Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

EARLY IMPLEMENTATION REVIEW OF QUALIFIED INDEPENDENT CONTRACTOR PROCESSING OF MEDICARE APPEALS RECONSIDERATIONS

Daniel R. Levinson
Inspector General

July 2008
OEI-06-06-00500

Office of Inspector General

http://oig.hhs.gov

The mission of the Office of Inspector General (OIG), as mandated by Public Law 95-452, as amended, is to protect the integrity of the Department of Health and Human Services (HHS) programs, as well as the health and welfare of beneficiaries served by those programs. This statutory mission is carried out through a nationwide network of audits, investigations, and inspections conducted by the following operating components:

Office of Audit Services

The Office of Audit Services (OAS) provides auditing services for HHS, either by conducting audits with its own audit resources or by overseeing audit work done by others. Audits examine the performance of HHS programs and/or its grantees and contractors in carrying out their respective responsibilities and are intended to provide independent assessments of HHS programs and operations. These assessments help reduce waste, abuse, and mismanagement and promote economy and efficiency throughout HHS.

Office of Evaluation and Inspections

The Office of Evaluation and Inspections (OEI) conducts national evaluations to provide HHS, Congress, and the public with timely, useful, and reliable information on significant issues. These evaluations focus on preventing fraud, waste, or abuse and promoting economy, efficiency, and effectiveness of departmental programs. To promote impact, OEI reports also present practical recommendations for improving program operations.

Office of Investigations

The Office of Investigations (OI) conducts criminal, civil, and administrative investigations of fraud and misconduct related to HHS programs, operations, and beneficiaries. With investigators working in all 50 States and the District of Columbia, OI utilizes its resources by actively coordinating with the Department of Justice and other Federal, State, and local law enforcement authorities. The investigative efforts of OI often lead to criminal convictions, administrative sanctions, and/or civil monetary penalties.

Office of Counsel to the Inspector General

The Office of Counsel to the Inspector General (OCIG) provides general legal services to OIG, rendering advice and opinions on HHS programs and operations and providing all legal support for OIG's internal operations. OCIG represents OIG in all civil and administrative fraud and abuse cases involving HHS programs, including False Claims Act, program exclusion, and civil monetary penalty cases. In connection with these cases, OCIG also negotiates and monitors corporate integrity agreements. OCIG renders advisory opinions, issues compliance program guidance, publishes fraud alerts, and provides other guidance to the health care industry concerning the anti-kickback statute and other OIG enforcement authorities.

EXECUTIVE SUMMARY

OBJECTIVE

To determine the extent to which Qualified Independent Contractors (QIC) followed timeliness, correspondence, and data entry requirements for Medicare Part A and Part B claims reconsiderations received from May 2005 to July 2006.

BACKGROUND

Section 521 of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000, P.L. No. 106-554, requires that QICs conduct the second level of Medicare appeals, called "reconsiderations," for Medicare Part A and Part B claims. The Centers for Medicare & Medicaid Services (CMS) contracted with two QICs that began processing Part A reconsiderations in May 2005 and with two QICs that began processing Part B reconsiderations in January 2006.

For this study, we determined whether QICs processed reconsiderations within 60 days, as required, by analyzing information contained in the Medicare Appeals System (the "appeals system") for all reconsideration cases through July 2006. We determined whether QICs sent correspondence to appellants as required and whether QICs entered accurate information in the appeals system by reviewing case files for a randomly selected sample of reconsiderations. We also conducted structured interviews with CMS, the four QICs, and staff who conduct Administrative Law Judge hearings at the third level of Medicare appeals.

FINDINGS

Part A Qualified Independent Contractors met the 60-day processing timeframe; however, Part B contractors did not for 58 percent of reconsiderations. One Part B QIC did not process 74 percent of reconsiderations within 60 days, and the other Part B QIC did not process 40 percent of reconsiderations within 60 days.

Qualified Independent Contractors did not meet all correspondence requirements but did include the appropriate content in reconsideration decision letters. Twenty-six percent of case files that we reviewed did not have documentation substantiating that QICs sent letters acknowledging appeal requests. Twelve percent of case files were missing reconsideration letters; however, when present, QICs'

decision letters included all required content. Forty percent of case files did not have documentation substantiating that QICs sent processing delay notifications for Part B cases that were decided late.

Qualified Independent Contractors entered inaccurate information into the Medicare Appeals System for 54 percent of reconsiderations. Fifty-four percent of reconsiderations contained at least one item of inaccurate information in the appeals system for appellant type, reconsideration request date, acknowledgment letter date, decision date, and/or decision type.

Factors contributing to deficiencies in timeliness, correspondence, and data entry include case transfer delays, unexpected case volume, and appeals system challenges. Three of the four QICs reported that lags in case file transfers from Affiliated Contractors that process claims affected adjudication timeframes and other operational activities. Both Part B QICs explained that unexpected case volume affected their ability to process cases on time. Additionally, all QICs reported that, during the early months of implementation, the appeals system was frequently unavailable or slow, did not have the ability to generate required correspondence, did not support resource management activities, and did not interface with databases that contained claims information, which affected timeliness and overall workflow.

RECOMMENDATION

During our review, the Part A QICs had been processing reconsiderations for 15 months and the Part B QICs for 7 months. We found that, during this timeframe, QICs had challenges meeting timeliness, correspondence, and data entry requirements. CMS made several changes to improve the reconsiderations process, including facilitating some improvements in the appeals system, restructuring the Part B workload into three jurisdictions, and recompeting the contracts among all QICs. However, given QICs' deficiencies cited in this report and the potential impact of these deficiencies on the overall Medicare appeals process, we recommend that CMS:

Take further action to ensure that QICs meet timeliness, correspondence, and data entry requirements. CMS currently employs several mechanisms to monitor QICs, which include weekly reviews of the appeals system data and annual site visit reviews. CMS may consider several options for augmenting these mechanisms to

ensure that QICs meet Federal requirements for processing reconsiderations. For example, CMS could add metrics, such as error rates, to its annual reviews to further assess the extent to which QICs meet correspondence and data entry requirements. In addition, to better ensure that appeals system data are accurate, CMS could validate these data during annual reviews. CMS could also evaluate the costs and feasibility of enabling the appeals system to extract information from databases that contain claims data, thereby reducing the need for manual data entry. Lastly, CMS could monitor the length of time that it takes Affiliated Contractors to transfer paper case files to QICs, to better ensure that QICs have a reasonable number of days to adjudicate reconsiderations.

