Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

MEDICARE ADMINISTRATIVE LAW JUDGE HEARINGS: EARLY IMPLEMENTATION, 2005–2006

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EXECUTIVE SUMMARY

OBJECTIVE

1. To assess the Office of Medicare Hearings and Appeals' (OMHA) use of telephone, video teleconference, and in-person hearings to decide Medicare administrative law judge (ALJ) cases during the first 13 months of operation.
2. To assess the timeliness of ALJ decisions during the first 13 months of operation.

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. The third level is ALJ hearings.

Beginning in July 2005, the responsibility for conducting ALJ hearings was transferred from the Social Security Administration (SSA) to OMHA in the Department of Health and Human Services. The SSA hearings were held primarily in person at the 141 Social Security offices throughout the country. Under SSA, there was no timeliness requirement for appeal decisions. In contrast, OMHA, with four field offices, planned to use primarily telephone and video teleconference to conduct ALJ hearings. Further, OMHA faced a new statutory requirement that certain cases be decided within 90 days.

In December 2005, members of Congress wrote to the Office of Inspector General (OIG) and requested that we assess the use of telephone, video teleconference, and in-person hearings to decide Medicare ALJ cases and that we examine the extent to which OMHA is meeting the new statutory requirement that it decide certain cases within 90 days. Other cases, including those filed prior to the transfer, are not subject to the 90-day decision requirement. The members of Congress were also concerned about whether a heavy reliance on telephone and video teleconference hearings might compromise Medicare beneficiaries' access to the ALJ appeals process. Additionally, a June 2005 Government Accountability Office study raised concerns about whether hearings held via video teleconference are an appropriate substitute for in-person hearings.

OMHA uses the Medicare Appeals System (hereafter referred to as the appeals system) to manage its caseload. We based this study on an analysis of data from the appeals system for OMHA's first 13 months of operation, structured interviews with appellants associated with a random sample of cases, and structured interviews with OMHA staff.

FINDINGS

In its first 13 months of operation, OMHA conducted an estimated three-quarters of its hearings by telephone. During its first 13 months of operation, OMHA conducted 78 percent of its hearings by telephone, 12 percent by video teleconference, and 10 percent in person. Several factors contributed to the high usage of hearings by telephone. Specifically, OMHA staff did not consistently offer hearings by video teleconference; when given the choice, appellants often selected hearings by telephone over hearings by video teleconference; and OMHA granted in-person hearings only in limited situations.

Most sample appellants were satisfied with their hearing format. Both OMHA staff and sample appellants highlighted specific advantages and disadvantages of each hearing format. Sample appellants who had telephone or video teleconference hearings reported some communication and technical difficulties with those hearing formats.

Incomplete and inaccurate data limit OMHA's ability to manage its caseload. For over 70 percent of the cases that were decided in the first 13 months of OMHA's operation, there was no indication about which parties were the primary appellants. Moreover, information about appellants was not consistently entered in the system, making it difficult for OMHA to appropriately consolidate cases and to track frequent users of the appeals process. In addition, many key dates in the system were inaccurate and many key dates were missing. Lastly, information about the hearing type and format was frequently incomplete or incorrect.

Available data indicate that in its first 13 months of operation, OMHA did not decide a number of its cases in a timely manner. We found that 15 percent of the cases that had a 90-day requirement and a decision date in the appeals system were not decided on time. On average, cases with the 90-day requirement took 82 days to decide. Cases without the 90-day requirement took an average of 25 days longer to decide. For cases both with and without the 90-day requirement,

delays occurred early in the appeals process—from the time when OMHA received the appeal request to the time when OMHA staff scheduled the hearing.

RECOMMENDATIONS

Based on the findings in the report, we recommend that OMHA:

Consistently offer appellants the option of video teleconference. OMHA should consistently direct appellants to hearings by video teleconference, if available. To ensure compliance with the regulations, OMHA should standardize its scheduling process and document whether the ALJ made a determination that video teleconference technology was available or whether the hearing request or administrative record suggested that a telephone hearing might be more convenient for one or more of the parties. Further, OMHA should encourage staff to identify available video teleconference sites before contacting the appellant to schedule the hearing, when appropriate. OMHA should also have standard protocols for making and documenting decisions to grant in-person hearings.

Continue to improve the timeliness of deciding cases with the 90-day decision requirement. OMHA should meet the 90-day statutory timeframe for all cases subject to this requirement. OMHA should pay particular attention to reducing the delays that occur between the time when OMHA receives the appeal request and the time when staff schedule a hearing. OMHA should also ensure that meeting the 90-day decision requirement does not cause undue delays for cases without the 90-day decision requirement.

Address problems associated with telephone and video teleconference hearings. OMHA should address the problems associated with holding hearings over the telephone and via video teleconference. OMHA should work with its contractors to ensure that the video teleconference equipment is set up on time and available for the duration of the hearing. It should also work to eliminate any technical difficulties, such as feedback and poor picture quality. Finally, OMHA should develop strategies for referring to documents in the case files to help improve communication between appellants and ALJs during the hearings.

Improve the quality of the data in the appeals system. OMHA should ensure that the data problems that we identified have been addressed. Specifically, OMHA should continue to improve the quality of the data

so that it can use the appeals system to better manage its caseload and more accurately report on key aspects of the program. OMHA should also continue to refine its data standardization policy and provide any necessary training to staff. Lastly, OMHA should institute regular data checks to eliminate invalid entries and instances of missing data.

AGENCY COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

OMHA concurred with all four of our recommendations based on our analysis of its first 13 months of operations. OMHA noted that it had previously identified the same findings and recommendations as internal areas of concern and has taken measures to address them.

In response to our first recommendation, OMHA noted that it has implemented a comprehensive training program for staff involved in scheduling hearings to standardize the scheduling process and ensure that staff understand the statutory and regulatory hearing requirements. It also performs random unannounced screenings of the scheduling procedures and has modified the appeals system to record and track the requested and actual hearing formats.

In response to our second recommendation, OMHA stated that it has improved its case processing times for the cases subject to the 90-day decision statutory timeframe as well as for the cases not subject to the 90-day requirement.

In response to our third recommendation, OMHA stated that it has taken numerous steps to address technical difficulties associated with telephone and video teleconference hearings. For example, OMHA performed significant software upgrades to its video teleconference infrastructure and has in place for staff guidance regarding coordination with vendors for real-time resolution of technical issues and extensions of hearing duration.

In response to our fourth recommendation, OMHA stated that it has instituted additional business rules and recurring data checks for logic in the appeals system. OMHA has also implemented a data standardization policy and training on the new requirements. OMHA is also examining inaccuracies in many date fields and will include date validation changes in upgrades to the appeals systems later this year.

We recognize OMHA's efforts to address these issues and encourage it to continue to make progress in these areas.

