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TO: Perry Rhew
Chief Administrative Law Judge
Office of Medicare Hearings and Appeals

FROM: Daniel R. Levinson /S/
Inspector General

SUBJECT: Memorandum Report: "Medicare Administrative Law Judge Hearings: Update, 2007–2008," OEI-02-06-00111

This memorandum report compares the performance of the Office of Medicare Hearings and Appeals (OMHA) during its first year of operation to its performance during its third year of operation. OMHA is responsible for administering Medicare administrative law judge (ALJ) hearings, which is the third level of the Medicare administrative appeals process. In September 2008, the Senate Committee on Finance requested that the Office of Inspector General (OIG) conduct a follow-up study to its previous report on OMHA's first year of operation.[1] The Committee specifically asked OIG to provide updated information regarding the timeliness of ALJ decisions and the quality of the data in the appeals system.

From the first to third year of operation, OMHA's caseload increased 37 percent and the proportion of cases subject to the 90-day decision requirement also increased. At the same time, there was little change in the hearing formats used and the types of primary appellants. In addition, OMHA improved the timeliness of its decisions from its first to third year of operation. For the cases that had a 90-day decision requirement, OMHA decided 94 percent on time in its third year, compared to 85 percent in its first year of operation. For the cases without the 90-day decision requirement, OMHA decided a slightly greater percentage of these cases within 6 months; however, there was also a slight increase in the average number of days to decide these cases. Lastly, OMHA improved the quality of the data in the appeals system from its first to its third year of operation.

BACKGROUND

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) changed the manner in which Medicare beneficiaries and providers exercise their right to appeal coverage decisions.[2] In particular, the MMA required a transfer of the responsibility for conducting ALJ

[1] OIG, "Medicare Administrative Law Judge Hearings: Early Implementation, 2005–2006," OEI-02-06-00110, July 2008.
[2] MMA, P.L. No. 108-173, §§ 931-940A.

hearings from the Social Security Administration (SSA) to the Department of Health and Human Services (HHS).[3] As a result, in July 2005, HHS opened OMHA, which assumed responsibility for certain Medicare administrative appeals previously handled by SSA.[4] Under SSA, hearings were held primarily in person at the 141 Social Security offices throughout the country, and there was no timeliness requirement for appeal decisions. In contrast, OMHA, with four field offices, planned to use primarily telephones and video teleconferences to conduct ALJ hearings. Further, OMHA faced a new statutory requirement that certain cases be decided within 90 days.

Given these changes, in December 2005, the Senate Committee on Finance requested that OIG assess the use of the telephone, video teleconference, and in-person hearings to decide Medicare ALJ cases and determine the extent to which OMHA was meeting the new statutory requirement to decide certain cases within 90 days. In response, OIG released a report entitled "Medicare Administrative Law Judge Hearings: Early Implementation, 2005–2006" (OEI-02-06-00110). OIG found that in OMHA's first 13 months of operation, it conducted an estimated three-quarters of its hearings by telephone. It also found that most sample appellants were satisfied with their hearing format but that incomplete and inaccurate data limited OMHA's ability to manage its caseload. Lastly, OIG found that available data indicated that in its first 13 months of operation, OMHA did not decide a number of its cases in a timely manner.

Four-Level Medicare Administrative Appeals Process

There are four levels of the Medicare administrative appeals process within HHS. For Medicare Parts A and B claims appeals, 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 cases 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 regarding Medicare Parts A and B entitlement and enrollment,[5] Medicare Part C (the Medicare Advantage program), and Medicare Part D (the Medicare prescription drug benefit). For Level One and Level Two, the entities that decide the appeals for Medicare Parts A and B entitlement and enrollment appeals and Medicare Parts C and D appeals are different from the entities that decide the appeals for Medicare

[3] MMA, P.L. No. 108-173, § 931.
[4] 70 Fed. Reg. 36386 (June 23, 2005). OMHA began operations on July 1, 2005.
[5] Parts A and B entitlement and enrollment appeals involve making decisions regarding Medicare benefits and beneficiaries that are unrelated to Medicare coverage and payment for specific items and services. SSA continues to handle the determinations and reconsiderations for these cases.