AGENCY COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

CMS concurred with our recommendation to take further action to ensure that QICs meet timeliness, correspondence, and data entry requirements and outlined efforts it has planned or has already taken to address it. These efforts include awarding a contract to a private entity that will conduct its own performance evaluation to determine QICs' adherence to Federal requirements; enabling the appeals system to interface with databases that contain claims data; and including financial incentives in its contracts with the new Medicare Administrative Contractors to forward case files to the QICs within 4 days for 85 percent of cases.

CMS also noted that, subsequent to the time period covered by our review, March 2005– July 2006, it had made several changes to the second level of Medicare appeals, which culminated in the award of three new Part B QIC contracts. CMS reported that all three Part B QICs completed over 98 percent of reconsiderations on a timely basis during October–March 2008. CMS provided a table that outlines timeliness information for all three Part B QICs during this period.

TABLE OF CONTENTS

INTRODUCTION

OBJECTIVE

To determine the extent to which Qualified Independent Contractors (QIC) followed timeliness, correspondence, and data entry requirements for Medicare Part A and Part B claims reconsiderations received from May 2005 to July 2006.

BACKGROUND

Medicare beneficiaries, providers, and suppliers of health care services can appeal certain decisions related to their Medicare claims. Currently, the Medicare administrative appeals process includes four levels. This study focuses on the second level, QIC reconsiderations.

Section 521 of the Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA), P.L. No. 106-554, made significant changes to the Medicare claims appeal process.[1] Among other things, it required that QICs conduct the second level of Medicare appeals, called "reconsiderations," for Medicare Part A and Part B claims.[2] The revised appeals process had a phased implementation, which took place in fiscal years (FY) 2005 and 2006. The Centers for Medicare & Medicaid Services (CMS), the agency that oversees QIC operations, obligated about $40 million for QIC activities during this timeframe.[3] Given the changes required by the BIPA, the Office of Inspector General (OIG) sought to determine whether QICs met processing requirements in the early phase of implementation from May 2005 to July 2006.

Medicare Administrative Appeal Process

Medicare Part A provides coverage for institutional care, such as inpatient hospital care, skilled nursing facility care, home health services, and hospice care. Medicare Part B provides coverage for the cost of noncustodial care, such as physician services, outpatient hospital services, and medical equipment and supplies. Under Medicare Parts A and B, a beneficiary can obtain health care services from any provider

[1] The BIPA was later modified by sections 931, 933, 939, and 940 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), P.L. No. 108-173.

[2] 42 U.S.C. § 1395ff(c)(1) (as amended by BIPA, § 521(a)).

[3] Budget estimates for FYs 2005 and 2006 provided to OIG by CMS.

that is qualified and chooses to participate in the Medicare program.[4] Generally, to receive payment for the provision of health care services, the provider or beneficiary can submit a claim for payment to the appropriate Affiliated Contractor.[5] For this report, the term "Affiliated Contractor" includes fiscal intermediaries (for all Part A claims and certain Part B claims) or carriers (for most claims under Part B). If the Affiliated Contractor determines that the claim for medical care is not covered under Medicare because it is invalid or incomplete or otherwise appears to be improper, it denies the claim.[6] When the Affiliated Contractor denies a claim, it notifies the provider or beneficiary of the denial and offers the opportunity to appeal the denial.[7]

There are four distinct administrative levels of appeal;

- Level One: Affiliated Contractor redeterminations,
- Level Two: QIC reconsiderations,
- Level Three: Administrative Law Judge hearings, and
- Level Four: Medicare Appeals Council hearings.

If these administrative appeal levels have been exhausted, appellants may bring their cases to a Federal district court.

Qualified Independent Contractors

CMS awarded four QIC contracts to conduct Parts A and B reconsiderations for FYs 2005 and 2006.

Part A QICs. On May 1, 2005, two QICs, First Coast Service Options (FCSO) and Maximus, began processing Part A reconsiderations.

Part B QICs. On January 1, 2006, Quality^{2}Administrators began processing Part B reconsiderations out of two separate locations (hereafter referred to as the Q2A East and the Q2A West). The Q2A East was responsible for Part B reconsiderations for 26 States, the District of Columbia, and 2 U.S. territories. The Q2A West was responsible for Part B reconsiderations for the other 24 States and

---

[4] 42 U.S.C. § 1395a.

[5] MMA (P.L. No. 108-173 § 911(d)) requires that Medicare Administrative Contractors (MAC) gradually assume the work currently performed by Affiliated Contractors, including fiscal intermediaries, carriers, and durable medical equipment regional carriers. CMS began replacing Affiliated Contractors in October 2005 and is expected to complete the transition by October 1, 2011 (42 CFR § 421.400).

[6] Social Security Act § 1869.

[7] 42 CFR § 405.921(a)(2).

3 U.S. territories, as well as reconsiderations for durable medical equipment, prosthetics, and supplies claims.[8]

Separate from the reconsideration contracts, CMS also awarded a contract to the Q2A to provide administrative services in support of QICs. Hereafter, we refer to this contractor as the administrative QIC.

Processing Requirements

Timeliness requirements. Pursuant to section 1869(c)(3)(C)(i) of the Social Security Act, QICs are required to render reconsideration decisions within 60 calendar days from the dates that they receive timely filed reconsideration requests and send written notices of the decisions to the appellants.[9] [10]

Correspondence requirements. In addition, pursuant to Federal regulations and/or QIC's Umbrella Statement of Work, QICs are required to send appellants the following correspondence:

- Acknowledgment Letters: Within 14 calendar days of the receipt of a request, QICs must send the appellant written acknowledgment of the appeal.[11] The acknowledgment letter must inform the appellant that the appeal has been received and provide instructions for obtaining further information.[12]
- Reconsideration Decision Letters: Within 60 days from the date of receipt of a reconsideration request, QICs must send a written letter notifying the appellant of the reconsideration decision.[13]

---

[8] For FY 2007, however, CMS restructured the Part B workload into three jurisdictions and recompeted the contracts among all QICs. The Q2A South (formerly Q2A East) began handling Part B reconsiderations for 16 States and 2 U.S. territories; FCSO began processing Part B reconsiderations for 34 States, 3 U.S. territories, and the District of Columbia; and Rivertrust Solutions began processing all durable medical equipment reconsiderations.

[9] This report does not address expedited appeal reconsiderations, which have different processing timeline requirements (Social Security Act § 1869(c)(3)(C)(iii)(I)).

[10] Under 42 CFR §§ 405.970(b)(1) and (3), decision deadlines may be extended if the QIC grants an appellant's request for an extension of the 180-day filing deadline and/or if a party to the reconsideration submits additional evidence after the request for reconsideration is filed.