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In December 2005, members of Congress wrote to the Office of Inspector General (OIG) and requested that we assess the use of telephone, video teleconference, and in-person hearings to decide Medicare ALJ cases and that we examine the extent to which OMHA is meeting the new statutory requirement that it decide certain cases within 90 days. Other cases, including those filed prior to the transfer, are not subject to the 90-day decision requirement. The members of Congress were also concerned about whether a heavy reliance on telephone and video teleconference might compromise Medicare beneficiaries' access to the ALJ appeals process. Additionally, a June 2005 Government Accountability Office (GAO) study raised concerns about whether

hearings held via video teleconference are an appropriate substitute for in-person hearings.[1]

Four-Level Medicare Administrative Appeals Process

There are four levels of the Medicare administrative appeals process within HHS. For Medicare Parts A and B, the four levels are:

- Level One: Affiliated Contractor redeterminations
- Level Two: Qualified Independent Contractor reconsiderations
- Level Three: ALJ hearings
- Level Four: Medicare Appeals Council hearings

If appellants disagree with the outcome of the prior level of appeal, they may take their case to the next level. For example, if an appellant is not satisfied with the reconsideration by the Qualified Independent Contractor, the appellant may request a hearing before an ALJ. The ALJ independently reviews the case and makes a decision in accordance with applicable laws and regulations. After exhausting the four levels of the administrative appeals process, an appellant may file an action in a Federal District Court. Appendix A provides an overview of each of the four levels of the administrative appeals process for Medicare Parts A and B.

Different procedures exist for appealing determinations under Medicare Parts C (the Medicare Advantage program) and D (the Medicare prescription drug benefit). For Level One and Level Two appeals, the entities that decide the appeals for Medicare Parts C and D are different from the entities that decide the appeals for Medicare Parts A and B. However, for Level Three, the ALJ is responsible for deciding all Medicare appeals, including Medicare Parts C and D appeals.[2]

OMHA

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) required SSA to transfer the responsibility for Medicare ALJ hearings to HHS.[3] On June 23, 2005, HHS established OMHA to conduct these hearings.[4]

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[1] GAO, "Medicare: Concerns Regarding Plans to Transfer the Appeals Workload from SSA to HHS Remain," GAO-05-703R, June 30, 2005.
[2] 42 CFR § 422.600 (regarding right to an ALJ hearing under Medicare Part C); 42 CFR § 423.610 (regarding right to an ALJ hearing under Medicare Part D).
[3] Medicare Prescription Drug, Improvement, and Modernization Act of 2003, P.L. No. 108-173, § 931.
[4] 70 Fed. Reg. 36386 (June 23, 2005). OMHA began operations on July 1, 2005.

When HHS established OMHA, it planned to use primarily telephones and video teleconferences for ALJ hearings. In a March 2004 report to Congress, HHS described its plan to expand the use of telephone and video teleconference hearings, stating that the plan would allow OMHA to conduct them more efficiently.[5] The report stated that, unlike SSA disability hearings where in-person hearings may be needed to evaluate credibility, Medicare hearings are less dependent on the physical presence of the appellant and other witnesses.

Currently, OMHA has offices in four cities around the country. OMHA's central office and one of its field offices are located in Arlington, Virginia; it has three other field offices in Cleveland, Ohio; Miami, Florida; and Irvine, California. Staff at the field offices are responsible for scheduling and conducting hearings.

Federal Requirements

Section 521 of the Medicare, Medicaid, and State Children's Health Insurance Program Benefits Improvement and Protection Act of 2000 (BIPA) amended section 1869 of the Social Security Act (the Act) to establish a uniform process for handling Medicare Parts A and B appeals and to impose shorter timeframes for the processing of appeals.[6] The Centers for Medicare & Medicaid Services promulgated regulations to address the changes to the appeals process required by the BIPA and the MMA.[7]

Section 1869(d)(1)(A) of the Act, as amended by the BIPA, generally requires that ALJs issue a decision about a case within 90 days of the date that the appeal request was filed.[8] The 90-day requirement applies to all Medicare Parts A and B appeals received after the implementation of the BIPA, unless the appellant waives the right to have the case decided within 90 days[9] or OMHA approves a request for an in-person hearing.[10] The 90-day requirement does not apply to Medicare Parts C or D appeals. An appellant can request an ALJ

[5] The Secretary of HHS and the Commissioner of SSA, "Report to Congress: Plan for the Transfer of Responsibility for Medicare Appeals," March 2004.
[6] Medicare, Medicaid, and State Children's Health Insurance Program Benefits Improvement and Protection Act of 2000, P.L. No. 106-554 § 521.
[7] 70 Fed. Reg. 11420 (Mar. 8, 2005), as amended at 70 Fed. Reg. 37700 (June 30, 2005).
[8] 42 U.S.C. § 1395ff(d)(1)(A); 42 CFR § 405.1016(a).
[9] 42 U.S.C. § 1395ff(d)(1)(B); 42 CFR § 405.1036(d).
[10] 42 CFR § 405.1020(i)(4). In addition, cases that are escalated to OMHA because the prior level did not complete the reconsideration within the federally required timeframe are not subject to the 90-day decision requirement. See 42 CFR § 405.1016(c).

hearing by filing a written request within 60 days of receiving a Level Two decision.[11] The ALJ must mail or serve a notice of hearing at least 20 days before the hearing.[12]

Federal regulations state that the ALJ will direct that the appearance of an individual be conducted by video teleconference, if the ALJ finds that video teleconferencing technology is available to conduct the appearance.[13] The regulations go on to state that the ALJ may also offer to conduct a hearing by telephone if the hearing request or administrative record suggests that a telephone hearing may be more convenient for one or more of the parties. If video teleconference technology is not available or if special or extraordinary circumstances exist, the ALJ may determine that an in-person hearing should be conducted. Moreover, if a party objects to a hearing via telephone or video teleconference, the party may file a written request for an in-person hearing, which the ALJ may grant if there is good cause.[14] To determine whether good cause exists, the ALJ considers the party's reason for requesting the change, the facts supporting the request, and the impact on the efficient administration of the hearing process.[15] For example, an ALJ may find that there is good cause for an in-person hearing if the party is close to and able to go to an OMHA field office or if the case presents complex, challenging, or novel presentation issues.[16] In certain circumstances, the ALJ may make an on-the-record decision that is based only on the case file and does not require a hearing.[17]

Medicare Appeals System

The Medicare Appeals System (hereinafter referred to as the appeals system) was designed to create a unified case tracking system across the

[11] 42 CFR § 405.1014(b)(1) (pertaining to Medicare Parts A and B). Similar requirements exist for Medicare Part C at 42 CFR § 422.602(b) and for Medicare Part D at 42 CFR § 423.612(b).
[12] 42 CFR § 405.1022(a).
[13] 42 CFR § 405.1020(b) (pertaining to Medicare Parts A and B). Federal regulations state that the time and place for ALJ hearings for Medicare Parts C and D must be set in accordance with 42 CFR § 405.1020. 42 CFR § 422.602(b) (regarding Medicare Part C); 42 CFR § 423.612(b) (regarding Medicare Part D).
[14] 42 CFR § 405.1020(i).
[15] 42 CFR § 405.1020(g).
[16] See 70 Fed. Reg. 11420, 11457 (Mar. 8, 2005) (preamble discussion regarding good cause for in-person hearings).
[17] 42 CFR § 405.1038. The ALJ can issue an on-the-record decision if the decision is fully favorable, if all parties wish to forgo a hearing, or if an appellant who lives outside the United States does not inform the ALJ that the appellant wants to appear and no other parties wish to appear.

four levels of administrative appeal once the ALJ function was transferred from SSA to HHS. The appeals system stores and facilitates the transfer of case-specific data. In September 2003, CMS contracted with CGI Federal to develop and maintain the appeals system. Currently, Levels Two and Three of the appeals process use the appeals system.

The appeals system includes a variety of case-specific information that OMHA uses to manage its caseload. It includes information such as the type of service being contested, the hearing format, the date when OMHA received the appeal request, and the date when the decision letter was sent to the appellant. It also lists the parties involved with each case; indicates which party is the primary appellant; and specifies whether each party is a Medicare provider or supplier, a beneficiary, or a State Medicaid organization.[18] OMHA staff can input new data into the appeals system regarding Level Three of the appeals process.

