

DEPARTMENT OF HEALTH AND  
HUMAN SERVICES

OFFICE OF  
INSPECTOR GENERAL

**Medicare Administrative Appeals  
The Potential Impact of BIPA**



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JANUARY 2002  
OEI-04-01-00290

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# EXECUTIVE SUMMARY

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## PURPOSE OF STUDY

To review the current Medicare administrative appeals system and assess the potential impact of the recently enacted Medicare, Medicaid and State Children's Health Insurance Program Benefits Improvement and Protection Act of 2000 on the appeals process.

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## BACKGROUND

The recently enacted Medicare, Medicaid and SCHIP Benefit Improvement and Protection Act of 2000 (BIPA) significantly revises the Medicare appeals process. Section 521 of BIPA, which takes effect October 1, 2002, establishes a uniform process for handling all Medicare Part A and Part B appeals and specifies time frames for filing appeals and rendering decisions.

This review focuses on Medicare Part B appeals. We conducted the study in March through May of 2001. During that time, we reviewed the statute and collected appeals related data. We also questioned Administrative Law Judges (ALJ), the Medicare Appeals Council at the Departmental Appeals Board, Part B carriers, and numerous other experts on the appeals process.

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## POTENTIAL PROBLEMS

- ▶ The current Medicare appeals system is backlogged, overwhelmed, and untimely, and the problems could be exacerbated by BIPA provisions.
- ▶ The system, designed for beneficiaries, is now used primarily by health care providers. The new system may be more difficult for beneficiaries to use and easier for providers.
- ▶ Appellants could lose their right to a hearing early in the appeals process with the elimination of the carrier hearing.
- ▶ Elevations of appeals not adjudicated in mandated time frames could further overload the system and provide opportunities for "gaming."
- ▶ The elevation of cases would increase the overall cost to the appeals system because administrative costs increase at higher levels of appeals.
- ▶ The significant reduction in the minimum amounts in controversy required for a hearing will likely render the threshold irrelevant.
- ▶ The cost of the creation of the Qualified Independent Contractors is difficult to estimate because of the myriad of details to be resolved before Qualified Independent Contractor implementation can occur. It is likely to be significant.

- ▶ The rigid time frames could compromise program integrity efforts and fraud investigations.
- ▶ Social Security Administration (SSA) ALJs are currently in an administrative structure that does not allow them to focus on Medicare work. The new system will likely increase their workload.
- ▶ The Medicare Appeals Council has only two judges and a small support staff, and is not prepared to handle a large influx in cases.
- ▶ The impact of BIPA on the U.S. District Courts is unknown. They are not prepared at this time for the implementation of BIPA.

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## RECOMMENDATIONS

- ▶ **Delay implementation of Section 521 of BIPA.**  
 Implement only after solving systemic problems addressed in this report and our prior report on the ALJ process. The Department should seek legislation to revise the effective date of the statute.
- ▶ **Establish an administrative appeals process that is dedicated to Medicare.**  
 An administrative appeals system within the Department of Health and Human Services may be structured in a variety of ways. Regardless of structure, however, consideration should be given to factors such as the number of levels of appeal, formats, timeliness standards, and qualifications of reviewers.
- ▶ **Ensure adequate resources for each level of the appeals process.**  
 Implementation of process changes should not occur until costs of revisions can be carefully estimated and provided for.
- ▶ **Modify the time frames mandated by BIPA--Provide adequate time for fair and effective processing, but ensure timely and efficient resolution of appeals.**  
 Time frames which can be met with a reasonable good faith effort by all parties to the appeals process should be established, and phased in over a reasonable time period.
- ▶ **Provide opportunity for CMS representation at higher levels of review.**  
 CMS representation is needed to assure fair and impartial hearings and to ensure that the interests of the Medicare program itself are effectively presented and considered.

- ▶ **Develop thorough, parallel training for reviewers at all levels of appeal.**

Both Medicare contractors and reviewers at all levels lack common knowledge, understanding, and information about the appeals system and results.

- ▶ **Develop and require all reviewers of Medicare claims to apply the same standards.**

Currently, the ALJs are bound only by law and regulations, while contractors are also bound by Local Medical Review Policy and contractor manuals. This contributes to a high reversal rate by ALJs. Therefore, greater standardization would be useful. However, we recognize that ALJ decision may continue to be based on evidence that was not presented to - or not fully considered by - a contractor.

- ▶ **Develop regulations or detailed specifications for conducting appeals.**

Currently, ALJs lack the necessary guidance to conduct Medicare appeals. Instead, they use SSA disability appeal regulations to adjudicate Medicare appeals.

- ▶ **Create formal communication and information networks that span the entire appeals system.**

The discrete levels of appeal inhibit communication and prevent the system from becoming fully integrated.

- ▶ **Modernize appeals processing mechanisms.**

A modernization effort could lead to reductions in both case preparation time and layers of appeal review and adjudication. The manual file systems need to be enhanced with electronic features.

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## **DEPARTMENT COMMENTS**

The Office of the Secretary presented a consolidated response representing the views of various components within the Department of Health and Human Services. Generally, the Department agreed with our conclusions and recommendations. Specifically, the Department agreed that a complete restructuring is needed to resolve serious shortcomings of the appeals system before Section 521 of the Benefits Improvement and Protection Act becomes effective.

Further, the Department's response to our report noted that many of our recommendations were also applicable to Section 522 of the Benefits Improvement and Protection Act, although we did not include an analysis of that Section in our study. Accordingly, the Department suggested that Section 522 should also be delayed until after a comprehensive resolution of systemic problems in the Medicare administrative appeals system.

The Department highlighted three principles that should serve to guide its efforts in reforming the system. They are:

- build on the appeals model included in the Benefits Improvement and Protection Act;
- achieve a more timely, efficient, and less costly administrative review process; and
- achieve more consistent case decisions.

The full text of Department of Health and Human Services comments on our report is shown in the appendix.

# INTRODUCTION

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## PURPOSE OF STUDY

To review the current Medicare Part B administrative appeals process and assess the potential impact of the recently enacted Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act of 2000 on this process.

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## BACKGROUND

### Medicare Part B Appeal Rights

Medicare beneficiaries have a statutory right to appeal their denied Part B claims either on the basis of coverage or payment under Section 1869 of the Social Security Act. Section 1879(d) extends these beneficiaries' appeals rights, in certain cases, to providers and suppliers who accept assignment. The rights conferred by Section 1869 are important guarantees to beneficiaries whose Medicare claims are denied.