[11] CMS, "Qualified Independent Contractor Umbrella Statement of Work," section III.A.2, September 1, 2005.

[12] Ibid.

[13] Pursuant to 42 CFR § 405.970(c)(1), QICs must send appellants one of three documents within 60 days: a decision letter, a dismissal notice, or an option to escalate their case to the next level. Our evaluation looked at whether QICs sent appellants any one of these documents within 60 days.

This letter must contain a statement indicating whether the decision is favorable or partially favorable, i.e., when a QIC overturns prior appeal decisions, or unfavorable, i.e., when a QIC upholds prior appeal decisions. Other content requirements for this kind of notification include a summary of the facts in the case; an explanation of how pertinent laws, regulations, coverage rules, and CMS policies apply to the facts of the case; and information concerning the appellant's right to an Administrative Law Judge hearing.[14] If QIC decides to dismiss the appellant's request for reconsideration, it must send a letter notifying the appellant of the dismissal within 60 days from the date of receipt of the reconsideration request.[15]

- Written Notification of Processing Delay and the Right to Escalate: If QIC fails to reach a decision within 60 days, it must send a written notice of the delay that offers the appellant the option to escalate the case to the Administrative Law Judge hearing level (these notifications must be sent within 60 days of receiving a reconsideration request).[16] To trigger the escalation, the appellant must respond with a written request.[17] However, for those cases in which the appellant does not request escalation, Federal regulations do not set forth additional processing timeline requirements.

Data entry requirements and the Medicare Appeals System. According to QIC's Umbrella Statement of Work, CMS requires QICs to enter and track information regarding the disposition of each reconsideration in the Medicare Appeals System (the "appeals system").[18] The appeals system was originally designed to store and facilitate the transfer of case-specific data across the four levels of administrative appeal.[19] In September 2003, CMS contracted with CGI Federal to develop and

[14] 42 CFR § 405.976(b).

[15] 42 CFR § 405.970(c)(3).

[16] 42 CFR § 405.970(c)(2).

[17] If the appellant requests escalation, then, within 5 days, the QIC must either finish processing the reconsideration or escalate the case to the Administrative Law Judge hearing level (42 CFR § 405.970(d–e)).

[18] CMS, "Qualified Independent Contractor Umbrella Statement of Work," Section II.A., September 2005.

[19] Department of Health and Human Services (HHS), "Report to Congress: Plan for the Transfer of Responsibility for Medicare Appeals," March 2004.

maintain the appeals system. Currently, Level Two and Level Three use the appeals system.[20]

The appeals system contains many data fields, which CMS requires QICs to populate with accurate information from reconsiderations.[21] Administrative Law Judge staff can view QIC-entered reconsideration data in the appeals system for cases that progress to that hearing level.

CMS Oversight

According to CMS, it uses the following mechanisms to monitor and assess QIC performance:[22]

Weekly reviews of Appeals System data. CMS analyzes information contained in the appeals system on a weekly basis to determine whether QICs are processing reconsiderations within 60 days and to ensure that QICs are sending required correspondence, such as acknowledgment and decision letters, to appellants.

Annual onsite reviews. Each fiscal year, CMS representatives visit QICs to determine compliance with program requirements and to assess overall QIC performance. During what are typically 5-day visits, CMS reviews paper case files for a random sample of reconsiderations to determine whether: acknowledgment letters were sent on time; decision letters were sent on time; decision letters contained required content, such as decision explanations and directions for filing further appeals; and case files contained complete information. CMS also reviews QIC decisions during the course of annual performance reviews. Findings from these evaluations are compiled in a written report.

Quality assurance program. In addition to these mechanisms, CMS requires each QIC to have an internal quality assurance program, to include regular case reviews and an overall self-assessment. On an annual basis, QICs submit to CMS written reports summarizing self-assessment results.

Related Work

In January 2002, prior to the full implementation of the BIPA, OIG released a report that analyzed the potential impact of the BIPA on the

---

[20] Staff from CMS's Medicare Enrollment and Appeals Group reported that, as of December 2006, there were no current plans to implement the Medicare appeals system (the appeals system) at the remaining appeals levels.

[21] CMS, "List of Required/Non Required Medicare Appeals System Fields," November 2005.

[22] OIG interview with staff from CMS's Medicare Enrollment and Appeals Group, December 2006.

Medicare administrative appeals process.[23] OIG found, among other things, that the former process for Administrative Law Judge appeals was backlogged and overwhelmed. The report recommended a modernization of the appeals process. OIG also recommended that HHS develop a training program for all reviewers at all levels of appeals to ensure common knowledge, understanding, and information about the appeals process. HHS concurred with these recommendations.

In a report released in October 2004, the Government Accountability Office (GAO) evaluated HHS's and the Social Security Administration's (SSA) plan to transfer Administrative Law Judge hearings to HHS.[24] [25] GAO found that the plan generally fulfilled all of the elements mandated by the MMA, such as a timetable, cost projections, and information about the development of a case-tracking system. However, the plan omitted important information, such as specific transition milestones and contingency arrangements. GAO recommended that HHS and SSA address these deficiencies. In its response, HHS generally agreed with GAO's recommendations.

In addition, OIG is currently reviewing the use of telephone, video, and in-person conferences to conduct Medicare Administrative Law Judge hearings.

METHODOLOGY

This study examines QICs' performance in processing reconsiderations. Specifically, we determined whether QICs:

- adjudicated reconsiderations within 60 days from the date of appeal requests by reviewing appeals system data for all reconsiderations opened from May 2005 to July 2006 for Medicare Part A cases and from January to July 2006 for Medicare Part B cases;[26]

[23] OIG, "Medicare Administrative Appeals: The Potential Impact of BIPA," OEI-04-01-00290, January 2002.

[24] Section 931 of the MMA required the transfer of the Medicare Administrative Law Judge hearing process from SSA to HHS.

[25] GAO, "Medicare: Incomplete Plan to Transfer Appeals Work Load from SSA to HHS Threatens Services to Appellants," GAO-05-45 (Washington, DC: October 4, 2004).

[26] We used July 2006 as a cutoff to ensure that (1) QICs had at least 60 days to process a given reconsideration and (2) the administrative QIC, which houses reconsideration case files after disposition, had sufficient time to collect and submit requested case files.

- provided required case correspondence to appellants, based on our analysis of a random sample of reconsiderations adjudicated during the study period; and
- entered accurate reconsideration information into the appeals system for five key data elements, based on our analysis of a random sample of reconsiderations adjudicated during the study period.