Related Work

In January 2002, OIG released a report that analyzed the potential impact of the BIPA on the Medicare administrative appeals process.[19] OIG found that the former process for ALJ appeals was backlogged and recommended modernizing the appeals process. It 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 the recommendations.

In a report released in October 2004, GAO evaluated the transfer plan developed by HHS and SSA.[20] GAO found that the plan generally addressed all of the elements mandated by the MMA, such as a timetable, cost projections, and information about the development of the appeals system. However, the plan omitted important information, such as specific transition milestones and details related to the feasibility of using video teleconferences to provide access to ALJs.

[18] These organizations serve as appointed representatives for State Medicaid agencies. A State Medicaid agency may appeal services provided to beneficiaries who are dually eligible for Medicaid and Medicare to determine whether Medicare is liable for the payment rather than the Medicaid program.

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

[20] GAO, "Medicare: Incomplete Plan to Transfer Appeals Work Load from SSA to HHS Threatens Service to Appellants," GAO-05-45, October 4, 2004.

In a follow-up report released in June 2005, GAO highlighted the challenges of ensuring sufficient availability of hearings given the limited access to in-person hearings.[21] GAO also noted that the hiring and training timetables for ALJs and support staff were ambitious and that HHS continued to face challenges such as the implementation of the appeals system.

In addition, OIG is currently conducting an evaluation of Level Two of the appeals process. That evaluation will assess the extent to which Qualified Independent Contractors met timeliness, correspondence, and data entry requirements for reconsiderations processed during the initial months of operation.

METHODOLOGY

We based this study on several sources: (1) an analysis of data from the appeals system for the first 13 months of OMHA's operation, (2) structured telephone interviews with appellants associated with a random sample of cases, and (3) structured interviews with key OMHA management staff and a randomly selected sample of OMHA field office staff.

Data From the Appeals System

We requested and reviewed the most recent data then available from the appeals system. These data were for the first 13 months of OMHA's operation, July 1, 2005, through July 31, 2006, and included 20,783 cases. The data were organized by case. Each case may have multiple claims. Each case may also have multiple parties, one of whom may be identified as the primary appellant. We met with OMHA staff on several occasions to ensure that we had a thorough understanding of the data and the way in which OMHA used the information.

Structured Telephone Interviews With Sample Appellants

We selected a random sample of cases and, between January and March 2007, conducted structured telephone interviews with the primary appellant associated with each. If the primary appellant was not identified in the appeals system, we contacted one of the parties and asked him or her to identify the primary appellant. We selected our sample based on case as opposed to primary appellant for several reasons: the data were organized by case, each party could be

[21] GAO, "Medicare: Concerns Regarding Plans to Transfer the Appeals Workload from SSA to HHS Remain," GAO-05-703R, June 30, 2005.

associated with multiple cases, and the appeals system did not always indicate which party was the primary appellant.

As a first step, we identified 6,203 cases in the appeals systems that had had a hearing.[22] A case may not have had a hearing primarily because it was decided through an on-the-record decision, it was consolidated with similar cases, or it was not completely processed at the time of our review.

We then selected a stratified random sample of 270 cases from these 6,203 cases. We stratified the sample based on the hearing format recorded in the appeals system to ensure that we interviewed appellants who used each of the hearing formats offered by OMHA. Our four strata were telephone, video teleconference, in-person, and an unidentified hearing format. We included a stratum for unidentified hearing format because 2,173 of the 6,203 cases did not have a hearing format recorded in the appeals system. Table 1 shows the number of cases we selected from each stratum.

Table 1: Population and Sample Size, by Stratum

Stratum	Number of Cases With Hearings in the Population	Number of Cases With Hearings in Our Sample
Telephone	3,132	70
Video Teleconference	464	75
In Person	434	75
Unidentified	2,173	50
Total	**6,203**	**270**

Source: OIG analysis of the Medicare Appeals System, 2007.

We excluded 16 sample cases from our analysis. At the time of our review, OIG was conducting investigations related to appellants associated with 11 of these cases. The other five cases were excluded because they had been incorrectly recorded in the appeals system as having had a hearing.

We successfully contacted the primary appellants associated with 225 of the remaining 254 cases, for a response rate of 89 percent. We were unable to contact the primary appellants or the primary appellants chose not to participate for the remaining 29 cases. Again, if the appeals system identified a primary appellant, we contacted that party.

[22] This number includes appeals under Medicare Parts A, B, C, and D.

Otherwise, we contacted one of the parties associated with the case and asked him or her to identify the primary appellant. Appendix B describes this information by stratum.

In total, we conducted structured interviews with the 131 appellants associated with the 225 cases. Twenty-two appellants were associated with more than one sample case, ranging from 2 to 35 cases. Because the appeals system was missing data on hearing format for a large percentage of the sample cases, we asked all appellants which format(s) they had used. Based on their responses, we found that in addition to lacking some data, the appeals system also had incorrect data on hearing format. See Appendix C for detailed information about the inaccuracies of the hearing format data. We discuss this issue further in the findings section of the report.

We asked all of the appellants about their experiences with scheduling their hearings, about the information they received regarding the three hearing formats, and about the advantages and disadvantages of the different formats. Three sample appellants had used two different hearing formats. For these, we included their responses in our analysis of each of the formats.

Structured Interviews With OMHA Staff

We conducted structured in-person interviews with key OMHA staff. We interviewed the Chief ALJ and the Executive Director of OMHA. We also interviewed the Managing ALJ and the Hearing Office Director at each of the four field offices. In addition, we interviewed 12 randomly selected ALJ teams (3 from each of the four field offices) out of 49 ALJ teams. Each ALJ team included an ALJ, an attorney, a hearing clerk, and a paralegal. For the purposes of this report, we refer to these respondents as OMHA staff.

Our interview questions focused primarily on OMHA's processes for scheduling and conducting hearings, including how they selected the hearing format. We also asked about any obstacles that they experienced in scheduling and holding hearings. Finally, we asked about advantages and disadvantages of each of the hearing formats. We conducted these interviews between May and July 2006.

Data Analysis

We projected the results from our 225 sample cases to the population of OMHA cases that had a hearing to estimate: (1) the percentage of hearings conducted by telephone, by video teleconference, and in person; and (2) the percentage of hearings by appellant type. We used the

sample of cases rather than the population of cases to determine the percentage of hearings conducted by telephone, by video teleconference, and in person because some data in the appeals system were inaccurate and some were missing from the system. Similarly, we used the sample of cases rather than the population of cases to determine the percentage of hearings by appellant type because the appeals system typically did not indicate which party was the primary appellant. We therefore used standard statistical formulas for producing estimates from a stratified random sample to arrive at these estimates. Appendix D provides the confidence intervals for these estimates.

In addition, we analyzed the data from the appeals system to assess the timeliness of ALJ decisions. We analyzed the cases that were subject to the 90-day requirement (6,085 cases) separately from the cases that were not subject to this requirement (14,682 cases).[23] As previously mentioned, the 90-day decision deadline applies to all Medicare Parts A or B appeals received after the implementation of the BIPA, unless the appellant signs a waiver relinquishing the right to have the case decided within 90 days, OMHA approves a request for an in-person hearing, or other special circumstances exist. The 90-day requirement does not apply to Medicare Parts C or D appeals.