Among the features that make the appeals process “user friendly” for beneficiaries are:

- ▶ An appeal can be filed for the denial of any claim, regardless of the amount of money in dispute at the first level of appeal, and at a low dollar threshold for the amount in controversy at subsequent levels;
- ▶ Non-adversarial proceedings at each appeal level where the government, directly, or through its agents, is not a party to the appeal;
- ▶ “De novo” proceedings where cases are decided anew at the contractor and ALJ levels instead of reviewed on the basis of whether the decision at the lower level was proper, as in a traditional appeals process used by the courts;
- ▶ The right to introduce new information at each level of appeal;
- ▶ The option to select the type of Medicare carrier hearing (e.g., by telephone or in person) based on the personal preferences of the appellant; and,
- ▶ The ability to combine claims to meet the thresholds for the amounts in controversy.

### Administrative Appeals Process

If a carrier denies payment for a claim, a provider or a beneficiary may appeal the denial. Appellants must file their appeal initially with the Medicare carrier. If dissatisfied with the carrier appeal decision, the appellant may appeal to an Administrative Law Judge (ALJ). ALJs are employed by the Social Security Administration (SSA), but they adjudicate Medicare appeals under a Memorandum of Understanding between SSA and the U.S. Department of Health and Human Services. After the ALJ hearing, cases may



be appealed to the Medicare Appeals Council (MAC) located within the Departmental Appeals Board (DAB) of the Department of Health and Human Services, the final level of administrative appeal. Cases may then be appealed to the U.S. District Courts following a MAC review. In each case, the lower level of appeal must be exhausted before the appeal can be elevated to the next level.

### Administrative Appeals Volume

Medicare Part B claims volume grew over 11 percent between Fiscal Years 1996 and 2000, while the number of reviews stayed about the same. However, the number of carrier hearings conducted increased 50 percent, from 70,716 to 106,480, during the same time.

The following table illustrates the volume of appeals and the current pending caseload.

#### One Quarter Part B Appeals Workload — 2001

	New Requests	Pending
Reviews	965,230	453,705
Carrier Hearings	24,507	25,654
ALJ	12,257	31,223
MAC	2289	10,333

\*All figures are from 2<sup>nd</sup> Quarter FY 2001.

### Previous Office of Inspector General Work

A report released in September 1999 by the Office of Inspector General (OIG)<sup>1</sup> examined the ALJ appeals level because of numerous reports of extensive problems in and related to that area. The report established that the number of Part B ALJ hearings increased a dramatic 99 percent from 1996 to 1998. It also confirmed that ALJs reversed a considerable percentage of cases that reached them. For example, 78 percent of durable medical equipment appeals were reversed by ALJs in 1997. An important reason for the reversals was that ALJs are not bound by the same standards as carrier hearing officers. More specifically, carrier hearing officers are bound by Local Medical Review Policy and contractor manuals, while the ALJs are bound only by statute, regulations and National Coverage Determinations.

Additionally, the earlier study found structural problems in the appeals process that weakened the system. These included:

- ▶ Contractors and ALJs use different criteria in ruling on coverage and payment issues;

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<sup>1</sup>Medicare Administrative Appeals: ALJ Hearings, OEI-04-97-00160

- ▶ Lack of precedent stature for Medicare Appeals Council rulings on ALJ appeals;
- ▶ Non-adversarial ALJ hearings, precluding Medicare the opportunity to defend its payment decisions; and
- ▶ Lack of common understanding or communication throughout the administrative appeals process.

There was also evidence of positive changes in the appeals process. The report identified a group of SSA ALJs who conduct the most complex and highest dollar value Part B cases. It was their work, in part, that supported our conclusion that a permanent cadre of judges hearing only Medicare cases would significantly improve the appeals system.

The OIG made several recommendations to HCFA (now Centers for Medicare & Medicaid Services -- CMS) intended to correct the structural problems of the administrative appeals system which were related to the development and establishment of a dedicated ALJ corps; dual administrative appeals processes for providers and beneficiaries; adversarial hearings for provider appeals; parallel training for Medicare contractors and ALJs; regulations for conducting Medicare ALJ Appeals; a case precedent system for Medicare Appeals Council rulings; and formal communication and information networks.

We also recommended requiring Medicare contractors and ALJs to apply the same standards. To date, none of these recommendations has been implemented.

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## SCOPE AND METHODOLOGY

This report focuses on the Part B Appeals Process. We focused on Medicare Part B due to its size and complexity. For Fiscal Year 2000, Medicare Part B first level appeals constituted over 90 percent of all first level appeals.

This study was conducted March through May of 2001. The study utilized several research methods:

- < *Literature Review*
- < *Data Collection*
  - Collected special data runs and summary data from HCFA (now CMS).
  - Obtained special data runs from SSA's Office of Hearings and Appeals and the DAB.
- < *Surveys*
  - Surveyed all 30 Part B ALJ cadre judges. Eighteen survey instruments were returned for a response rate of 60 percent.
  - Surveyed all 24 Medicare Part B Carriers and Durable Medical Equipment Regional Carriers. Fifteen survey instruments were returned for a response rate of 63 percent.

- < *In-Person and Telephone Interviews*
  - DAB judges
  - OHA officials
  - CMS officials
  - Carrier hearing officers and appeals managers
  - Staff from the Center for Health Dispute Resolution
  - Staff from the Administrative Office of U. S. Courts
  
- < *Focus Group*
  - Conducted a focus group with five Part B ALJ Cadre Judges

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We conducted this inspection in accordance with the *Quality Standards for Inspections* issued by the President’s Council on Integrity and Efficiency.

## SUMMARY OF BIPA PROVISIONS

The recently enacted Medicare, Medicaid and SCHIP Benefit Improvement and Protection Act of 2000 (BIPA) significantly revises the Medicare appeals process. Section 521 of BIPA, which takes effect October 1, 2002, establishes a uniform process for the handling of all Medicare Part A and Part B appeals and specifies time frames for the filing of appeals and rendering of decisions.