Analysis of Appeals System Data

Through CMS and the administrative QIC, we obtained data from the appeals system for all reconsideration requests initiated from May 2005 to July 2006. We analyzed these data to determine the:

- timeliness of QICs' processing of reconsiderations;
- characteristics associated with late reconsiderations, i.e., the number of days that the reconsiderations were late and the number of days associated with case file transfers from the Affiliated Contractors that handle redetermination appeals at Level One;
- number of reconsideration requests received by each QIC; and
- number of claims associated with reconsiderations.

Case File Reviews

From appeals system data, we identified all reconsiderations that were labeled as "closed" by the four QICs during the study period.[27] From this population, we selected a random sample of 110 cases from each QIC, for a total of 440 cases. We then contacted the administrative

[27] We defined "closed cases" as reconsideration cases in our specified sample timeframe that have dismissed, favorable, partially favorable, or unfavorable decision findings in the appeals system.

QIC and requested the corresponding case files for each sample case. We received a total of 423 case files.[28] [29]

We reviewed case file documentation to confirm whether QICs processed reconsiderations on time by determining the number of days between the date of receipt of the reconsideration request and the date of the reconsideration decision letter. We also reviewed case files to determine whether documents showed that required correspondence, i.e., acknowledgment and decision letters and written notifications of processing delay (where appropriate), were sent on time. We labeled correspondence as "missing" if the case file did not contain supporting documentation.

We also compared the information contained in the case files with data contained in the appeals system to determine the accuracy of data entered for five key elements. We considered appeals system data to be inaccurate when it differed from information contained in the case files. Specifically, we examined whether the appeals system accurately reflected the:

- appellant type;
- date of receipt of the reconsideration request;
- date of acknowledgment letter;
- date of decision letter; and
- reconsideration decision, e.g., dismissed, favorable, partially favorable, or unfavorable.

Confidence intervals for estimates contained in this report are listed in Appendix A.

---

[28] The administrative QIC was unable to locate 2 files for FCSO, 1 file for Maximus, 10 files for Q2A East, and 3 files for Q2A West. The administrative QIC reported that QICs do not develop case files under two circumstances: (1) if the QIC establishes that the appeal is outside of its jurisdiction, it records the disposition as "misrouted" in the appeals system and forwards the request and associated materials to the QIC with jurisdiction; and (2) if a MAC redetermination appeal has not been conducted, the QIC records the disposition as "dismissed" in the appeals system. In both circumstances, the QIC develops an appeals system record, but no case file.

[29] One of FCSO's cases was an expedited appeal, which OIG did not include in the 423 cases it reviewed. OIG had asked the administrative QIC to exclude all Part A expedited cases. According to the administrative QIC, the expedited case was not labeled appropriately in the appeals system, which explains its inclusion in our universe of cases. Our review does not include Part A expedited reconsiderations because adjudication procedures differ from those of standard Part A and Part B cases.

Structured Interviews With QIC Staff

We conducted structured interviews with QIC staff at FCSO, Maximus, and Q2A East. During these interviews, we spoke with managers, adjudication staff, and staff responsible for entering information into the appeals system. We also conducted a structured interview with management staff at Q2A West. We asked about the four QICs' protocols for adjudicating reconsiderations and challenges that they experienced with the reconsideration process.

Structured Interviews With Administrative Law Judge Staff

We conducted structured interviews with Administrative Law Judge teams in each of the four hearing offices within HHS's Office of Medicare Hearings and Appeals.[30] Each Administrative Law Judge team included the primary docket clerk, one attorney, and one Administrative Law Judge. We asked Administrative Law Judge teams about their experiences in working with QICs, particularly as they related to the accuracy of the appeals system data entered by QICs.

Structured Interviews With CMS Staff

We conducted structured interviews with representatives from CMS's Medicare Enrollment and Appeals Group. We asked about the mechanisms that CMS uses to ensure QIC adherence to program requirements.

Quality Standards

This study was conducted in accordance with the "Quality Standards for Inspections" issued by the President's Council on Integrity and Efficiency and the Executive Council on Integrity and Efficiency.

[30] The Office of Medicare Hearings and Appeals is responsible for overseeing the Administrative Law Judge hearing level process. During a hearing, an Administrative Law Judge conducts a new ("de novo") review of an appellant's case and issues a decision based on the facts and the law. The Chief Administrative Law Judge leads the agency, which consists of four hearings offices, located in Arlington, Virginia; Cleveland, Ohio; Irvine, California; and Miami, Florida.

Part A Qualified Independent Contractors met the 60-day processing timeframe; however, Part B contractors did not for 58 percent of reconsiderations

Based on our analysis of the appeals system data for all reconsiderations received from May 2005 to July 2006, both Part A QICs processed virtually all reconsiderations within 60 days, as required (see Table 1).[31] However, Part B QICs did not meet timeframes for 58 percent of reconsiderations. Specifically, Q2A West did not process 74 percent of reconsiderations within 60 days and Q2A East did not process 40 percent of reconsiderations within 60 days. Of these late decisions, Q2A West's reconsiderations averaged 56 days late and Q2A East's averaged 21 days late. Our review of paper case files associated with a random sample of reconsiderations corroborated timeliness findings from our appeals system analysis.

Table 1: Timeliness of Medicare Reconsideration Appeals Processed by Qualified Independent Contractors

	Part A QICs N=28,035		Part B QICs N=77,973	
Cases Not Meeting 60-Day Timeframes	< 1%		58%	
	FCSO N=9,195	**Maximus N=18,840**	**Q2A East N=36,842**	**Q2A West N=41,131**
Cases Not Meeting 60-Day Timeframes	< 1%	< 1%	40%	74%
Cases Open More Than 90 Days	0%	0%	12%	39%
Average No. of Days Late	0	0	21	56

Source: OIG analysis of Medicare Appeals System data: Part A, May 2005–July 2006 and Part B, January–July 2006.

To address the Part B QICs' performance issues, CMS took two key actions. It placed both Part B QICs on improvement plans. For FY 2007, CMS also restructured the Part B workload into three jurisdictions and recompeted the contracts among all QICs. Although Q2A West was not awarded a contract to conduct new appeals, CMS did extend its existing contract to handle approximately

[31] In our timeliness calculations, we took into account reconsideration extensions permitted under 42 CFR § 405.970(b).

26,000 reconsiderations that were pending decisions. According to CMS officials, these reconsiderations were all completed by September 2007.

Qualified Independent Contractors did not meet all correspondence requirements but did include the appropriate content in reconsideration decision letters

Case correspondence, such as acknowledgment letters, late notices, and decision letters, serve as important case updates and notifications of appeal rights. Documents contained in case files do not substantiate that the four QICs sent all required correspondence, and some correspondence was not sent within required timeframes. QICs did, however, include all required content in decision letters.