To conduct our analysis, we compared the date when OMHA received the appeal request to the date when OMHA sent a decision letter to the appellant. We did not include the cases that did not have decision letter dates. A case may not have this date because it was not decided or because the date had not been recorded in the appeals system. Because data were missing from other fields, we could not assume that the case had not been decided. Lastly, we included any allotted extension days plus a 3-day grace period to cover any holiday weekends.[24]

Limitations

We limited our results about appellants' satisfaction with the different hearing formats to sample appellants. We could not generalize our results to all appellants because our unit of analysis was a case, rather

[23] Six of the cases subject to the 90-day requirement were excluded from the analysis because the decision date in the appeals system was recorded erroneously as being earlier than the date the appeals request was received. Ten of the cases not subject to the 90-day requirement were excluded for the same reason.

[24] The regulations provide for extension days in cases in which the hearing is postponed at the request of the appellant or in certain other circumstances, such as a party requesting discovery from another party. See 42 CFR §§ 405.1020(h) and 405.1037(f).

than an appellant. As mentioned, data limitations in the appeals system did not allow us to sample by appellant. We discuss other limitations of the appeals system data in the findings section of the report.

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.

In its first 13 months of operation, OMHA conducted an estimated three-quarters of hearings by telephone

During its first 13 months of operation, OMHA conducted 78 percent of its hearings by telephone, 12 percent by video teleconference, and 10 percent in person. In 78 percent of the cases that had hearings, the primary appellants were Medicare providers or suppliers. Another 15 percent of these cases had primary appellants who were Medicare beneficiaries, and 8 percent were pursued by State Medicaid organizations.[25]

Several factors contributed to the high usage of hearings by telephone. Specifically, OMHA staff did not consistently offer hearings by video teleconference; when given the choice, appellants often selected hearings by telephone over hearings by video teleconference; and OMHA granted in-person hearings only in limited situations.

OMHA staff did not consistently offer video teleconference

OMHA staff explained that, generally, they decide the hearing format when they contact the primary appellant to schedule the hearing. Five of the twelve ALJ teams that we interviewed stated that they directed appellants to a video teleconference hearing as the default option, whereas five other teams said that they offered both video teleconference and telephone hearing options at the same time. The two remaining teams discussed the process more generally. All of the teams noted that appellants' preferences are an important factor in deciding the hearing format.

Staff further explained that they do not have a standardized script for discussing the format options with the primary appellant or a standard way of documenting how the format decision is made. They noted that OMHA uses two private companies that have video teleconference sites around the country. They can locate the 120 sites from one of the companies online but need to call the other company to identify specific video teleconference sites. Staff reported varying procedures for how and when they identify available video teleconference sites for an upcoming hearing.

In addition, sample appellants reported that OMHA staff promoted telephone hearings over the other formats and did not always provide video teleconference hearings as an option. Specifically, 35 percent

[25] These numbers do not add to 100 percent because of rounding.

(46 of 131) of sample appellants reported that they were never offered video teleconference as an option. Three appellants reported that OMHA also promoted the telephone format by sending a letter stating that the hearing would be conducted over the telephone. It was not possible to determine the extent to which staff directed appellants toward video teleconference hearings in accordance with the regulations. OMHA does not currently require staff to document how the hearing format was decided, including documenting whether video teleconference technology was available or whether the hearing request or administrative record suggested that a telephone hearing may be more convenient for one or more of the parties.

Appellants often selected the telephone over video teleconference

For just over half of the hearings, appellants reported being offered both the telephone and video teleconference formats. Given the choice between the two formats, appellants selected the telephone format for over 75 percent of these hearings. OMHA staff and sample appellants commonly noted that appellants preferred the telephone format because it is convenient and cost-effective.

OMHA granted in-person hearings in limited situations

OMHA staff explained that in-person hearings are granted only in limited situations. Most sample appellants reported being granted in-person hearings because they were located near one of the four OMHA field offices or because they were willing to travel to one of the field offices at their own expense. OMHA staff further indicated that they did not have standardized protocols or written criteria for making and documenting decisions about in-person hearings.

Several sample appellants noted that they would have preferred to have their hearing in person, as opposed to by video teleconference or telephone. Specifically, one-fifth of sample appellants who had a telephone or video teleconference hearing (22 of the 102) would have preferred to have their hearing in person. Most of these appellants (14 of 22), however, did not request an in-person hearing because of the time, travel, or cost involved in going to an OMHA field office or because they were not aware that an in-person hearing was available.

Most sample appellants were satisfied with their hearing format

Although appellants were not consistently offered all hearing format options, most sample appellants reported being satisfied with the format of their hearings. Sample appellants and OMHA staff also highlighted specific advantages and disadvantages of each hearing format.

Almost all of the sample appellants who had telephone hearings were satisfied with that format

Eighty of the eighty-four sample appellants who had a hearing over the telephone were satisfied with that format. Over 80 percent of these appellants stated that having their hearings over the telephone was convenient and saved them time and money because they did not have to travel to another location. Several appellants who were providers noted that the telephone option enabled them to have full access to their files during the hearing. A number of appellants explained that having their hearing in a familiar setting, such as their home or office, was an advantage.

In addition, OMHA staff stated that holding hearings over the telephone is efficient and cost-effective. They explained that telephone hearings are easier to schedule than other types of hearings, partly because multiple parties can participate from different locations. They also generally noted that the telephone is the most inexpensive and convenient way by which to hear cases.

Sample appellants and OMHA staff both noted several disadvantages of telephone hearings. Twenty-five appellants noted that communication suffered because of the lack of face-to-face contact with the ALJ, and 31 appellants reported difficulties pointing out specific evidence in the case files. In addition, five appellants said that they did not have the same documents as the ALJ to refer to during the hearing. Finally, several appellants and OMHA staff also reported that they experienced technical difficulties with the telephone, such as hearing an echo or having the call dropped.

Most of the sample appellants whose hearings were held via video teleconference were satisfied with that format

Fourteen of the twenty sample appellants who had a hearing via video teleconference were satisfied with that format. Over half of these sample appellants reported that being able to see the ALJ made communication easier. They commonly cited benefits such as the

convenience and the time and cost savings resulting from not having to travel to an in-person hearing.

Based on our sample, 13 of the 20 appellants had their hearings at video teleconference sites owned by one company. The remaining appellants had their hearings either at Government buildings or at private sites. Over half of the sample appellants traveled less than 15 miles to their hearing site. The remaining sample appellants traveled less than 75 miles.

Sample appellants and OMHA staff identified several disadvantages of conducting hearings via video teleconference. Nine of the twenty sample appellants reported technical difficulties, such as feedback, a lag in audio communication, difficulty setting up equipment, and poor picture quality. A few other appellants were unable to see or hear the other participants for some portion of the hearing. Additionally, two appellants reported that not enough time was scheduled for their hearings. OMHA staff also noted a few instances in which the equipment shut down before the hearing ended or the equipment had not been set up on time.

Almost all of the sample appellants who had in-person hearings were satisfied with that format

Twenty-eight of the thirty sample appellants who had an in-person hearing were satisfied with that format. Over three-quarters of these appellants noted that face-to-face contact with the ALJ was an advantage. Specifically, attending the hearings in person enabled appellants to more easily refer to evidence in the case files and to provide visual demonstrations, such as how to use certain medical equipment. OMHA staff similarly reported that in-person hearings allowed for an easy exchange of documents, which can be particularly helpful for hearings that involve a large number of claims.