Parts A and B claims appeals.[6] However, for Level Three, the ALJ is responsible for deciding all Medicare appeals.[7]

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 claims appeals and to impose shorter timeframes for the processing of these appeals.[8] The Centers for Medicare & Medicaid Services promulgated regulations to address the changes to the claims appeals process required by the BIPA and the MMA.[9]

Section 1869(d)(1)(A) of the Act, as amended by the BIPA, generally requires that an ALJ issue a decision about a case within 90 days of the date when the appeal request was filed.[10] The 90-day requirement generally applies to all Medicare Parts A and B claims appeals received after the implementation of the BIPA, unless the appellant waives the right to have the case decided within 90 days[11] or OMHA approves a request for an in-person hearing.[12] [13] The 90-day requirement does not apply to Medicare Parts A and B entitlement and enrollment appeals or to Medicare Parts C or D appeals. An appellant may request an ALJ hearing by filing a written request within 60 days of receiving a Level Two decision.[14] The ALJ must mail or serve a notice of hearing at least 20 days before the hearing.[15]

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.[16] 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

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[6] For requirements for the appeal process prior to Level 3 for Medicare Parts A and B entitlement and enrollment, see 20 CFR pt. 404, subpart J; for Medicare Part C, see 42 CFR pt. 422, subpart M; and for Medicare Part D, see 42 CFR pt. 423, subpart M.

[7] Regarding the right to an ALJ hearing for Medicare Parts A and B entitlement and enrollment appeals, see 20 CFR § 404.929; for Medicare Parts A and B claims appeals, see 42 CFR § 405.1002; for Medicare Part C, see 42 CFR § 422.600; and for Medicare Part D, see 42 CFR § 423.610.

[8] BIPA, P.L. No. 106-554 § 521.

[9] 70 Fed. Reg. 11420 (Mar. 8, 2005), as amended at 70 Fed. Reg. 37700 (June 30, 2005).

[10] 42 U.S.C. § 1395ff(d)(1)(A); 42 CFR § 405.1016(a).

[11] 42 U.S.C. § 1395ff(d)(1)(B); 42 CFR § 405.1036(d).

[12] 42 CFR § 405.1020(i). OMHA's approval of an appellant's request for an in-person hearing is different from an OMHA determination that an in-person hearing should be conducted because video teleconference technology is not available or because special or extraordinary circumstances exist. In the latter situation, the 90-day requirement applies.

[13] 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).

[14] 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).

[15] 42 CFR § 405.1022(a).

[16] 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).

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.[17] 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.[18] 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.[19] 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.[20]

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 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. 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.[21] OMHA staff can input new data into the appeals system regarding Level Three of the appeals process.

METHODOLOGY

The information provided in this report is based on an analysis of data from the appeals system for OMHA's third year of operation. These data include all cases received by OMHA between June 1, 2007, and May 31, 2008. Our previous report is based on data from the appeals system for OMHA's first 13 months of operation (hereinafter referred to as the first year of operation). That report included data for all cases received by OMHA between July 1, 2005, and July 31, 2006.[22] The data from the appeals system 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.

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[17] 42 CFR § 405.1020(i).

[18] 42 CFR § 405.1020(g).

[19] See 70 Fed. Reg. 11420, 11457 (Mar. 8, 2005) (preamble discussion regarding good cause for in-person hearings).

[20] 42 CFR § 405.1038. The ALJ may 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.

[21] 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 Medicaid.

[22] For the third year of operation, the data included all information about these cases through September 1, 2008; for the first year, the data included all information about these cases through September 12, 2006.

We first assessed the composition of OMHA's caseload to identify any changes from its first year to its third year of operation.[23] Specifically, we compared the total number of cases and the percentage of cases by Medicare appeal type, by hearing format type, and by type of primary appellant.

We also analyzed the data to assess the timeliness of ALJ decisions. To accomplish this, we analyzed the cases that were subject to the 90-day requirement separately from the cases that were not subject to this requirement. As previously mentioned, the 90-day decision requirement generally applies to all Medicare Parts A or B claims appeals received after the implementation of the BIPA unless the appellant signs a waiver or OMHA approves an appellant request for an in-person hearing.[24] The 90-day requirement does not apply to Medicare entitlement and enrollment appeals or to Medicare Parts C or D appeals.