Acknowledgment letters. Twenty-six percent of QIC case files we reviewed were missing letters acknowledging appellants' reconsideration requests, and 20 percent of case files showed that these letters were sent after 14 days from the dates of receipt of the reconsideration requests. (See Table 2 on the next page.) The percentage of case files missing acknowledgment letters ranged from a low of 16 percent for Q2A West to a high of 37 percent for Maximus. Additionally, three QICs sent acknowledgment letters after required timeframes, ranging from a low of 8 percent of reconsiderations for Q2A East to a high of 37 percent for Q2A West.

Reconsideration decision letters. Twelve percent of QIC case files were missing reconsideration decision letters, ranging from a low of 7 percent of reconsiderations for Q2A East to a high of 16 percent for Maximus. However, when present, QICs' decision letters contained all required content, including the reconsideration decision; a summary of the facts in the case; an explanation of how pertinent laws, regulations, coverage rules, and CMS policies apply to the facts of the case; and the appellant's right to an Administrative Law Judge hearing.

Written notification of processing delay and the right to escalate. For late Part B reconsiderations, 40 percent of case files were missing documentation substantiating that the Part B QICs sent notifications of processing delays to appellants by the 60th day following the receipt of their reconsideration requests, as required. Another 37 percent of case files for late Part B reconsiderations show that these notifications were sent after 60 days. Such notifications serve to make appellants aware of their right to escalate their cases to the Administrative Law Judge hearing level.

Table 2: Missing or Untimely Correspondence for Medicare Reconsideration Appeals Processed by Qualified Independent Contractors

	Overall	Part A QICs		Part B QICs	
		FCSO	Maximus	Q2A East	Q2A West
Acknowledgment Letters					
Missing Documentation	26%	26%	37%	33%	16%
Letters Sent After Required Timeframe	20%	0%	16%	8%	37%
Reconsideration Decision Letters					
Missing Documentation	12%	10%	16%	7%	14%
Written Notification of Processing Delay and the Right to Escalate					
Missing Documentation	40%	N/A	N/A*	46%	37%
Notifications Sent After Required Timeframe	37%	N/A	N/A	23%	43%

Source: OIG review of 423 Medicare reconsideration appeals case files: Part A, May 2005–July 2006 and Part B, January–July 2006.
*Maximus was missing documentation substantiating that it sent written notifications of processing delay to appellants for its two late decisions. However, because so few decisions were decided late, we were unable to report statistics for missing notifications of processing delays with a reasonable level of confidence.

Qualified Independent Contractors entered inaccurate information into the Medicare Appeals System for 54 percent of reconsiderations

We reviewed a sample of paper case files to verify the accuracy of information entered into the appeals system by each QIC. We found that, for the five items we reviewed, QICs entered inaccurate information in the appeals system for 54 percent of reconsiderations.[32] (See Table 3 on the next page.) The five items we reviewed were: appellant type; date of receipt of the reconsideration request; acknowledgment letter date; decision date; and

[32] As stated previously, we analyzed appeals system data to determine whether QICs processed reconsiderations within 60 days. Although we found that QICs entered inaccurate information in the appeals system for the five items identified in this report, we were able to corroborate our findings regarding timeliness through the review of paper case files associated with a random sample of reconsiderations.

decision type, i.e., dismissed, partially favorable, favorable, or unfavorable.

Table 3: Percentage of Inaccuracies in Medicare Appeals System Data for Reconsideration Appeals Processed by Qualified Independent Contractors

Information Reviewed	Overall	FCSO	Maximus	Q2A East	Q2A West
Percentage of Cases With Any Incorrect Information	54%	15%	43%	60%	62%
Appellant Type, e.g., Beneficiary, Provider	11%	5%	14%	6%	16%
Reconsideration Request Date	3%	2%	5%	4%	1%
Acknowledgment Letter Date	18%	0%	28%	7%	27%
Decision Date	33%	8%	6%	49%	38%
Decision, e.g., Dismissed, Favorable, Partially Favorable, Unfavorable	3%	1%	4%	1%	4%

Source: OIG review of 423 reconsideration case files: Part A, May 2005–July 2006 and Part B, January–July 2006.

Specifically, we found that 11 percent of reconsiderations had the incorrect appellant types,[33] 3 percent had incorrect reconsideration request dates, 18 percent had incorrect acknowledgment letter dates, 33 percent had incorrect decision dates, and 3 percent had the incorrect decision type.

Administrative Law Judge teams reported that reconsideration information entered by QICs is often inaccurate or missing. Specifically, Administrative Law Judges cited incorrect health insurance claim numbers, missing dates of service, inaccurate claims information, and incorrect appellant types. Administrative Law Judges reported that they rely entirely on paper case files to conduct hearings, in part because they presume that the data contained in the appeals system are unreliable.

[33] The appellant-type designation is important because it may affect adjudication procedures. For example, QICs have special requirements for the content and the complexity of the language used in decision letters sent to beneficiary appellants.

Factors contributing to deficiencies in timeliness, correspondence, and data entry include case transfer delays, unexpected case volume, and appeals system challenges

Based on data obtained through structured interviews with QICs and our analysis of appeals system data, we identified three factors that contributed to processing deficiencies. These include delays in case file transfers from the Affiliated Contractors to QICs, a large and unexpected Part B reconsideration case volume, and functionality challenges with the appeals system. As discussed below, CMS took steps to address some of these issues.

Case transfer delays

Three of the four QICs reported that lags in case file transfers from Affiliated Contractors at Level One affected reconsideration adjudication timeframes and their ability to complete other activities, such as entering data into the appeals system and reviewing case information to reach decisions. According to appeals system data, QICs received redetermination paper case files an average of 14 days after QICs' requests. These case file transfers occur within QICs' 60-day adjudication timeframe, meaning that delays in case transfers reduce the amount of time that QICs have to process reconsiderations. Indeed, appeals system data show that for 15 percent of late reconsideration decisions, QICs received case files after 30 days from the date of the request, leaving only 30 days to process reconsiderations.

Part B case volume

Part B QIC officials cited unexpected case volume as the primary reason for their inability to process cases on time. Our analysis confirmed that as of July 2007, Part B QICs had received about 20 percent more cases than the assumptions identified in their contracts with CMS.[34] [35] Beyond timeliness effects, Part B QIC officials also reported that case volume prompted them to reassign quality review staff to process

[34] Case volume estimates were based on Q2A East and Q2A West Business Proposals, dated December 8, 2005.