Sample appellants highlighted several disadvantages of this format. Almost half of the 30 sample appellants who had in-person hearings reported that these hearings were less convenient because of the travel time and the cost associated with having to go to an OMHA field office. In fact, over one-third of these appellants (13 of 30) had to travel more than 75 miles to the hearing site.

Incomplete and inaccurate data limit OMHA's ability to manage its caseload

OMHA relies on the appeals system as the primary mechanism to collect data about the program and to manage its caseload. Based on our review of the data for the first 13 months of OMHA's operation, we found that information in the system was frequently inaccurate and that some information was missing from the system.

We found that information about the primary appellant was often incomplete and inaccurate. For over 70 percent of the 11,778 cases that had a decision, there was no indication about which party was the primary appellant. Additionally, when we compared the data from our sample appellants to the data in the system, we found that, for 13 percent of our sample cases, the primary appellant was not listed as one of the parties in the appeals system.

Moreover, information about appellants was not consistently entered in the system. For example, one supplier that had almost 400 cases in the system was identified in a variety of ways: it had a standard Unique Physician Identification Number (UPIN) for 26 percent of its cases but no UPIN or an incomplete UPIN for 74 percent of its cases.[26] These inconsistencies make it difficult for OMHA to appropriately consolidate related cases and to track frequent users of the appeals process.

Also, many key dates in the system were inaccurate and many key dates were missing from the system. Specifically, the date field that indicates when OMHA sends letters to appellants acknowledging that their requests were received was missing for 71 percent of the cases that had been decided. The dates when OMHA requested and received the case file from the previous level of appeals were also missing for over three-quarters of the cases. Furthermore, for over 20 percent of the cases, at least one date was out of chronological order.

Finally, as mentioned earlier, information about the hearing type and format was frequently incomplete or incorrect. Most notably, there was no information about whether there was a hearing or an on-the-record decision for almost one-third of the decided cases. For over a third of the cases that had a hearing, there was no information about whether it was conducted by telephone, by video teleconference, or in person. In addition, when we compared the responses from our sample appellants,

[26] We identified the cases for this supplier by matching UPINs, as well as the business name, address, and phone number, which were also not recorded consistently in the system.

we found that the format for 11 percent of their hearings was incorrectly identified in the appeals system. In these cases, the system most commonly indicated that the hearing was in person when it actually occurred over the telephone. See Appendix C for more details.

Subsequent to our analysis of the data, OMHA staff explained that they have worked with the contractor to continually update the system and to improve the quality of the data. They noted that they modified many of the data fields, including those related to identifying the primary appellant and processing dates. In addition, they developed an internal data standardization policy that provides staff guidance on the definitions and use of each data field to promote more consistent data entry.

Available data indicate that in its first 13 months of operation, OMHA did not decide a number of its cases in a timely manner

During its first 13 months of operation, OMHA received 6,085 cases that were required to be decided within 90 days.[27] OMHA received an additional 14,682 cases that were not required to be decided within 90 days.

Fifteen percent of the cases that had a 90-day decision requirement and a decision date in the appeals system were not decided on time

Of the 6,085 cases that were subject to the 90-day decision requirement, 3,278 had a decision date recorded in the appeals system. On average, OMHA decided these cases in 82 days. As shown in Table 2 on the next page, 15 percent of these cases (501) were not decided within 90 days.

[27] This requirement applies to cases that were received after the implementation of the BIPA that pertain to Medicare Parts A or B. It does not apply if OMHA approves a request for an in-person hearing, if the appellant signs a waiver relinquishing the right to have the case decided within 90 days, and in other special circumstances such as when a case is escalated to the ALJ level because the prior level did not complete the reconsideration within the federally required timeframe. Furthermore, it does not apply to Medicare Parts C or D cases.

Table 2: Timeliness of Cases With a 90-Day Decision Requirement	
	Number of Cases
Cases With a Decision Date in Appeals System (N=3,278)	
Decided within 90 days	2,777
Not decided within 90 days	501
Cases Without a Decision Date in Appeals System (N=2,807)	
In appeals system for longer than 90 days	1,180
Not in the appeals system for 90 days	1,627
Total Number of Cases With a 90-Day Decision Requirement	**6,085**

Source: OIG analysis of the Medicare Appeals System, 2007.

In addition, 2,807 cases that had a 90-day decision requirement did not have a decision date recorded in the appeals system. Of these, 1,180 cases had been in the system longer than 90 days, indicating that OMHA either had not decided these cases within 90 days or had not recorded the decision dates in the appeals system. The remaining 1,627 cases did not have a decision date but had not been in the appeals system for 90 days.

The percentage of cases with a decision date that were decided within the 90-day timeframe increased during the first four quarters of OMHA's operation. Notably, 37 percent of the cases received by OMHA in its first quarter of operation failed to meet the 90-day decision requirement. In comparison, 10 percent of the cases that OMHA received in its fourth quarter of operation failed to meet the 90-day requirement. See Appendix E for an analysis by quarter.

In addition, the average number of days that OMHA took to decide these cases differed by field office and by size of the case. Among the four OMHA field offices, the average number of days varied from 59 to 88. Cases with 10 or more associated claims took an average of 95 days, compared to 82 days for cases with only one associated claim. See Appendix F for additional information about the average number of days to decision.

Cases without the 90-day decision requirement took longer to decide

A total of 14,682 cases were not subject to the 90-day decision requirement. About 90 percent of these cases were Medicare Parts A or B cases; the remaining cases were Parts C or D cases.

Almost all of the Parts A and B cases (94 percent) were submitted prior to the implementation of the BIPA.

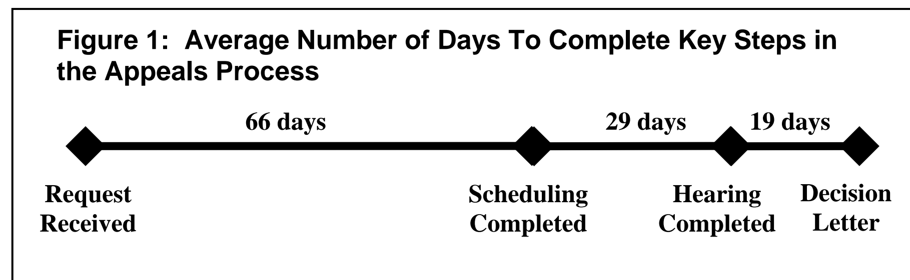
Of the 14,682 cases, 8,500 had a decision date in the appeals system. Of these, 45 percent took longer than 90 days to decide, and 12 percent took longer than 6 months to decide. On average, these cases were decided in 107 days, about 25 days longer than the cases that had a 90-day requirement. The other 6,182 cases did not have a decision date recorded in the appeals system. Approximately 35 percent of these cases had been in the appeals system longer than 6 months.

On average, the Parts C and D cases without the 90-day decision requirement were decided in 82 days, the same as the cases with a 90-day decision requirement. In contrast, the Parts A and B cases without the 90-day decision requirement were decided, on average, in 110 days. See Appendix G for more information about the cases that were not subject to the 90-day requirement.

Delays occurred early in the appeals process

For cases both with and without a 90-day decision requirement, delays occurred early in the appeals process. As shown in Figure 1 below, for the 6,203 cases that had a hearing, OMHA took an average of 66 days to schedule a hearing from the time that it received the appeals request.[28] The next stage—from scheduling the hearing to the completion of the hearing—took 29 days, on average. Finally, the last stage, from the completion of the hearing to mailing the decision letter to the appellant, took an average of 19 days. Other than the 90-day decision requirement and the requirement that the notice of hearing be sent at least 20 days before the hearing, there are no other Federal requirements regarding the timeline for processing appeals requests.