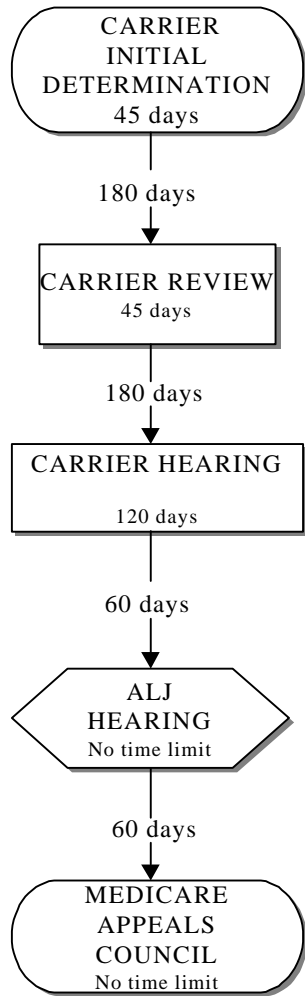
BIPA mandates several structural and procedural changes to the administrative appeals process which:

- ▶ Reduce time to request first level of contractor appeal from 180 days to 120 days in Part B;
- ▶ Reduce time to conduct first level of contractor appeal from 45 days to 30 days;
- ▶ Reduce time to conduct second level of contractor appeal from 120 days to 30 days;
- ▶ Replace second level contractor appeal (contractor hearing) with a reconsideration by a new appeals entity, the Qualified Independent Contractor (QIC);
- ▶ Reduce amount in controversy required at all levels of appeal. Eliminates amount required for contractor levels of appeal. Reduces amount required from \$500 to \$100 at the ALJ and MAC levels of appeal;
- ▶ Impose 90 day time limits to conduct ALJ and MAC appeals. At present, there are no time limits at these levels;
- ▶ Impose “de novo” review and possibly hearings at the MAC level of appeal; and
- ▶ Impose “de novo” review at the Federal court level.

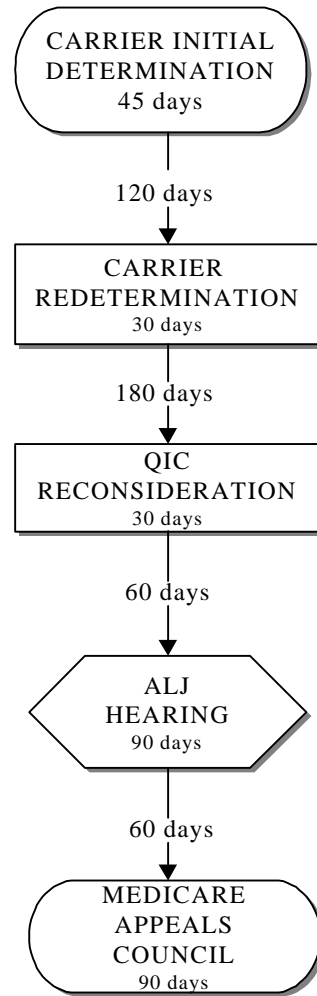
We will discuss each of these provisions in greater detail as we consider their potential implications in the sections below. The figure on the next page illustrates the flow of the current appeals process and the process stipulated under BIPA.

# Current and New Administrative Appeals Systems

## CURRENT SYSTEM



## NEW SYSTEM



\*Time in boxes represents time allowed to complete appeal.

\*\*Time between boxes represents time allowed to file for appeal.

# THE POTENTIAL IMPACT OF BIPA

The changes mandated by BIPA will create significant implementation challenges and will require detailed advance planning and careful budgeting. BIPA will impose requirements that cannot be accommodated without significant changes in the structure of and resources for the current system. Because the present appeals process continues to suffer from serious structural problems, some of BIPA's mandates are likely to exacerbate existing problems, and create unintended consequences. These potential problems are described below.

## TIME LIMITS FOR APPEALS

BIPA mandates new and shorter time limits at all Part B levels of appeal. For most levels of appeal, these time limits are dramatically shorter than what is currently required. In fact, the ALJ and Medicare Appeals Council levels currently have no time limit for conducting appeals. BIPA's time limits for these levels are significantly less than the time ALJs and the MAC presently require to conduct an appeal.

The following table illustrates the time limits BIPA mandates for appeals and compares them to what is currently required and what is currently achieved.

**Time Limits for Completion of Appeals**

	BIPA	Current Standard	Current Actual
Redetermination/ Review	30 days	45 days (95% within this time)	45 days (89% within this time)
Reconsideration/ Carrier Hearing	30 days	120 days (90% within this time)	120 days (92% within this time)
ALJ	90 days	none	441 days
MAC	90 days	none	661 days

All figures are from 2<sup>nd</sup> Quarter FY 2001

## FLOW OF PAPER RECORDS

Implementation of Section 521 could be significantly hampered by the paper record-keeping and file transport system used in the current Medicare appeals system. Currently, case files must first travel from the carrier to the hearing officer (if off-site). If the appeal continues, case files are then sent to the Social Security Administration's Office of Hearings and Appeals (OHA) in Falls Church, Virginia. CMS data shows that it takes about 28 days to prepare and transfer a case from the hearing officer to OHA. OHA staff then assign docket status to appeals files and prepare the files for hearing to

make them more usable and better organized for the ALJs. This often means removing what OHA staff consider to be extraneous information. After this process, OHA distributes the files to the ALJ Hearing Offices.

Nearly all parties we interviewed agreed that serious problems arise from this reorganization of files. Carriers complain that when files are returned following adjudication, many are incomplete and missing important documentation. Many ALJs also question the value of OHA preparation of the appeals files. They maintain that support documents become lost or separated from related cases which can cause considerable delay and confusion as they adjudicate their cases. When the files reach the ALJ offices, they often need to be restructured to make them more usable to the ALJs. Judges at the MAC also complain that the restructuring of files can be counterproductive and causes some problems, including lost records and delays, at their level.

Another problem associated with this paper transfer system is the lack of consistent case identifiers. As a case proceeds through the appeals system, a request for payment is assigned a claim number, carrier hearing appeal number, OHA docket number, MAC docket number, and a civil action number if the case goes to court. It is extremely difficult to track an appeal through the system without a consistent locator number. For example, it is not possible for a carrier to call OHA to easily determine the status of a case because the case would now have an OHA docket number. In effect, for other parties in the system, and CMS, these files are 'lost', until they are adjudicated and forwarded from the ALJ office.

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## **INCREASE IN NUMBER OF APPEALS**

With the implementation of BIPA, the volume of appeals could increase dramatically for a number of reasons. First, Section 521 presents a new appeals system. The attractiveness of a speedier system, with drastically reduced time frames, may encourage some to appeal denied claims when they would not have done so under the prior system.

Although specific estimates are not available, experts we spoke with agree that the increases could be significant.

Second, appeals could increase due to the increased control given to appellants. Under the new system, appellants will be able to dictate to a great degree how quickly their appeal moves through the system. If a case is not decided by an ALJ or the MAC within 90 days, it progresses to the next level at the appellant's discretion. This allows appellants to use the system to their advantage by accelerating to, or remaining at, the level of the system they consider to be most advantageous.