[35] Representatives from CMS and the Part B QICs reported that underestimated case volume may be explained, in part, by CMS's assumption that provider appellants would aggregate approximately five claims under one appeal. If multiple claims were aggregated under one appeal, QICs could gain efficiencies by producing fewer letters and entering less overall data into the appeals system. However, according to appeals system data, Part B reconsiderations involved an average of only 1.3 claims rather than the estimated five claims. CMS officials indicated that case volume assumptions were based on historical information from the former hearing officer level of appeals, which handled the second level of Part B administrative appeals prior to the implementation of BIPA.

incoming reconsideration requests and to adjudicate cases, and prevented support staff from entering required data into the appeals system. CMS officials reported that case volume estimates were adjusted for FY 2007.

Medicare appeals system challenges

All QICs reported that challenges related to the appeals system affected timeliness and overall workflow during the initial months of operation. Specifically, the appeals system was frequently unavailable or slow, did not have the ability to generate appellant correspondence, and/or did not support resource management activities. Further, the appeals system did not interface with databases that contained claims information. Consequently, QIC staff needed to manually enter claim-specific information, which was prone to human error. According to all four QICs, these appeals system issues prompted them to develop ancillary systems to generate letters, support workflow management, and gather claims data. CMS worked with CGI Federal to address these issues. However, as of December 2007, the appeals system was still not capable of interfacing with Medicare claims systems, which each of QICs report as essential to ensure that claim-level information is valid for a given reconsideration.

RECOMMENDATION

During our review, the Part A QICs had been processing reconsiderations for 15 months and the Part B QICs for 7 months. We found that, during this time, two QICs were not processing the majority of their Part B reconsiderations within 60 days, case files did not substantiate that QICs sent correspondence to appellants for all reconsiderations, and data entered by QICs in the appeals system were inaccurate. CMS made several changes to improve the reconsiderations process, including facilitating some improvements in the appeals system, restructuring the Part B workload into three jurisdictions, and recompeting the contracts among all QICs. Although these actions may have improved some areas of reconsiderations processing, given the deficiencies cited in this report and the potential impact of these deficiencies on the overall Medicare appeals process, we recommend that CMS:

Take Further Action To Ensure That QICs Meet Timeliness, Correspondence, and Data Entry Requirements

CMS currently employs several mechanisms to monitor QICs, which include weekly reviews of the appeals system data and annual site visit reviews. CMS may consider several options for augmenting these mechanisms to ensure that QICs meet Federal requirements for processing reconsiderations. For example, CMS could add metrics, such as error rates, to its annual reviews to further assess the extent to which QICs meet correspondence and data entry requirements. In addition, to better ensure that appeals system data are accurate, CMS could validate these data during annual reviews. CMS could also evaluate the costs and feasibility of enabling the appeals system to extract information from databases that contain claims data, thereby reducing the need for manual data entry. Lastly, CMS could monitor the length of time that it takes Affiliated Contractors to transfer paper case files to QICs, to better ensure that QICs have a reasonable number of days to adjudicate reconsiderations.

AGENCY COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

CMS concurred with our recommendation to take further action to ensure that QICs meet timeliness, correspondence, and data entry

requirements and outlined efforts it has planned or has already taken to address it.

In response to our suggestion to consider adding metrics to its annual performance evaluations, CMS responded that, during annual evaluations of each QIC, it reviews a sample of case files to determine a percentage of "inaccurate decisions." The percentage of inaccurate decisions found during the review is then used to determine whether the QIC is eligible for a portion of the contract award fee. However, we noted that performance evaluation review reports supplied by CMS did not contain errors specific to correspondence and data entry requirements. Given the extent to which we found problems in these areas, we continue to recommend that CMS may consider adding metrics to gauge QICs' performance related to correspondence and appeals system data entry. Further, CMS reported that it augmented its review of QICs by awarding a contract to a private entity that will conduct its own performance evaluation to determine QICs' adherence to Federal requirements. To better ensure that appeals system data are accurate, the contractor will also validate the accuracy of appeals system data for the cases it selects, according to CMS.

In response to our suggestion that CMS work toward enabling the appeals system to extract information from databases that contain claims data, CMS reported that it has developed such an interface. This system change is scheduled to be implemented in July 2008.

In response to our suggestion that CMS monitor the length of time it takes affiliated contractors to transfer paper case files to QICs, CMS stated that it is reviewing weekly and/or monthly reports on transfer timeliness, and uses this information as part of the affiliated contractors' annual performance evaluation. CMS reported that, as of May 2008, most affiliated contractors were meeting established timeliness standards for forwarding case files. Looking forward, CMS indicated that it included financial incentives in its contracts with the new MACs to forward case files to QICs within 4 days for 85 percent of cases.

Finally, CMS noted that, subsequent to the time period covered by our review, March 2005–July 2006, it has made several changes to the second level of Medicare appeals, which culminated in the award of three new Part B QIC contracts. CMS reported that all three Part B QICs completed over 98 percent of reconsiderations on a timely basis during October 2007–March 2008. Although OIG has not independently

verified the supporting data, we have included a table that CMS provided, which outlines timeliness information for all three Part B QICs as part of the agency's comments.

The full text of CMS's comments is provided in Appendix B.

APPENDIX ~ A

Point Estimates and Confidence Intervals

Table 1: Missing or Untimely Correspondence for Medicare Reconsideration Appeals Processed by Qualified Independent Contractors

Estimate Description	N	Estimate	95-Percent Confidence Interval
Overall Percentage of Case Files Missing Acknowledgment Letters	423	26.3%	21.8–30.8%
Overall Percentage of Acknowledgment Letters Sent Late	423	20.0%	15.7–24.2%
Overall Percentage of Case Files Missing Decision Letters	423	11.7%	8.3–15.0%
Overall Percentage of Case Files Missing Written Notifications of Processing Delays	115	39.7%	30.7–48.9%
Overall Percentage of Written Notifications of Processing Delays Sent Late	115	37.0%	28.0–45.5%

Source: Office of Inspector General (OIG) review of 423 reconsideration case files: Part A, May 2005–July 2006 and Part B, January–July 2006.

Table 2: Estimate of Missing or Untimely Correspondence by Part A Qualified Independent Contractors

	First Coast N=107		Maximus N=109	
Estimate Description	Estimate	95-Percent Confidence Interval	Estimate	95-Percent Confidence Interval
Missing Acknowledgment Letters	26.2%	17.8–34.6%	36.7%	27.5–45.9%
Acknowledgment Letters Sent After 14 Days	N/A	N/A	15.6%	8.7–22.5%
Missing Decision Letters	10.3%	4.5–16.1%	15.6%	8.7–22.5%

Source: OIG analysis of 423 Medicare reconsideration appeals case files: Part A, May 2005–July 2006.