Figure 1: Average Number of Days To Complete Key Steps in the Appeals Process



Source: OIG analysis of the Medicare Appeals System, 2007.

[28] The analyses in this section include only the cases that have information on the relevant dates in the appeals system.

Several appellants noted that the longest time lag in the appeals process occurred between filing the appeal and receiving the first communication from OMHA, either in the form of a letter acknowledging receipt of the appeal request or a telephone call. Sample appellants and OMHA staff suggested that some of the delay is due to OMHA's difficulties in obtaining the complete case files from the prior level of appeals.

In the first 13 months of its operation, OMHA conducted most of its hearings by telephone rather than by video teleconference or in person. Some sample appellants reported that OMHA staff promoted the telephone option over the other formats and did not always provide video teleconference as an option. We also found that most sample appellants were satisfied with the format of their hearings, although several experienced technical difficulties with telephone and video teleconference hearings.

Additionally, we found that some of the data in the appeals system were incomplete and inaccurate. This not only limited our ability to analyze the data, but also limits OMHA's ability to manage its caseload. Finally, based on available data, we found that 15 percent of the cases that had a 90-day decision requirement and a decision date in the appeals system were not decided on time. The delays for these cases, as well as for cases that did not have a 90-day decision requirement, occurred primarily early in the appeals process.

Based on the findings in this report, we recommend that OMHA:

Consistently Offer Appellants the Option of Video Teleconference

OMHA should consistently direct appellants to hearings by video teleconference, if available. To ensure compliance with the regulations, OMHA should standardize its scheduling process and document the factors that ALJs consider when selecting the hearing format (e.g., whether video teleconference technology is available and whether the hearing request or administrative record suggests that a telephone hearing might be more convenient for one or more of the parties). Further, OMHA should encourage staff to identify available video teleconference sites before contacting the appellant to schedule the hearing, when appropriate. OMHA should also have standard protocols for making and documenting decisions to grant in-person hearings.

Continue To Improve the Timeliness of Cases With the 90-Day Decision Requirement

OMHA should meet the 90-day decision statutory timeframe for all cases subject to this requirement. OMHA should pay particular attention to reducing the delays that occur between the time when OMHA receives the appeal request and the time when staff schedule a hearing. OMHA should also ensure that meeting the 90-day decision

requirement does not cause undue delays for cases without the 90-day decision requirement.

Address Problems Associated With Telephone and Video Teleconference Hearings

OMHA should address the problems associated with holding hearings over the telephone and via video teleconference. OMHA should work with its contractors to ensure that the video teleconference equipment is set up on time and available for the duration of the hearing. It should also work to eliminate any technical difficulties, such as feedback and poor picture quality. Finally, OMHA should develop strategies for referring to documents in the case files to help improve communication during the hearing between appellants and ALJs.

Improve the Quality of the Data in the Appeals System

OMHA should ensure that the data problems that we identified have been addressed. Specifically, OMHA should continue to improve the quality of the data so that it can use the appeals system to better manage its caseload and more accurately report on key aspects of the program. OMHA should also continue to refine its data standardization policy and provide any necessary training to staff. Lastly, OMHA should institute regular data checks to eliminate invalid entries and instances of missing data.

AGENCY COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

OMHA concurred with all four of our recommendations based on our analysis of its first 13 months of operations. OMHA noted that it had previously identified the same findings and recommendations as internal areas of concern and has taken measures to address them.

In response to our first recommendation, OMHA noted that since OIG conducted its analysis, it has implemented a comprehensive training program for staff involved in scheduling hearings to standardize the scheduling process. OMHA implemented a "train the trainer" course so that every field office understands the statutory and regulatory hearing requirements. It also performs random unannounced screenings of the scheduling procedures to ascertain the effectiveness of the training and to institute remedial measures, if necessary. Additionally, OMHA modified the appeals system to record and track the requested and actual hearing formats.

In response to our second recommendation, OMHA stated that it has improved its case processing times for the cases subject to the 90-day decision statutory timeframe. Further, OMHA noted that a substantial number of delays occurred because it was not timely receiving the full case files from the previous appeals level. To address this concern, OMHA reported meeting regularly and entering into a memorandum of understanding with the CMS and its contractors that adjudicate Level 2 appeals. OMHA also noted that it has reduced its processing times for the cases not subject to the 90-day requirement.

In response to our third recommendation, OMHA stated that it has taken numerous steps to address technical difficulties associated with telephone and video teleconference hearings. For example, OMHA performed significant software upgrades to its video teleconference infrastructure. It also has in place for staff guidance regarding coordination with vendors for real-time resolution of technical issues and extensions of hearing duration. Further, OMHA developed a more refined process for accurately referencing documents in the case file during a hearing. It provided supplemental guidance to ALJs regarding the exhibit list that should be prepared and required the exhibit lists to be provided to all parties along with the Notice of Hearing or at the earliest opportunity before the hearing.

In response to our fourth recommendation, OMHA stated that it has instituted additional business rules and recurring data checks for logic in the appeals system. OMHA has also implemented a data standardization policy and training on the new requirements. In addition, OMHA stated that it is examining many date fields identified in the report as missing or inaccurate and will include additional date validation changes in upgrades to the appeals system later this year. OMHA noted that it has established a users group to explore appeals system improvements and that its headquarters performs weekly and monthly data quality checks and alerts field offices when errors or anomalies are identified.

We recognize OMHA's efforts to address these issues and encourage it to continue to make progress in these areas. The full text of OMHA's comments is included in Appendix H.

Medicare Parts A and B Administrative Appeals Process

Below is an overview of the four levels of the Medicare administrative appeals process for Medicare Parts A and B.

Level One: Affiliated Contractor Redetermination

At the first level, an appellant may request a redetermination with an Affiliated Contractor (i.e., Medicare carrier or fiscal intermediary) within 120 days of receipt of the notice of the initial determination.[29] The redetermination must be made by an individual who was not involved in the initial determination. This individual reviews evidence, including previously submitted evidence and any additional evidence that the parties submit or the individual obtains, to uphold or reject the initial determination. At both this level and the second level, the appellant may contest a denied claim of any dollar amount. Generally, the Affiliated Contractor must make a redetermination decision within 60 days of receipt of the request for redetermination.

Level Two: Qualified Independent Contractor Reconsideration

If the appellant does not agree with the Level One decision, the appellant may request a reconsideration with a Qualified Independent Contractor (QIC) within 180 days of receipt of the Level One decision.[30] In a manner similar to the Level One review, the QIC reviews historical evidence and prior findings, as well as any new evidence submitted by the appellant. QICs are bound by national coverage determinations (NCDs), the Centers for Medicare & Medicaid Services (CMS) Rulings, and applicable laws and regulations.[31] QICs are not bound by local coverage determinations (LCDs), local medical review policies (LMRPs), or CMS program guidance, such as program memoranda and manual instructions, but do give substantial deference to those policies, if

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[29] See generally 42 U.S.C. §§ 1395ff(a)(3) and (5) and 42 CFR §§ 405.940–405.958 (specifying Federal requirements for redeterminations).

[30] 42 U.S.C. § 1395ff(b)(1)(D)(i). QICs are a new type of Medicare contractor created to conduct reconsiderations. See generally 42 U.S.C. § 1395ff(c) and 42 CFR §§ 405.960–405.978 (specifying Federal requirements for reconsiderations).