Finally, appeals may increase due to the greatly lowered minimum amount in controversy. At a time when many experts counseled raising the amount in controversy for providers, while maintaining or lowering it for beneficiaries, Section 521 lowers that amount for all appellants. Data on the number of cases dismissed for not meeting the amount in controversy is unavailable. The following table illustrates the BIPA change in the amount in controversy required for the various levels of appeal.

### Amount in Controversy Required to Conduct Appeal

	Redetermination*/ Review	Reconsideration*/ Carrier Hearing	ALJ	DAB	Court
BIPA	none	none	\$100	\$100	\$1000
Current	none	\$100	\$500	\$500**	\$1000

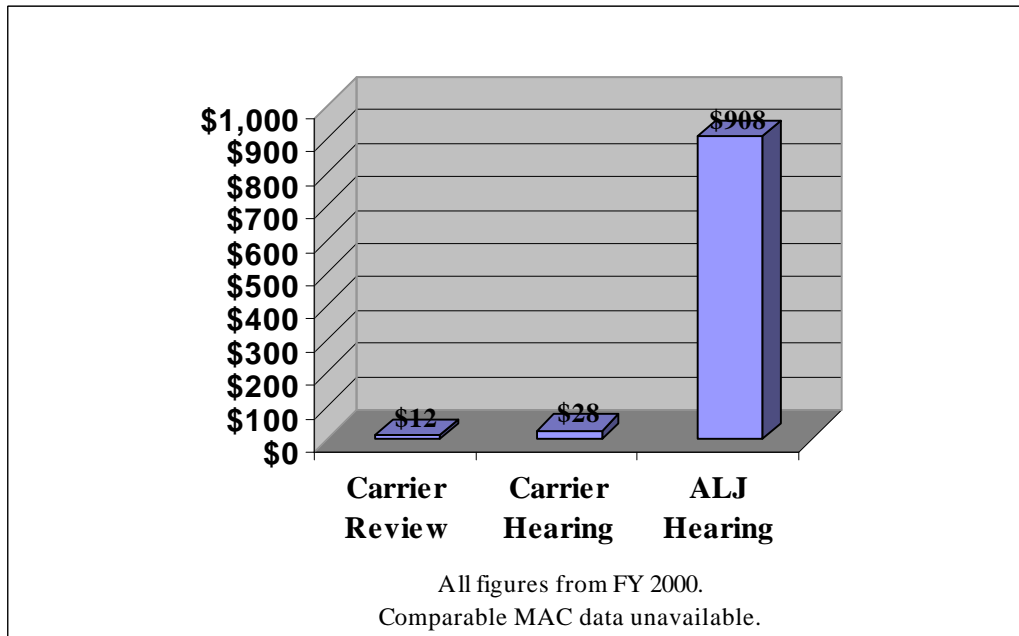
\*Redetermination and reconsiderations are the new, BIPA designated names for these levels of appeal.

\*\*The DAB has discretion to hear cases with a smaller amount in controversy, but rarely does so.

### INCREASE IN COST OF APPEALS SYSTEM

While the Congressional Budget Office was not required to project the financial impact of BIPA, we estimate that these changes could dramatically increase costs associated with the appeals process. First, with the shortened time frames at the early levels of appeal, it is likely that more cases will escalate to the higher levels of appeal. The figure below illustrates the average current cost of adjudicating a Part B appeal at each level.

**Part B Appeals Cost Per Case**



From this figure, it can be seen that the costs increase as each case proceeds to a higher level. Therefore, as more cases are elevated to progressively higher and more expensive levels of the process, the costs for each case will increase.

As described in the prior section, BIPA could also result in an increase in the overall number of appeals filed. An increase in the total volume of cases could, therefore, compound the impact of the increase in costs per case and increase overall costs dramatically. Current total costs at each level appear in the table below.



### Total FY 2000 Costs for Medicare Part B Appeals

Carrier Reviews	Carrier Hearings	ALJ Hearings
\$64,013,200	\$27,048,688	\$66,610,967

Finally, the greatest initial cost will result from the creation of the Qualified Independent Contractors. Per BIPA, there must be at least twelve QICs, independent of the contractors involved with the initial determination of claims. These QICs must be adequately staffed to render decisions on all appeals within 30 days, in addition to many other responsibilities required by BIPA. CMS sources estimate that the cost of these new contractors will be significant.

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## PROGRAM INTEGRITY ISSUES

BIPA is likely to affect the ability to develop and prosecute suspected fraud cases. To a large degree, program integrity and speedy appeals are in conflict. Fraud cases take time to develop. Providers, who believe they are under suspicion of fraud, can use this to their advantage in the appeals system. For example, when providers learn they have claims under focused medical review, or are under carrier fraud investigation, they could attempt to bring their case to an ALJ as quickly as possible. There are some reports of ALJs approving claims under suspected fraud investigation. ALJs may not be aware that cases they are hearing are also under fraud investigations.

While the ALJ does not adjudicate fraud, once the ALJ rules in favor of the appellant, the fraud accusations are effectively ended. Carriers have few options with their fraud cases at that point. In fact, this issue reaches even higher levels. Some U.S. Attorneys are frustrated and concerned when their pending fraud investigations are severely limited or ended after an ALJ rules in favor of an appellant.

CMS recently established a number of new program integrity initiatives that may be impossible to continue under Section 521 without some clarification and special dispensation. For example, in one Durable Medical Equipment Regional Carrier, appeals involving suspected fraudulent claims are referred to a specialized contractor, TriCenturion, for preliminary screening, analysis and work-up. This referral is allowed 25 days. That time frame cannot be accommodated with BIPA's 30-day time limits for contractor appeals.

These issues raise significant questions about how to deal with suspected fraud cases under BIPA's provisions for reduced times to adjudicate appeals. BIPA itself offers no guidance on these questions.

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## QUALITY OF RECORD

At each level of the appeals process, there is serious concern given to the quality of case records and the effect of BIPA's reduced time frames on this quality. It is very important that each level, particularly the ALJ and MAC levels, have a clear, definitive file to examine. At present, there are often complaints about the quality of the record. Questions arise about the rationale of the carrier hearing officer decisions because of the

file's lack of a clear written decision, supporting documentation, and references to relevant contractor manuals or Local Medical Review Policy. There are many reports of ALJs being unable to ascertain the hearing officer's justification for the continued denial of a claim.