Table 3: Estimate of Missing or Untimely Correspondence by Part B Qualified Independent Contractors

	Q2A East N=100		Q2A West N=107	
Estimate Description	**Estimate**	**95-Percent Confidence Interval**	**Estimate**	**95-Percent Confidence Interval**
Missing Acknowledgment Letters	33.0%	23.6–42.4%	15.9%	8.9–22.9%
Acknowledgment Letters Sent After 14 Days	8.0%	2.7–13.3%	36.5%	27.4–45.6%
Missing Decision Letters	7.0%	1.9–12.1%	14.0%	7.3–20.7%
	N=39		N=76	
Missing Documentation of Notifications of Processing Delay	46.2%	30.6–61.8%	36.8%	25.9–47.7%
Notifications of Processing Delay Sent After Required Timeframe	23.1%	9.9–36.3%	43.4%	32.3–54.5

Source: OIG analysis of 423 Medicare reconsideration appeals case files: Part B, January–July 2006.

Table 4: Estimate of Inaccuracies in Medicare Appeals System Data for Reconsideration Appeals Processed by Qualified Independent Contractors

	N=423	
Estimate Description	**Estimate**	**95-Percent Confidence Interval**
Overall Percentage of Cases With Any Incorrect Information	53.6%	48.4–58.8%
Overall Appellant Type Inaccuracies	11.2%	7.8–14.6%
Overall Reconsideration Request Date Inaccuracies	2.7%	1.0–4.4%
Overall Acknowledgment Letter Date Inaccuracies	18.1%	14.1–22.2%
Overall Decision Date Inaccuracies	33.0%	28.1–38.1%
Overall Decision Inaccuracies, e.g., Dismissed, Favorable, Partially Favorable, Unfavorable	2.6%	0.9–4.3%

Source: OIG review of 423 reconsideration case files: Part A, May 2005–July 2006 and Part B, January–July 2006.

Table 5: Estimate of Inaccuracies in Medicare Appeals System Data for Reconsideration Appeals Processed by Part A Qualified Independent Contractors

	First Coast N=107		Maximus N=109	
Estimate Description	**Estimate**	**95-Percent Confidence Interval**	**Estimate**	**95-Percent Confidence Interval**
Percentage of Cases With Any Incorrect Information	15.0%	8.1–21.8%	43.1%	33.7–52.5%
Appellant Type, e.g., Beneficiary, Provider	4.7%	0.6–8.7%	13.8%	7.2–20.3%
Reconsideration Request Date	1.9%	0.23–6.59%*	4.6%	0.6–8.6%
Acknowledgment Letter Date Inaccuracies	N/A	N/A	27.5%	19.0–36.0%
Decision Date Inaccuracies	7.5%	2.4–12.5%	5.5%	1.2–9.8%
Decision Inaccuracies, e.g., Dismissed, Favorable, Partially Favorable, Unfavorable	0.9%	0.02–5.10%*	3.7%	0.1–7.2%

Source: OIG review of 423 reconsideration appeals case files: Part A, May 2005–July 2006.
*Confidence interval calculated with an exact method based on the binomial distribution.

Table 6: Estimate of Inaccuracies in Medicare Appeals System Data for Reconsideration Appeals Processed by Part B Qualified Independent Contractors

	Q2A East N=100		Q2A West N=107	
Estimate Description	**Estimate**	**95-Percent Confidence Interval**	**Estimate**	**95-Percent Confidence Interval**
Percentage of Cases With Any Incorrect Information	60.0%	50.2–69.8%	61.7%	52.3–71.0%
Appellant-Type Inaccuracies	6.0%	1.3–10.7%	15.9%	8.9–22.9%
Reconsideration Request Date Inaccuracies	4.0%	0.1–7.9%	0.9%	0.0002–0.051%*
Acknowledgment Letter Date Inaccuracies	7.0%	1.9–12.1%	27.1%	18.6–35.7%
Decision Date Inaccuracies	49.0%	39.0–59.0%	38.3%	29.0–47.7%
Decision Inaccuracies, e.g., Dismissed, Favorable, Partially Favorable, Unfavorable	1.0%	0.02–5.45%*	3.7%	0.1–7.4%

Source: OIG review of 423 reconsideration case files: Part B, January–July 2006.
*Confidence interval calculated with an exact method based on the binomial distribution.

APPENDIX ~ B

Agency Comments

DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Office of the Administrator
Washington, DC 20201

DATE: MAY 30 2008

TO: Daniel R. Levinson
Inspector General

FROM: Kerry Weems
Acting Administrator

SUBJECT: Office of Inspector General (OIG) Draft Report: "Early Implementation Review of Qualified Independent Contractor Processing of Medicare Appeals Reconsiderations" (OEI-06-06-00500)

Thank you for the opportunity to review and comment on the above OIG Draft Report. The OIG's study focused on the early stages of the Centers for Medicare & Medicaid Services (CMS) implementation of the Qualified Independent Contractor (QIC) program and the QICs' performance in processing fee-for-service reconsiderations. We appreciate the OIG's thorough review of the issues involved, as well as the recommendations for improving the future operations and oversight of the QIC program. As discussed below, CMS concurs with the OIG's recommendation and, in fact, we have already implemented some of them and are in the process of implementing the rest.

The CMS agrees that the performance of the QICs is vitally important to the Medicare program and the due process rights of the beneficiaries we serve. CMS actively monitors QIC performance, and QICs that do not perform within CMS' standards are placed on corrective action plans (CAPs) until performance improves. If a QIC's performance does not improve after issuance of a CAP, the QIC faces possible non-renewal or termination of its contract with CMS.

Thus, although we agree with the OIG's recommendations, we note that the OIG analysis was done for reconsideration requests initiated from May 2005 to July 2006 and we strongly believe that the report should acknowledge the success of the efforts CMS has already taken since then to address the various issues identified in the report. For instance, we have taken swift and decisive action to deal with the performance problems identified in this draft report, culminating in the award of the three new Part B QIC contracts late in 2006.

Attached is a table that illustrates this success, with all three Part B QICs completing over 98 percent of reconsiderations on a timely basis during the first half of fiscal year (FY) 2008. Thus, we respectfully request that the OIG's final report include the addition of updated information regarding Part B appeals timeliness to reflect the results of changes

CMS has made, as acknowledged in the report. The attached data show Part B appeals timeliness for the first 6 months of FY 2008. These data essentially parallel the reporting period used in the report and present an up-to-date picture of QIC performance. We have provided the updated data in the attached Excel spreadsheet.