[31] 42 CFR § 405.968(b)(1).

applicable.[32] Generally, a QIC has 60 days to make a decision from the date when the appellant filed an appeal.[33]

Level Three: Administrative Law Judge Hearing

If an appellant wants to contest a Level Two reconsideration, the appellant may request a hearing before an administrative law judge (ALJ).[34] [35] This request must be filed within 60 days from the receipt of notice of the Level Two reconsideration decision. At this level, the minimum amount in controversy is $120.[36] ALJs are bound by NCDs, but an ALJ may review the facts of a particular case to determine whether an NCD applies to a specific claim for benefits and, if so, whether the NCD was applied correctly to the claim.[37] ALJs are not bound by LCDs, LMRPs, or CMS program guidance, such as program memorandums and manual instructions, but ALJs do give substantial deference to those policies, if applicable.[38] Generally, the ALJ must decide the case within 90 days of the date that the appeal request was filed.

Level Four: Medicare Appeals Council Review

If the appellant disagrees with the Level Three decision, the appellant may request a review with the Medicare Appeals Council (MAC)[39] within 60 days of receipt of the ALJ hearing decision.[40] This is the last level of administrative review available to appellants. MAC may deny a request, undertake a review, or remand the case to an ALJ for further action. When MAC reviews an ALJ decision, it undertakes a

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[32] 42 CFR § 405. 968(b)(2).

[33] Starting at Level Two, an appellant may escalate an appeal if it is not dealt with in a timely manner by the appeals body. For example, a request for an administrative law judge (ALJ) hearing may be submitted if the QIC does not decide the appeal within 60 days. 42 U.S.C. § 1395ff(c)(3)(C)(ii).

[34] ALJs also handle Level Three appeals for Medicare Parts C and D. For Part C, see 42 CFR §§ 422.600 and 422.602; for Part D, see 42 CFR §§ 423.610 and 423.612.

[35] See generally 42 U.S.C. § 1395ff(d) and 42 CFR § 405.1000–405.1054 (specifying Federal requirements for ALJ hearings).

[36] 42 U.S.C. § 1395ff(b)(1)(E); 42 CFR § 405.1006(b)(1). See 72 Fed. Reg. 73348 (Dec. 27, 2007) for adjustment to Medicare appeals amount in controversy for 2008.

[37] 42 CFR § 405.1060(b).

[38] 42 CFR § 405.1062(a).

[39] Medicare Parts C and D also provide for a Level Four review with the Medicare Appeals Council. For Part C, see 42 CFR § 422.608; for Part D, see 42 CFR § 423.620.

[40] 42 CFR § 405.1102(a)(1). MAC is a division of the Department of Health and Human Services' Departmental Appeals Board and consists of Administrative Appeals Judges. An appellant may also request a review by MAC if the ALJ does not complete its review within 90 days. 42 U.S.C. § 1395ff(d)(3)(A), 42 CFR § 405.1106(b). See generally 42 U.S.C. § 1395ff(d) and 42 CFR §§ 405.1100–405.1140 (specifying Federal requirements for MAC reviews).

de novo review. MAC is bound by NCDs, but may review the facts of a particular case to determine whether an NCD applies to a specific claim for benefits and, if so, whether the NCD was applied correctly to the claim.[41] MAC is not bound by LCDs, LMRPs, or CMS program guidance, but MAC does give substantial deference to those policies, if applicable.[42] Generally, MAC must make a decision within 90 days of the filing date. If the appellant disagrees with the MAC decision and the amount in controversy is at least $1,180,[43] the appellant may file a civil action in Federal District Court within 60 days of receiving the MAC decision.

[41] 42 CFR § 405.1060(c).
[42] 42 CFR § 405.1062(a).
[43] 42 CFR § 405.1136, 42 U.S.C. § 1395ff(b)(1)(E); 42 CFR § 405.1006(c)(1). See 72 Fed. Reg. 73348 (Dec. 27, 2007) for adjustment to Medicare appeals amount in controversy for 2008.

Number of Sample Cases, by Stratum				
Stratum	**Number of Sample Cases**	**Number of Cases Removed From Sample**	**Number of Cases in Which the Appellant Did Not Respond**	**Number of Cases in Which the Appellant Responded**
Telephone	70	2	10	58
Video Teleconference	75	2	9	64
In Person	75	10	5	60
Unidentified	50	2	5	43
Total	**270**	**16**	**29**	**225**

Note: Cases were removed from the sample either because the Office of Inspector General (OIG) was conducting investigations related to appellants associated with the cases or because they did not have hearings.

Source: OIG analysis of sample cases, 2007.

Inaccuracies in the Hearing Format Data in the Appeals System						
	Hearing Format as Reported by Sample Appellants			**Identified in Appeals System**		
					Incorrectly	
Hearing Format as Reported in the Appeals System	**Telephone**	**Video Teleconference**	**In Person**	**Correctly**	**Number**	**Percentage**
Telephone	56	1	1	56	2	3%
Video Teleconference	3	61	0	61	3	5%
In Person	14	1	45	45	15	25%
Unidentified	34	4	5	N/A	N/A	N/A
Total	**107**	**67**	**51**	**162**	**20**	**11%**

Source: OIG analysis of interviews with sample appellants, 2007.

Confidence intervals for Selected Estimates (Sample size = 225 cases that had hearings)		
Percentage of Hearings Conducted:	**Point Estimate**	**95-Percent Confidence Interval**
By telephone	78.4%	73.4%–83.4%
By video teleconference	11.6%	8.0%–15.1%
In person	10.0%	6.1%–13.9%
Percentage of Cases That Had Hearings:	**Point Estimate**	**95-Percent Confidence Interval**
In which the primary appellant was a Medicare provider or supplier	77.8%	71.3%–84.4%
In which the primary appellant was a beneficiary	14.5%	8.5%–20.5%
That were pursued by State Medicaid organizations	7.6%	4.3%–10.9%

Source: OIG analysis of interviews with sample appellants, 2007.

Number and Percentage of Cases That Failed To Meet the 90-Day Requirement, by Quarter			
Quarter	Number of Decided Cases	Number of Cases That Failed To Meet 90-Day Requirement	Percentage of Cases That Failed To Meet 90-Day Requirement
1st	147	54	37%
2nd	490	103	21%
3rd	1,138	204	18%
4th	1,407	140	10%

Note: Ninety-six cases were excluded from this analysis because they were received after the 4th quarter.

Source: Office of Inspector General analysis of the first 12 months of the Medicare Appeals System, 2007.

Average Number of Days to Decision for Cases With a 90-Day Requirement, by Office of Medicare Hearings and Appeals Field Office		
Field Office	**Number of Decided Cases**	**Average Number of Days to Decision**
Arlington	70	59
Cleveland	1,587	88
Irvine	778	67
Miami	843	88

Source: OIG analysis of the first 13 months of the Medicare Appeals System, 2007.

Average Number of Days to Decision for Cases With a 90-Day Requirement, by Number of Claims		
Case Size	**Number of Decided Cases**	**Average Number of Days to Decision**
1 Claim	2,855	82
2—9 Claims	364	87
≥10 Claims	28	95

Note: Thirty-one cases were excluded from this analysis because the number of associated claims was missing from the appeals system.

Source: OIG analysis of the first 13 months of the Medicare Appeals System, 2007.

