Report from a Medicare Whistleblower Part 1: Claims Processing Goes Awry

Theresa Burr

When I first began working as a claims examiner for Blue Cross Blue Shield of Florida, I hated keying in claims. I knew that claims were about real people with real health problems, not just paperwork, and the pain and suffering touched me deeply.

One day while I was keying in information on a claim, I was stunned by what a patient had written: "I pray you have a Merry Christmas and many more, as I have just been told this is my last."

I sat at my desk and said, "Lord, I can't do this." The Lord gently let me know, "What better way to pray for the sick?" At that point my work became worthwhile. It gave me a name and a diagnosis and a little information about the patient's condition. From that moment forth, I took claims very seriously.

I considered it a privilege to be able to pray for the patients. I also prayed that the professionals working with them would be skilled and compassionate. No longer was a claim a piece of paper. It represented human beings with needs to be met. The patients, the physicians, and the suppliers of medical goods and services were all in the system together.

But I later discovered that facts and figures were manipulated, and truth was tainted.

Delays and Denials

I began working as a BCBSF claims examiner in August, 1980. After extensive training I became a medical examiner. In 1983 I was assigned to work on a request-for-proposal for an upgraded system with Electronic Data Systems(EDS), and I gained a broad range of knowledge about processing and finishing claims.

Later I became a member of a company task force to monitor claims with potential abuse. I also was able to build files for claims with special needs, and I helped establish reasons for extra coverage.

Whenever an instance of fraud or abuse was found involving one or more suppliers, according to newly imposed criteria, all other suppliers submitting claims with the same codes were targeted. Reviewing such large numbers of suspended claims caused delays.

In 1986 the corporate side of Blue Cross developed a system for electronic claims submission. Because the claims appeared to have insufficient information, they were denied or paid incorrectly.

When this happened, a Florida supplier sued. Every claim it submitted from then on came under scrutiny. Its claims were held, and the delays and denials caused serious financial trouble. BCBSF called the IRS to audit this company.

When I was asked whether physicians or vendors had claims delayed because they questioned an insurance carrier, my response was "absolutely." I was also required to look for fraud and/or abuse and suspend claims in order to impede the money flow.

Another BCBSF tactic was to automatically deny a fourth of all claims, in hope that many would never resubmit and the patient would then be forced to make payment. Physicians and suppliers discovered that the payments were so inconsistent that they began to look for other means to obtain payment. This caused physicians great difficulty with "exceptions to the rule" based on the entire medical condition of the patient.

When the Office of Inspector General (OIG) or other government agencies monitored claims for fraud and abuse, investigators looked at claims with the assumption that all contained either or both. A physician or vendor could not consider giving a discount or rebate, as that would appear to be deviating from what was reported as true.

In 1987 BCBSF published a Request for Proposal (RFP) for a Medicare contract. Criteria for the award included technical review of what the vendor could do, at least on paper. I was assigned to rate the durable medical equipment (DME) part of the bid. Electronic Data Systems (EDS), Mandat Data Corporation (MDC), and the telecommunications company GTE submitted bids. GTE won, MDC sued, and EDS walked away.

In May 1988 I was assigned as a team leader for DME. Six other leaders were selected for testing and preparation, including the medical, correspondence, technical, and claims categories. Quality and electronic claims were designated as specific areas for crossover to the new system. I conducted studies in all these areas since DME's relationship in each area was also a part of processing.

From its infancy, the claims processing system appeared severely inadequate. A big backlog grew after the system went online. Management knew the system was faulty but ordered personnel not to discuss the matter outside the company, and instead present a picture that all was well, even though a company was suing because of the bid.

MDC may have sued in part because the scoring system based on a company's ability to process claims was said to be improper and defective. Also, competitor GTE was a telecommunications business with no claims processing experience. Why GTE was given a higher score and awarded the contract has never been stated publicly. Despite all that was going on, or not going on, the on-site Health Care Financing Administration (HCFA) representative said all systems were working satisfactorily.

Management was aware of the magnitude of the problem. It took examiners a while to understand that the system did not work. After the first couple of weeks, while waiting for the system to come up to process claims, everyone on the inside knew GTE was in trouble. Nevertheless, quality reports were excellent because any claim was walked through "by the book."