Under Section 521, there may not be adequate time to determine the reasoning for the decisions made at the prior level of appeal. By the time the rationale is explained or documentation located, the case could possibly be escalated to the next level.

It is possible that cases may reach the District Courts without decisions and case development from prior administrative levels of appeal. This could happen when cases are escalated through the ALJ and/or MAC levels because of failures to meet time limits for adjudication. Consequently, the Courts could receive appeals without any case development or administrative appeal decisions.

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## **TRANSITION TO NEW APPEALS SYSTEM**

BIPA gives little guidance on transitioning to the new appeals system. It simply indicates that Section 521 applies to "initial determinations," i.e., claims made on or after the effective date of October 1, 2002. For some period, estimated from 18-30 months, Medicare will therefore be operating two appeals systems at the carrier level. This transition could take a considerable period of time due to the cases pending in the system when BIPA takes effect. It is expected that the ALJ and MAC levels will require many years to reduce existing backlogs in their pipelines at the time of BIPA implementation.

Unless CMS procedures for assigning priority to these older cases are clear, claims pending at the carrier when Section 521 takes effect may immediately lose priority. The carriers may take the position that the "timed" claims are priority and the older claims which have no time frames are to be worked in as time permits. This practice of assigning lower priority to claims not under BIPA's strict time frames may occur at other levels of appeal as well.

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## **EFFECT ON BENEFICIARIES**

Although the current appeals process is dominated by provider appellants, beneficiaries continue to bring appeals on their own behalf. The Medicare program is intended to serve the beneficiary, and the appeals process was originally designed for beneficiaries. BIPA changes could negatively affect beneficiaries in several ways.

First, BIPA reduces the amount of time appellants have to appeal Part B claim denials. Currently, the time limit is 180 days for requesting an initial review of a Part B claim. BIPA reduces that time to 120 days, a reduction of 60 days (33 percent). Beneficiaries will therefore lose time to obtain medical records and information needed for their appeal. Unlike most providers, beneficiaries may have little control or leverage over how long it will take their doctor or medical supplier to send records necessary to complete their case file.

Second, beneficiaries could lose their right to a hearing at the contractor level. Presently, beneficiaries may request an in-person hearing, a telephone hearing, or an on-the-record decision. The new QIC reconsideration could possibly not include a hearing as BIPA

does not require a hearing at this level. It is unlikely that the new QICs will be able to conduct hearings given their 30-day time limit. Should this happen, the beneficiary's opportunity to be heard will have been significantly curtailed. Providers and suppliers are much better able to present their case, complete with necessary documentation and expert witnesses, for an on-the-record-decision.

Finally, it is possible that some providers, aware of the shorter time frames under BIPA, may hold their appeals until after BIPA is implemented. Beneficiaries, who are generally less knowledgeable about Medicare rules, would more likely continue to appeal at the same rate without regard for future system changes under BIPA. Therefore, a disproportionate number of appeals pending during the transition phase could be those of beneficiaries.

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## **CARRIER APPEALS**

Section 521 makes several important changes at the carrier level. First, the time to conduct a carrier review, to be called a redetermination, will be reduced by 33 percent, from 45 to 30 days. All carriers who responded to our survey indicated that they will need additional resources to meet the new time limits for redeterminations. The second major change is the elimination of the carrier fair hearing level of appeal. The carrier hearing will be replaced with a reconsideration by the Qualified Independent Contractor.

Section 521 will also create transition challenges for the carriers as they phase out fair hearings and fair hearings officers. Because it will be some time before fair hearings officers are completely removed from the process, it could be difficult and costly to retain hearings officers since they know their positions are being phased out.

Finally, it requires the carriers to interface with a new entity, the QIC. The carriers expressed concerns and doubts about interfacing with the new QICs. Carriers raise important questions including:

- ▶ Will QICs have access to carrier databases?
- ▶ Will carriers remain responsible for preparing cases for ALJ hearings?
- ▶ And, will carriers remain responsible for the effectuation (ordering the payment) of overturned cases?

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## **THE QUALIFIED INDEPENDENT CONTRACTOR**

BIPA creates a new appeals entity. These new contractors, called Qualified Independent Contractors (QIC), will replace the fair hearings level in Part B. According to Section 521, CMS must maintain contracts with at least 12 QICs. However, Section 521 provides little guidance on the composition, staffing, location, and organization of the QICs.

The QICs will operate under greatly reduced time frames compared to the hearing officers. Hearings officers currently have 120 days to conduct their appeals, while QICs will only have 30 days. A QIC is not required to hold a hearing and given their tight time frames, it is likely that their process will only consist of an on-the-record appeal. Decision making of the new QICs will be further complicated by the case files they will receive from the carriers. Presently, the files of the previous level of appeal, the carrier review, have very brief decisions with little or no accompanying rationale. The new and

inexperienced QICs will be using this brief record as the basis for their on-the-record decisions. Tight time frames of the QICs could therefore reduce the quality of QIC decisions compared to fair hearing decisions. And, subsequent appeal levels could receive less clear records of the reason for denial by the QICs.

At present, Medicare has only one independent contractor who conducts appeals separate from organizations which are payers of claims, the Center for Health Dispute Resolution (CHDR). The CHDR conducts managed care appeals, and is independent of Managed Care Organizations (MCO). Some have suggested using the CHDR as a model for the new QICs. Several ALJs we spoke with remarked that CHDR appeal files are generally better prepared than fee-for-service appeal files. And, CHDR meets its time frames 95 percent of the time.

For a number of reasons, however, the CHDR is not very similar to the proposed QICs.

- ▶ CHDR conducts far fewer appeals than will the new QICs. In FY 2000, CHDR conducted about 24,000 appeals, while hearing officers heard 965,638 cases. On average, this will mean about 80,000 appeals per QIC.
- ▶ CHDR cases are much simpler than fee-for-service cases. CHDR cases cannot be combined as can fee-for-service cases. CHDR cases often address single issues such as denied services, not complex issues such as overpayments and partial payment of services.
- ▶ CHDR is bound by MCO policies while QICs are not bound by contractor Local Medical Review Policy.
- ▶ CHDR is a single entity. With only one CHDR, there are no communication and inconsistency problems inherent with multiple contractors.
- ▶ Only about one-third of CHDR cases are retrospective appeals. The bulk are pre-service expedited cases, revolving around whether a beneficiary is entitled to a service under their managed care plan.
- ▶ Only a limited number of CHDR cases can be appealed to an ALJ. Only beneficiaries and non-participating providers can appeal their CHDR denials to an ALJ.

