "referred" pain. It starts in the right shoulder where there are weak muscles between the active and inactive muscle areas, but can radiate to different parts of the body. "It can be both shoulders and neck," he says. "I'm just a rack of pain sometimes. When I'm moving, it hurts all the time."

Mr. Erringer depended -- and still does -- on Mr. Shepherd, who became his legal guardian in the early 1970s, when Mr. Erringer was around 13. Mr. Shepherd, now 65, took in Mr. Erringer after a bitter argument between the boy and his adoptive father, the culmination of a long conflict between the two. Mr. Shepherd was a family friend: He had bought some property from the adoptive father and for a short time the two were in business together. After Mr. Erringer was shot, and other arrangements to care for him fell through, Mr. Shepherd stopped working and took care of him full-time. Mr. Shepherd gets a low hourly wage from the state to care for Mr. Erringer.

For Mr. Erringer's muscle spasms, starting at "trigger points" in his neck and back, doctors prescribed physical therapy, epidural injections and running electrical current through the muscles. "It didn't help, except for the cheap thrill of getting shocked," Mr. Erringer says.

The only thing that worked was injections of the anesthetic Marcaine, made by AstraZeneca PLC, and occasional steroids, which he no longer gets. Every two or three weeks, doctors would inject the anesthetic, often in several different shots, directly into his tightly knotted muscles. Relief lasted about 10 days.

His doctors saw few alternatives. "Aggressive pain management improves Chris's ability to care for himself and to maintain some quality of life," says Charles Blake, a specialist in rehabilitation medicine. "In spite of all this, he's a nice person."

Then, in September 1999, came the letter from Noridian Administrative Services, an insurer in Fargo, N.D., that handles Medicare claims in Arizona. Noridian handles more than 56 million claims a year from 11 states.

Mr. Erringer's four injections from August 1999, which totaled \$157.25, had been denied. "The information we have in your case does not support the need for this many visits or treatments," the letter said, without further explanation.

Mr. Erringer felt panicky and confused. "I wasn't faking," he says. "Who would want needles stuck two inches deep in knotted-up muscles unless they needed it?"

Noridian subsequently refused to pay for the trigger-point injections -- totalling almost \$1,100 -- that Mr. Erringer got from August 1999 through early February 2000. He and his doctors appealed. Dr. Blake submitted office notes showing concern about Mr. Erringer's discomfort. Noridian personnel in Fargo, N.D., who weren't involved in the initial denial, turned down the first two appeals.

Traci Arzt, the Noridian hearing officer who denied the second appeal, wrote in her decision that Mr. Erringer's file didn't show the medical necessity of more than 12 shots a year. "There was no indication that you were showing improvement from these injections," she wrote.

Mr. Erringer, who lives on Social Security disability benefits of about \$660 a month, was furious. The medical necessity of the shots had never been called into question before, and nobody had ever asked if he were "showing improvement." He says he finds the whole idea of improvement ludicrous, given his condition. "It shows they didn't know anything about me," he says.

He contacted Sally Hart, of the Arizona Center for Disability Law and Center for Medicare Advocacy in Tucson. Ms. Hart, who had helped Mr. Erringer on a separate medical-bureaucracy issue, studied the rejection letters and found a valuable clue. The denials were based on a new "local medical review policy" -- one of the most contentious features of the Medicare system.

CMS has issued hundreds of rules since its creation in 1965, on everything from liver transplants to cardiac pacemakers, specifying what the government will pay for and for which patients. Beyond those guidelines, Medicare gives its regional gatekeepers broad leeway to establish their own standards, known as local medical review policies, or LMRPs. The guiding criterion in establishing these policies: that procedures be "reasonable and necessary."

Medicare gave private insurers a prominent role in the program to assuage the American Medical Association's fears that Medicare was the first step toward nationalized health care. For years, the insurers raised few questions about the claims submitted. But over the past decade, Medicare officials, in an effort to reduce billions of dollars in fraudulent and improper payments, have encouraged insurers to be more aggressive in setting policies in making sure doctors bill the program correctly.

The result: The insurers have created more than 9,000 local medical-review policies. CMS in recent years has pushed the insurers to set more uniform policies, solicit more physician and public response before enacting them, and then post the rules on the Internet so it's easier for people to find them.

Ms. Hart was familiar with local medical-review policies from her work as a patient advocate. She got a copy of Noridian's policy on trigger-point injections and appealed to the Social Security Administration, whose administrative-law judges handle Medicare appeals if a patient wants to go beyond the insurance-company decision. Unlike the insurers' employees, Social Security judges aren't bound by local medical-review policies. Usually in consultation with a medical adviser, these judges determine whether a service is reasonable and necessary.

Six months later, at an August 2001 hearing in Tucson, administrative-law judge James Lawwill sided with Mr. Erringer and ordered Noridian to pay the bill for the past claims. All other methods of treatment, he later wrote in his decision on the case, "have been unsuccessful in controlling his intractable pain."