We address the report's Recommendation/Suggestions below.

OIG Recommendation

The OIG recommends that CMS take further action to ensure that QICs meet timeliness, correspondence, and data entry requirements. For example:

- ***CMS could add metrics, such as an error rate, to its annual review to further assess the extent to which QICs meet correspondence and data entry requirements.***

  CMS Response

  The CMS concurs with this recommendation. CMS currently performs annual evaluations of each QIC. These evaluations focus on the quality, accuracy, and timeliness of the QICs' decisions, as well as compliance with regulatory and contractual appeals requirements. During this review, CMS can and does determine if a QIC is issuing an unacceptable percentage of inaccurate decisions. The percentage of inaccurate decisions found during the review of the sample of selected case files is applied to the universe of that QIC's cases and used to determine whether the QIC will be eligible for a portion of the contract award fee.

  In addition, to further enhance the current review process, CMS awarded an Evaluation and Oversight (E & O) contract to a small business that will conduct performance evaluations of all QICs to determine that reconsiderations are being processed in accordance with Federal laws, regulations, and program guidance. The reviews will specifically look at the quality and accuracy of the QICs' decisions. The E & O contractor has specialized staff with clinical expertise (i.e., RNs and MDs) to review the QICs' decisions. These individuals will apply their own clinical judgment, comparing it to clinical decisions issued by the QIC physicians. The accuracy rate determined during the E & O reviews will be used in determining a QIC's eligibility for contract award fees.

- ***In addition, to better ensure that appeals system data are accurate, CMS could validate these data during annual reviews.***

  CMS Response

  The CMS concurs with this recommendation. The Medicare Appeals System (MAS) is a valuable tool and it was through analysis of information in the system that CMS was able to identify Q2A's performance issues promptly in 2006. CMS

routinely reviews cases in MAS as a part of our ongoing oversight of the QIC program. Additionally, the E & O contractor will validate associated data in MAS for each case it selects for review. If the results of this data validation reveal inaccuracies, the information will appear in each QIC's performance report to CMS. CMS can then take appropriate action to correct or improve performance. Records in MAS are also validated when an inquiry is received from an appellant, the Office of Medicare Hearings and Appeals, or a Congressional Office.

- ***CMS could also evaluate the cost and feasibility of enabling the appeals system to extract information from databases that contain claims data, thereby reducing the need for manual data entry.***

CMS Response

The CMS concurs with this recommendation. CMS agrees that the establishment of the claims processing systems interfaces will greatly reduce the need for manual entry at the QICs, and therefore reduce the number of data entry errors. CMS has developed claims processing system interfaces with the MAS, and interfaces are on schedule to be implemented in July 2008. CMS is confident that the claims interface will also make the use of the MAS and the QICs' processing of reconsiderations considerably more efficient, given the amount of time saved on data entry.

- ***The CMS could monitor the length of time it takes affiliated contractors (ACs) to transfer paper case files to QICs, to better ensure that QICs have a reasonable number of days to adjudicate reconsiderations.***

CMS Response

The CMS concurs with this recommendation. CMS receives weekly and/or monthly reports from the QICs that highlight the average time it takes the ACs to forward case files to the QICs. Most ACs are meeting established timeliness standards for forwarding case files to the QICs. Further, this is reviewed as part of the ACs' annual contractor performance evaluation. In addition, CMS has included financial incentives through award fee plans for the new Medicare Administrative Contractors (MACs) to forward case files to the QICs within 4 days 85 percent of the time. This has proven to be an effective incentive, since most MACs are meeting this stretch goal.

Again, we appreciate the opportunity to review and comment on this draft report.

Attachment

Timeliness: Monthly Breakdown

For Decision Dates Between Oct 1, 2007 and Mar 31, 2008

QIC	Appeal Priority	Year	Month	Appeals Decided	Decided Timely	% Timely	Decided Non-Timely	% Non-Timely
Rivertrust DME All	Standard	2007	October	3,039	2,965	97.56%	74	2.44%
			November	2,535	2,498	98.54%	37	1.46%
			December	2,294	2,253	98.21%	41	1.79%
		2008	January	2,569	2,537	98.75%	32	1.25%
			February	2,976	2,954	99.26%	22	0.74%
			March	3,548	3,481	98.11%	67	1.89%
	Standard			**16,961**	**16,688**	**98.39%**	**273**	**1.61%**
	Rivertrust DME All			**16,961**	**16,688**	**98.39%**	**273**	**1.61%**
First Coast B North	Standard	2007	October	7,359	7,358	99.99%	1	0.01%
			November	6,544	6,535	99.86%	9	0.14%
			December	7,627	7,618	99.88%	9	0.12%
		2008	January	4,485	4,485	100.00%	0	0.00%
			February	5,198	5,198	100.00%	0	0.00%
			March	4,876	4,875	99.98%	1	0.02%
	Standard			**36,089**	**36,069**	**99.94%**	**20**	**0.06%**
	First Coast B North			**36,089**	**36,069**	**99.94%**	**20**	**0.06%**
Q2A B South	Standard	2007	October	3,771	3,754	99.55%	17	0.45%
			November	4,403	4,401	99.95%	2	0.05%
			December	4,355	4,352	99.93%	3	0.07%
		2008	January	3,932	3,931	99.97%	1	0.03%
			February	3,222	3,221	99.97%	1	0.03%
			March	2,717	2,717	100.00%	0	0.00%
	Standard			**22,400**	**22,376**	**99.89%**	**24**	**0.11%**
	Q2A B South			**22,400**	**22,376**	**99.89%**	**24**	**0.11%**

Notes:
1) Appeals with a Status of Combined are excluded
2) An appeal is considered Non-Timely if the Decision Date is later than the Deadline Date

3) The Appeal Deadline Date is recalculated if there is an Appeal Extension

Prepared by Q2Administrators, LLC - 1 - Apr 3, 2008

ACKNOWLEDGMENTS

This report was prepared under the direction of Kevin K. Golladay, Regional Inspector General for Evaluation and Inspections in the Dallas regional office, and A. Blaine Collins, Deputy Regional Inspector General.

Christi Macrina served as the team leader for this study. Other principal Office of Evaluation and Inspections staff from the Dallas regional office who contributed to the report include Susan C. Bowman and Anthony Guerrero-Soto; central office staff who contributed include Barbara Tedesco, Kevin Farber, and Scott Manley.