For these reasons, CHDR is not a viable model for the QICs. CMS will have to develop new policies to enable the QICs to meet the specific requirements of BIPA.

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## SSA ALJ HEARINGS

BIPA may have a significant impact on the ALJ level of appeals. The newly mandated BIPA time frames and reduced amount in controversy required to appeal could exacerbate existing problems at this level.

As indicated earlier, the ALJ process is lengthy and backlogged. Currently, it takes 441 days, on average, to adjudicate a Medicare Part B case. Further, the volume of Part B

ALJ appeals continues to increase. In FY 1996, there were 34,917 requests for ALJ hearings. In FY 2000 there were 77,872. At the end of 2<sup>nd</sup> quarter FY 2001, there were 31,223 ALJ appeals pending adjudication. However, while the number of appeals at the ALJ level is increasing, the number of ALJs is decreasing. In 1996, there were 1,087 active ALJs. Currently, there are 915; a decline of almost 16 percent. The number of ALJs cannot increase due to a freeze on the hiring of new, and the replacement of departing, ALJs.

ALJs also continue to have SSA disability cases as their top priority. Although the Part B Medicare cadre continues to exist, even those ALJs still have disability responsibilities. These competing interests were exacerbated by the recent SSA implementation of Hearings Process Improvement (HPI) which mandates that all support staff, which includes paralegals and staff attorneys, rotate every 3-9 months into another part of their office. This precludes support staff from gaining much expertise in Medicare. HPI has, by some reports, reduced the total production of SSA ALJs by 25 percent.

Additionally, BIPA raises serious questions of equity because of the dual workload of the ALJs. There is no current absolute time limit for adjudication of SSA disability cases, and the average time of an ALJ to decide an SSA appeal is 291 days. Cadre judges and OHA administrators question the fairness of different standards for the two workloads.

The lowered amount in controversy under BIPA could have the effect of increasing appeals at the ALJ level. Currently, an appellant must have a claim with at least \$500 in controversy to request an ALJ hearing. BIPA lowers the amount in controversy to \$100 at the ALJ level, the same as is required for an appeal to a QIC. Given that more than 90 percent of appellants are providers, who can combine individual claims to meet the amount in controversy, it seems likely that almost any denial upheld by a QIC could be appealed to an ALJ. In 2<sup>nd</sup> quarter FY 2001, almost 9,000 appeals were upheld, in full, at the carrier hearing level. Under BIPA, most of these appeals could reach ALJs.

In addition to the increased workload, ALJs may have less information with which to make decisions. For instance, if the QIC does not meet its time frame and the appeal is escalated up to an ALJ without a QIC decision, the ALJ would need to rely solely on information from the review/redetermination level of appeal which currently provides little written rationale or documentation. This lack of information will be especially challenging due to lack of Medicare expertise of most ALJs and the greatly reduced time frames of BIPA.

Further, because the ALJ cases are non-adversarial, judges already have the responsibility of finding expert witnesses to testify to medical and statistical sampling issues. This is a difficult process because there is no existing roster of experts to consult and ALJs are limited to \$2,500 per case. Any requests for fees over \$2,500 must go through a central budget process and bids must be requested, which can take months. If all cases are held to the 90-day adjudication limit, it is unlikely that expert witnesses could be identified and contracted in time.

Cadre ALJs, along with OHA administrators, expressed concern that these rigid time frames will also adversely affect due process. First, the reduced quality of decisions at all levels and the inability to provide expert witnesses could harm the ability to get a well-reasoned decision. Second, Part B cadre judges and OHA officials expressed concern

that ALJs, working under severe time restrictions, will have incentives to produce favorable decisions in more cases. Such decisions are less time-consuming to produce and can be done on-the-record, eliminating the need for a hearing. Finally, if CMS reimburses SSA for completed cases only, judges will likely be under pressure to issue decisions within 90 days to assure that the case is not escalated to the MAC, and payment opportunities lost. OHA officials and individual cadre ALJs agreed that this reimbursement situation would create such incentives.

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## **MEDICARE APPEALS COUNCIL**

Section 521 of BIPA could have a very serious impact at the highest level of appeal, the Medicare Appeals Council (MAC).

The MAC currently only has a small staff which is already facing a large and growing number of requests. The MAC has two senior judges, and a support staff of sixteen. Although other judges on the DAB review some Medicare cases, the two judges and support staff identified above have primary responsibility for the Medicare caseload. The MAC hears and renders full decisions only on a small percentage of cases.

Section 521 fundamentally changes the nature of a MAC review. In its present role, the MAC is similar to an appeals court, in that it reviews the ALJ decisions for legal sufficiency and whether the ALJs have exceeded their legal authority. This is very different from the “de novo” process of the ALJ and earlier hearings. Section 521 seems to make the MAC review “de novo.” Such reviews would allow the MAC to review even fewer cases.

Section 521 also makes reference to a “hearing procedure” at the MAC level. It is unclear how this will be interpreted. At present, oral arguments on appeal at the MAC are very rare. A MAC review is, with few exceptions, limited to examination of the documentary record and the recording of the ALJ hearing. If hearings are required at the MAC level, that would further impede the ability of MAC to hear cases and meet deadlines. Some question how two judges could conduct a large number of hearings. And, hearings in only one location, Washington, D.C., may raise questions of equity and access.

BIPA may increase the number of cases the MAC receives in several ways. First, as discussed, BIPA could increase cases entering the appeals system. Second, cases that do not receive timely resolution by ALJs would escalate to the MAC. Finally, the disposition of cases by the U.S. District Court is still unknown. While it is possible that the Courts will hear these cases, it is also possible that the courts will remand them because they have no administrative record. The Courts may consider that such cases have not exhausted their administrative appeal. The result would be cases being elevated up the line to the MAC and cases remanded back to the MAC from the Courts.

A serious question of adequate resources has existed at the MAC level for years. With present resources, the MAC cannot accommodate BIPA changes.

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## U. S. DISTRICT COURTS

We approached the U.S. District Court System about the impact of BIPA to ascertain any preparations made by the Courts for their potentially increased Medicare Appeal caseload, and the reaction of their judges to this possibility. We were concerned about whether Court Judges were likely to remand cases reaching them without an administrative record. Because of BIPA's acceleration provisions, cases may reach the Courts lacking decisions from the ALJ and/or the MAC levels of appeals. At present, there are no provisions for a major influx of cases into their jurisdiction in any upcoming budget.