While pursuing the administrative appeals, Ms. Hart, Mr. Erringer's lawyer, brought a class-action suit against the government in federal district court in Tucson. The suit, filed jointly with lawyers at the Center for Medicare Advocacy in Willimantic, Conn., was intended to force Medicare to notify beneficiaries when claims are denied due to a local policy change, so they can appeal more effectively. Medicare agreed last fall to make the change nationwide as part of a settlement, and also told its contractors to inform patients how to get copies of the LMRPs at issue.

But Mr. Erringer lost another part of his case: The suit also sought to require the government to publicly define "reasonable and necessary" and other criteria used by contracted insurers in setting local coverage policies. The judge ruled that Medicare wasn't required to do so because such criteria are interpretive, and thus exempt from federal rule-making requirements. Medicare has tried in the past to define "reasonable and necessary," but the effort has been derailed by criticism from one side or the other. Ms. Hart and Mr. Erringer are appealing the decision.

Still, there was one question Mr. Erringer couldn't answer. Why did Noridian change its policy in the first place?

Insurers may adopt local medical policies if they see a problem that suggests overuse of a specific service or a "significant risk" to the Medicare trust funds. That's what happened with the trigger-point injections, says William Mangold, a Noridian medical director in Phoenix.

In the fall of 1998, TransAmerica Occidental Life Insurance Co., which analyzed claims trends for Noridian, brought Dr. Mangold and his five fellow medical directors a problem. In analyzing claims to look for trends in demand, TransAmerica noticed a substantial increase in trigger-point injections. Medicare medical directors around the U.S. had noticed similar trends. So TransAmerica suggested restricting coverage to one injection a month in most cases. The policy added that patients with chronic pain might need more shots, even weekly, if there were strong evidence of medical need.

Dr. Mangold and the other Noridian medical directors adopted the injection policy, effective July 1, 1999, after running it by their physician-advisory committees. The change was published in a newsletter sent to doctors who participate in Medicare. Mr. Erringer's doctors say they didn't see the announcement because they're inundated with information from various sources and don't have a chance to read it all.

Dr. Mangold, an avid biker and former marathon runner who spent most of his career as a family physician and then plastic surgeon, says his goal is to make sure patients get what they need while ensuring Medicare doesn't pay for inappropriate treatments. He resisted friends who urged him to apply for a Medicare medical-director job when it became available in 1997. "Are you kidding? I hate Medicare," the 60-year-old doctor recalls telling his friends. To him, it was "a large organization, it was tough to find a person to discuss things with."

That's why you should do it, they responded. So he agreed, in an effort to "put a human face on Medicare."

Dr. Mangold, the former president of the Arizona Medical Association, says he first heard of Chris Erringer when details of the proposed class-action settlement in the case were posted last November on the CMS Web site. He's chagrined that the dispute went so far. "The doctors, when denied, should have called me and said, 'This guy really needs this,' " he says today. He says that he has authority, within boundaries, to decide whether a service should be covered and that doctors call each week.

Dr. Blake and his staff say they never heard of such an approach. "Noridian tells us to appeal everything to [headquarters in] Fargo, and that's what we did," says Barbara Ellis, Dr. Blake's office manager, adding that documentation was provided to show Mr. Erringer's chronic-pain problem. A Noridian spokesman says medical directors aren't the front line in appeals.

Still, Dr. Mangold says he isn't sure if he would have approved the shots had Mr. Erringer's doctors contacted him. Such frequent shots are "controversial," even for someone with Mr. Erringer's condition, he says. Based on factors including his own experience and discussions with pain specialists, "it doesn't sound like a good way to treat pain over the long term."

James Rathmell, professor of anesthesiology at the University of Vermont College of Medicine and a specialist in pain treatments, says there's little consensus in the medical community about how many injections are appropriate. Indeed, a number of other Medicare insurers limit the frequency of the shots. Dr. Rathmell, who doesn't know Mr. Erringer, says that in his case, injections every two to three weeks "sounds reasonable, and doesn't seem excessive."

For now, Mr. Erringer continues to get shots just once a month and endure the pain when the effects wear off. Noridian covers the injections, but he's reluctant to try for more shots, afraid it would ignite another battle. Indeed, Noridian's newest policy, adopted in August 2002, is tougher than the previous one; citing a new study, it generally limits patients to injections every other month, although it says more are permitted with proof of medical need.

Even if Noridian approved as many shots as Mr. Erringer thinks he needs, he doesn't know if he could afford the \$11.50 in copayments for each visit. He'll have a little more money now that his friend Mr. Shepherd is going on Social Security -- but that raises a whole other set of concerns. "We aren't getting any younger," he says. And without Mr. Shepherd, "I see 20 to 30 years of sitting in a nursing home."

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