APPENDIX ~ G

Timeliness of Cases Without a 90-Day Requirement	
	Number of Cases
Cases With a Decision Date in Appeals System (N=8,500)	
Decided within 6 months	7,500
Not decided within 6 months	1,000
Cases Without a Decision Date in Appeals System (N=6,182)	
In appeals system for longer than 6 months	2,141
Not in the appeals system for 6 months	4,041
Total Number of Cases Without a 90-Day Requirement	**14,682**

Source: Office of Inspector General analysis of the Medicare Appeals System, 2007.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Office of Medicare Hearings and Appeals
Office of the Chief Administrative Law Judge

Judge Perry Rhew

DATE: July 3, 2008

TO: Daniel R. Levinson
Inspector General

SUBJECT: Office of Inspector General (OIG) Draft Report: Medicare Administrative Law Judge Hearings: Early Implementation, 2005-2006 OEI-02-06-00110

Thank you for the opportunity to review and comment on the above draft OIG Report. The Office of Medicare Hearings and Appeals (OMHA) appreciates the thoroughness of the report and concurs with the recommendation resulting from the OIG analysis focused on our first year of operations in 2005-2006. As discussed below, OMHA management had previously identified the same findings and recommendation as internal areas of concern and took measures to address them.

Due to the improvements resulting from these measures, OMHA believes that the report should acknowledge the success of these ongoing efforts to address the issues identified in the report. In doing so, the report's findings would provide a fuller context of the early challenges faced by the agency and our subsequent progress in overcoming them. OMHA believes that the public will be best served if the final report references the numerous improvements that have been made to the Medicare appeals process.

RECOMMENDATION: Consistently Offer Appellants the Option of Video Teleconference

COMMENTS: OMHA concurs with this recommendation and agrees that appellants should be notified of the hearing format options. Since the OIG conducted its analysis, OMHA has implemented a comprehensive training program for ALJ support staff members involved in scheduling hearings to standardize the scheduling process and to ensure that every appellant is afforded full due process rights. OMHA implemented a "train the trainer" course so that every field office understands the statutory and regulatory hearing requirements and has the resources to properly train the scheduling staff. Random unannounced screenings of the scheduling procedures are performed by OMHA staff to ascertain effectiveness of the training and to institute remedial measures if necessary. In August 2006, OMHA implemented the Hearing Screen and View in the Medicare Appeals Systems (MAS) for ALJ-level users to record and track hearings on appeals. Users can now indicate the "Requested Hearing Format" and the "Actual Hearing Format." OMHA leadership is confident that the protocols currently in place fully inform appellants of the hearing options at their disposal and standardize scheduling procedures across all ALJ teams.

RECOMMENDATION: Address Problems Associated with Telephone and Video Teleconference Hearings

COMMENTS: OMHA concurs with this recommendation. OMHA believes that many of the early difficulties encountered involved new staff using unfamiliar equipment serviced by new contractors.

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Since OMHA's first year of operations, OMHA has taken numerous steps to address these technical difficulties which have resulted in a marked decrease of overall reported occurrences. For example, OMHA performed significant software upgrades to its video teleconference infrastructure during February and March of 2007. Since that time, reports of telephone and video teleconference difficulties have decreased significantly. Technicians are on call at all OMHA and vendor facilities to address technical issues prior to and during hearings.

Guidance for OMHA staff is in place regarding coordination with vendors for real-time resolution of technical issues and extensions of hearing duration. In April 2008, OMHA began re-evaluating the technical and operational configuration of all its hearing rooms to further improve the quality of the video teleconference infrastructure.

OMHA has also developed a more refined process for accurately referencing documents in the case file. Consistent with the regulations, OMHA provided supplemental guidance to ALJs regarding the exhibit list that should be prepared to clearly identify the contents of each exhibit. OMHA staff has also received guidance requiring the exhibit lists to be provided to all parties along with the Notice of Hearing or at the earliest opportunity before the hearing. The Notice of Hearing also informs the parties that they should contact the OMHA field office to obtain a copy of the administrative record for their case.

RECOMMENDATION: Improve Quality of the Data in the Appeals System

COMMENTS: OMHA concurs with this recommendation. OMHA places high importance on obtaining and maintaining accurate and complete data in the Medicare Appeals System (MAS). Since OIG conducted its analysis, OMHA instituted additional business rules and recurring data checks for logic in MAS. For example, OMHA has taken steps to correctly identify party types associated to appeals by implementing business rules to ensure the primary appellant flag was indicated before closing the appeal. Another new business rule requires address, city, and state information for the primary appellant.

OMHA has also implemented a data standardization policy coupled with training on the new requirements. In August 2008, a new MAS Claims Interface will be released that will significantly improve the data quality. Specifically, this functionality will allow users to pull claim data into an appeal record in MAS from the original claim information, eliminating typographical and interpretive errors and increasing the integrity of the data.

The Report stated that many dates in the system were missing or inaccurate. OMHA has begun to examine many date fields that originally did not have business rules associated with them. Additional date validation logic changes will be included in the August and November 2008 MAS releases.

OMHA established a MAS Users Group to explore MAS system improvements. In addition, OMHA headquarters performs weekly and monthly data quality checks and alerts the field offices when errors or anomalies are identified.

RECOMMENDATION: Continue to Improve the Timeliness of Cases with the 90-Day Decision Requirement.

COMMENTS: OMHA concurs with the three recommendations identified by the OIG and will address each in turn.

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First, the OIG has recommended that "OMHA should meet the 90-day decision statutory timeframe for all cases subject to this requirement." Since OIG performed its analysis, OMHA has improved its case processing times. By mid-year FY08, 95% of cases subject to the 90-day statutory timeframe met the 90-day requirement, and OMHA was taking on average 67.5-days to decide an appeal.

Second, the OIG has recommended that "OMHA should pay particular attention to reducing the delays that occur between the time when OMHA receives the appeal request and the time when staff schedule a hearing." While not addressed in the OIG report, it should be noted that a substantial number of delays in the early docketing stages occurred because OMHA was not timely receiving the full case files from the independent contractors adjudicating the Level 2 appeal. To address this concern and improve efficiency, OMHA meets regularly with CMS and Level 2 contractors and has entered into a memorandum of understanding with them, resulting in a steady decrease in overall docketing time. A preliminary MAS Data Standardization policy was developed to streamline data entry and emphasize essential data elements required for case adjudication. Through these efforts, OMHA has reduced docket process times by 48% from the initial average measure of 34.9 days (42.0 days for the three large offices, which process approximately 95 percent of OMHA cases) to 16.6 days (13.9 for the three large offices).

Third, the OIG has recommended that "OMHA should also ensure that meeting the 90-day decision requirement does not cause undue delays for cases without the 90-day decision requirement." Since the analysis performed by OIG, OMHA has decreased its processing times for cases not subject to the 90-day requirement. Currently, non-BIPA cases take an average of 75.9 days to process. Moreover, the Strategic Plan launched in January, 2007, sets forth agency-wide goals consistent with measurements contained in OMB's Program Assessment Rating Tool (PART). To ensure that all OMHA staff has the training necessary to adjudicate cases in timely manner, OMHA has developed a comprehensive training program.

Again, we appreciate the opportunity to review and comment on the Report. Please contact me if you have any questions regarding this response.

Judge Perry Rhew
Chief Administrative Law Judge

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This report was prepared under the direction of Jodi Nudelman, Regional Inspector General for Evaluation and Inspections in the New York regional office, and Meridith Seife, Deputy Regional Inspector General.

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