The Courts do have a number of questions regarding BIPA changes. Central among these are critical questions regarding those cases escalated through the appeals system without decisions from all prior levels of administrative review. The Courts question whether those appeals would meet the requirements for judicial review under the Administrative Procedures Act. BIPA allows cases to escalate to the Courts if not decided at the MAC in time, but seems to imply that the Courts will hear all of these cases.

Many in the administrative appeals process have serious concerns about what the Courts will do with these cases. Some believe that the Court will simply remand these cases back to the MAC for lack of full administrative review. However, this will render the 90-day MAC time ineffectual, as those cases will be sent back to a level that could not process them timely in the first place. Others believe that the Court will conclude that because the Medicare program failed to meet its time limits, appellants should win their appeals. Consequently, many appeals could be decided in favor of the appellant by the Courts.

# RECOMMENDATIONS

Our review of the current appeals process reveals that the new appeals system required by BIPA will be coming in on top of a system that is already stressed. While changes can be made within the current system to mitigate some of the unintended adverse impacts of the BIPA requirements, only a complete restructuring of the appeals system would both eliminate the serious shortcomings of the current system and meet the goals of the BIPA legislation. A recently completed OIG study of ALJ appeals (OEI-04-97-00160) shed light on the broader issues of the Medicare appeals process and included recommendations to address them. We re-examined those recommendations in light of the findings of this study on the BIPA provisions, and we developed a single set of recommendations to address the system as a whole.

We believe these recommendations, if implemented, could significantly reduce the time it takes to process appeals, ensure access to and equitable procedures for beneficiaries and health care provider appellants, provide fair and consistent rulings, protect the financial integrity of the Medicare program, ensure competence and accountability of reviewing agencies, and improve efficiency at all levels. Following are our recommendations.

▶ **Delay implementation of Section 521 of BIPA.**

Implementation of Section 521 should occur only after solving systemic problems addressed in this report and our prior report on the ALJ process. The Department should seek legislation to revise the effective date of the statute.

▶ **Establish an administrative appeals process that is dedicated to Medicare.**

One major facet of the current appeals process—the reviews conducted by ALJ’s—lies in the Social Security Administration (SSA), beyond the control of the Medicare program. Our earlier report on this subject describes serious shortcomings of this system, including inconsistencies in the criteria used by ALJ’s and lower level reviewers, lack of communication among reviewers at various levels, and lack of departmental representation at hearings.

The decisions of adjudicators must stem from a fair and equitable process and be independent of lower level reviews. However, the process itself should be within or controlled by the Department of Health and Human Services. For example, the Department should have control over the acquisition and training of personnel resources, and the techniques and processes used for Medicare appeals. Adjudication of appeals should be done by individuals who are trained and have expertise and current experience with Medicare policy and operations. Thus, we recommend severing the link between the Medicare appeals system and the Social Security ALJs, relying instead on an administrative appeals system overseen exclusively by the Department.

There are a variety of ways to structure an administrative appeals system outside the Social Security ALJ system, with options on factors such as the number of levels of appeal, formats, timeliness standards, and qualifications of reviewers. Administrative



reviews could be conducted by Departmental employees (such as ALJs) or by independent external reviewers under contract to the Department.

Obviously, such restructuring would have to meet certain minimum requirements. First and foremost, the appeals process must provide independent, neutral, and competent adjudicators. It must be trusted by all parties who use it and by the public at large who funds it. Sufficient time must be allowed and effective procedures must be established to ensure that beneficiaries and health care providers have easy access to it and have the opportunity to have their concerns, arguments, and evidence fairly considered.

Other, subsidiary, issues need to be resolved either in legislation or system implementation. These include: size, number, locations, and structure of the independent components of the appeals process; and the nature and extent of CMS oversight of the system.

▶ **Ensure adequate resources for each level of the appeals process.**

This is critical for all levels of appeal. Implementation of process changes should not occur until the costs of these changes can be carefully estimated and provided for. Resources can be made available by eliminating funding for ALJs now handling Medicare cases within SSA. Funds now transferred to SSA can be reallocated to the appeals process that would be established entirely under HHS control.

▶ **Modify the time frames mandated by BIPA--Provide adequate time for fair and effective processing, but ensure timely and efficient resolution of appeals.**

Time frames which can be met with a reasonable good faith effort by all parties to the appeals process should be established. However, flexibility should be allowed for exceptional cases, such as those potentially involving fraud. Revised time frames should be phased in over a reasonable time period. While time frames longer than those required by BIPA are needed, there is also a need to complete Medicare appeals more timely than is currently done. All parties to Medicare appeals desire prompt adjudication of appeals, but it is particularly important to providers and beneficiaries.

Consideration can be given to eliminating one or more of the levels of administrative review included in both the current and BIPA proposed systems. This could reduce the overall length of time for completing all appeals while conserving resources which could then be used to ensure timely resolution and fair and effective processing of appeals in the remaining levels.

▶ **Provide opportunity for CMS representation at higher levels of review.**

The current appeals process was designed based on that of the Social Security program, with its emphasis on the needs of beneficiaries who often would not have the benefit of representation by attorneys. However, the Medicare appeals system has become one that largely receives appeals from providers whose financial stakes may be high and who may have strong legal representation. Furthermore, even some beneficiary appeals may have important consequences for the Medicare program. However, the Department is not provided the

opportunity for representation in the appeals process. Such representation is needed to assure fair and impartial hearings and to ensure that the interests of the Medicare program itself are effectively presented and considered.

- ▶ **Develop thorough, parallel training for reviewers at all levels of appeal.**

Both Medicare contractors and reviewers at all levels need a thorough knowledge of the program. The appeals process suffers from lack of common knowledge, understanding and information. Consistency is needed across all levels of review, and within each level as well.

- ▶ **Develop and require all reviewers of Medicare claims to apply the same standards.**

Currently, the ALJs are bound only by law and regulations, while contractors are also bound by Local Medical Review Policy and contractor manuals. This contributes to the high reversal rate by ALJs. Therefore, greater standardization would be useful. However, we recognize that ALJ decision may continue to be based on evidence that was not presented to - or not fully considered by - the contractor.

- ▶ **Develop regulations or detailed specifications for conducting appeals.**

Currently, ALJs use SSA disability appeal regulations to adjudicate Medicare appeals. ALJs lack the necessary guidance to conduct Medicare appeals. If ALJs are used in a reconstructed appeals system, regulations governing the ALJ appeal level would be necessary. If contractors were used for higher levels of review, the contracts should specify in detail the procedures or standards to be used in order to ensure fairness, competency, consistency, and timeliness.