From October through February the system operated at a snail's pace, though the figures submitted to HCFA never faltered. Edits and audits were turned off. Claims were forced through the system with special coding by examiners and sometimes by programmers.

False prescriptions were entered into the system for DME claims. Thousands of claims were deleted. Personnel ranging from the mailroom to the examiner in the system, including programmers, deleted entire blocks of claims to keep the system moving and the reports flowing. It was a massive cover-up.

The Annual Contractor Evaluation Report (ACER), showing performance and the insurance carrier's self-examination of contractor performance, was fiction. While physicians and vendors pleaded for their funds, the carrier's figures and reports showed that everyone was being paid.

Many patients lost their equipment – and some reportedly died – because their claims were not being paid. Physicians were not able to meet their payrolls. Many doctors and vendors stopped accepting

Medicare patients, resulting in treatment and services being denied to patients. Some vendors went out of business or borrowed money to continue.

While the management mantra was that "all is well," examiners sat hours on end waiting for work. During this time a large number of people were hired to meet the initial crossover and catch up. Although the expectation was that these employees would be terminated after a couple of months, this never occurred because in fact still more people were needed.

Methods that were supposed to increase production and cut costs through use of fewer examiners became a nightmare. Examiners were put on mandatory time for production and then sat most of the time pre-coding by pencil or pen and hoping the system would come up so they might get the claims processed. When claimants inquired about their claims, they were told to wait or resubmit. When claims were resubmitted, and the duplicates, error payments, or false payments started to come in, claimants were targeted for overpayments. Administrative costs were greatly inflated, to the benefit of the insurer.

Battles were a daily routine, and after trying to manage and fix the chaos, I resigned from BCBSF. The vice-president asked me to stay. I declined. The vice-president was fully aware of the problems and how long it would take to resolve them, and that the cover-up had made it all worse. If a responsible team had been formed, the system might have been repaired. But apparently no one cared enough to take responsibility. In fact, no one even appeared to feel any remorse about the situation, though thousands of innocent people were affected. I was called "disgruntled."

Investigations and Lawsuits Begin

When I left, I decided to try to assist physicians and vendors in submitting claims. I went to a few cities and gave some seminars to teach processing of DME claims. While in Miami, I was asked to meet with one of the dealers in West Palm Beach. It was then that I told parts of this story.

I was referred to an attorney in Washington, D.C., and asked to sign an affidavit. This would be taken to an ad hoc meeting in the Capitol concerning the problems at BCBSF. Many wanted to sue but were afraid of retaliation. I felt called to speak for those who could not speak for themselves.

On September 12, 1989, I signed the affidavit, and the ad hoc meeting began the next day. The press made the meeting the top story in many cities. A congressional group turned the matter over to the OIG. HCFA was called in. The AMA demanded answers, as did lawyers, agents, and the press. The OIG called me, and its agents released all the evidence I had in my possession, which filled more than eight banker boxes. My manager had told me to put this material in the dumpster.

A lawyer involved in the MDC lawsuit, which was pending against BCBSF, subpoenaed me. I was also subpoenaed in another lawsuit brought by the sister of a Washington attorney against BCBSF. BCBSF used this lawsuit as a means to discover what evidence I had and what information I might release. It surprised me that after my deposition in each lawsuit, BCBSF settled almost immediately.

Soon after this, a grand jury was convened. The U.S. attorney granted me immunity from prosecution although I had not requested it. My testimony impressed the jurors, and the government attorney allowed me to answer their questions in open court. Others testified behind closed doors. I was told that there would be indictments, and that people would be fired and some barred from working under government contracts.

In the years that followed, however, interest waned. In February 1991, I brought a *qui tam* suit, a mechanism that allows an individual to bring an action against another party "in the name of the King," against BCBSF. This remained under seal until the Department of Justice intervened. The same Washington lawyer who had me sign the affidavit, and whose sister sued BCBSF, has now been awarded the highest honor as an attorney in the medical industry. Her work, and the implications of material revealed in the lawsuit, will be the subject of another part of this story.

Theresa Burr is Vice President and Co-Director of The INN Ministry, Inc., Jacksonville, FL. E-mail: Tburr07213@aol.com.