- ▶ **Create formal communication and information networks that span the entire appeals system.**

The present appeals system features a number of reviewers and judges, each of whom operates in relative isolation from the others. These discrete levels of appeal inhibit communication and prevent the system from becoming fully integrated.

- ▶ **Modernize appeals processing mechanisms.**

Restructuring the appeals system within the department is also needed to facilitate modernizing the entire process. The manual file systems need to be enhanced with electronic features which would facilitate storage, retrieval, transport, and use. A modernization effort could lead to reductions in both case preparation time and layers of appeal review and adjudication.

## Agency Comments

The Office of the Secretary presented a consolidated response representing the views of various components within the Department of Health and Human Services. Generally, the Department agreed with our conclusions and recommendations. Specifically, the Department agreed that a complete restructuring is needed to resolve serious shortcomings of the appeals system before Section 521 of the Benefits Improvement and Protection Act becomes effective.

Further, the Department's response to our report noted that many of our recommendations were also applicable to Section 522 of the Benefits Improvement and Protection Act, although we did not include an analysis of that Section in our study. Accordingly, the Department suggested that Section 522 should also be delayed until after a comprehensive resolution of systemic problems in the Medicare administrative appeals system.

The Department highlighted three principles that should serve to guide efforts in reforming the system. They are:

- build on the appeals model included in the Benefits Improvement and Protection Act;
- achieve a more timely, efficient, and less costly administrative review process; and
- achieve more consistent case decisions.

The full text of Department of Health and Human Services comments on our report begins on the following page.

**Department of Health and Human Services Comments**



- DEPARTMENT OF HEALTH & HUMAN SERVICES


Office of the Secretary

Washington, D.C. 20201

IG	<input checked="" type="checkbox"/>
EAIG	<input type="checkbox"/>
PDIG	<input checked="" type="checkbox"/>
DIG-AS	<input type="checkbox"/>
DIG-EI	<input checked="" type="checkbox"/>
DIG-OI	<input type="checkbox"/>
DIG-MP	<input type="checkbox"/>
OCIG	<input type="checkbox"/>
ExecSec	<input checked="" type="checkbox"/>
Date Sent	11-21

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**MEMORANDUM FOR THE INSPECTOR GENERAL**

**FROM:** Ann Agnew  
Executive Secretary 

**SUBJECT:** Office of the Inspector General (OIG) Draft Report: Medicare Administrative Appeals: The Potential Impact of BIPA (OEI-04-00290)

Thank you for the opportunity to comment on the above-referenced draft report regarding the impact of amendments made by the Benefits Improvement and Protection Act of 2000 (BIPA) to the Medicare appeals system. I am providing the Department's comments in accord with your policy that this be done in cases where multiple agency comments were received by your office.

The report generally does an excellent job of analyzing the problems in the existing appeals system. We agree with your conclusion that "...only a complete restructuring of the appeals system would both eliminate the serious shortcomings of the current system ..... We also agree that systemic problems must be addressed in the appeals system as a whole before section 521 of BIPA takes effect. Moreover, since many of the OIG report's recommendations are also relevant to section 522 of BIPA, we are confident you will agree that appeals system changes should be addressed in a comprehensive way, recognizing the impact of both sections, prior to implementation.

We are committed to improving the Medicare appeals function. HHS believes that any reformed appeals system should adhere to three principles:

- Build on the model enacted in BIPA;
- Result in a more timely and efficient and less costly administrative review process; and
- Result in more consistent Medicare decisions.

HHS particularly appreciates the OIG's discussion of options available to the Department if the decision is made to separate the Medicare appeals system from the Social Security Administrative Law Judge system. This document will serve as valuable guidance as the Department explores how to improve the Medicare appeals system.

We believe your recommendations are generally sound, and have the following specific comments.

OIG Recommendation

Delay the implementation of Section 521.

OS Comment

A change in the effective dates of both sections 521 and 522 is needed to permit time to address systemic problems and to avoid the potential negative impacts of BIPA identified in the Draft Report. Merely delaying "implementation" will not avoid potential problems from certain provisions of section 521, in particular the "de novo" review provision and the escalation clause. A delay period should be used to consider whether to modify such provisions and, if so, how.

OIG Recommendation

Establish an administrative appeals process that is dedicated to Medicare.

OS Comment

We agree generally with the principles expressed under this recommendation and agree with your conclusion that "... there are a variety of ways to structure an administrative appeals system outside the Social Security ALJ system, with options regarding the number of levels of appeal, formats, timeliness standards, qualifications of reviewers, etc. Administrative reviews could be conducted by Departmental employees (such as ALJ'S) or by independent external reviewers under contract to the Department." We are committed to pursuing options and alternatives in this area and will seek your assistance as we proceed.

OIG Recommendation

Ensure adequate resources for each level of the appeals process.

OS Comment

We agree.

OIG Recommendation

Modify the time frames mandated by BIPA. Provide adequate time for fair and effective processing, but ensure timely resolution of appeals.

OS Comment

We agree. As the Draft Report indicates, however, the system must be flexible enough not only to address fraud concerns, but also to permit efficient case processing.

OIG Recommendation

Provide opportunity for CMS representation at higher levels of review.

OS Comment

We agree. Currently, CMS may file a protest seeking review of an ALJ decision with which CMS disagrees. CMS representation during AILJ hearings could sharpen the issues and improve decisions.

OIG Recommendation

Develop thorough, parallel training for reviewers at all levels, of appeal.

OS Comment

We agree.

OIG Recommendation

Develop and require all reviewers of Medicare claims to apply the same standards.

OS Comment

We are in general agreement with this recommendation. We note that an ALJ decision may be different from a contractor's determination for reasons that have nothing to do with the standards applied. The ALJ decision may be based on evidence that was not presented to - or not fully considered by - the contractor.

OIG Recommendation

Develop regulations or detailed specifications for conducting appeals.

OS Comment

We agree. Having procedures in regulations protects providers and beneficiaries and ensures that they have an opportunity for input into changes that could affect their rights. The regulations need to be developed.

OIG Recommendation

Create formal communication and information networks that span the entire appeals system.

OS Comment

We agree that communications concerning procedural and administrative matters are important to an effective appeals system. Such communications are appropriate, but should be distinguished from communications that might compromise the independence of the adjudicators or the fairness of the process.

OIG Recommendation

Modernize appeals processing mechanisms.

OS Comment

We agree. Electronic systems for file storage and transport and for uniform case tracking are critical to reducing case age.