To conduct this analysis, we compared the date when OMHA received the appeal request to the date when OMHA sent a decision letter to the appellant, including any allotted extension days plus a 3-day grace period to cover any holiday weekends.[25] 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. For cases with the 90-day requirement, we determined the percentage of cases that had been decided on time. For cases without the 90-day decision requirement, we determined the percentage of cases that had been decided within 6 months. For cases with and without the 90-day requirement, we calculated the average number of days between the dates when OMHA received the appeal requests and the dates when OMHA sent decision letters to the appellants.

Limitations

The information about OMHA's third year of operation was based on an analysis of data from the appeals system. In contrast, the information about OMHA's first year of operation was based on an analysis of data from the appeals system and on structured interviews with a sample of appellants. In the first year, because some of the data in the appeals system were inaccurate or missing, the results for several estimates were based on projections from our sample rather than on the population of cases in the appeals system. These estimates included the percentage of hearings conducted by telephone, by video teleconference, and in person and the percentage of hearings by appellant type. For these estimates, we compared the results for OMHA's third year to the confidence interval for the estimate for OMHA's first year of operation. Lastly, the calculation of the total number of cases subject to the 90-day requirement in the first year in this report differs slightly from our previous report. For this report, we recategorized six cases that

[23] We excluded three cases from the analysis of the third year because the decision dates in the appeals system were recorded erroneously as being earlier than the dates when the appeals requests were received. We excluded 16 cases from the analysis of the first year for this reason.

[24] Note that in some cases, OMHA staff may make determinations that in-person hearings should be conducted without receiving official requests from appellants. In these cases, the hearings would need to be decided within 90 days. In our analysis, all cases with in-person hearings were treated as not being subject to the 90-day requirement as OMHA's appeals system does not distinguish between cases in which appellants made the requests for in-person hearings from cases in which OMHA staff made such determinations.

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

were Medicare Parts A and B entitlement and enrollment appeals. These cases were not, in fact, subject to the 90-day requirement. This change, however, does not alter the percentage of cases meeting the 90-day requirement in the previous report.

Standards
This review 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.

RESULTS

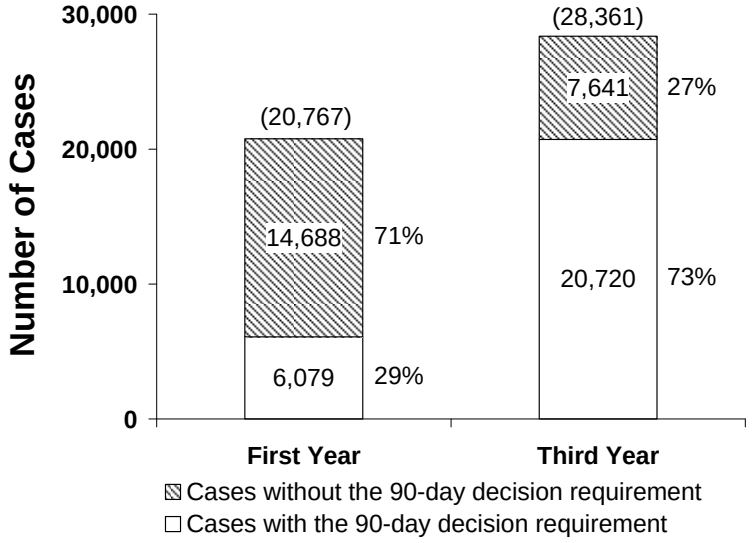
From Its First to Third Year of Operation, OMHA's Caseload Increased 37 Percent and the Proportion of Cases Subject to the 90-day Decision Requirement Also Increased

From its first to third year of operation, OMHA's overall caseload increased 37 percent from 20,767 to 28,361 cases. The number of Medicare Parts A and B cases that OMHA received increased by 37 percent from 19,432 to 26,529. The number of Part C cases increased by 29 percent from 1,196 to 1,539 cases, and the number of Part D cases increased by 111 percent from 139 to 293 cases. Approximately one quarter of the increase in OMHA's caseload was attributable to appeals associated with the Recovery Audit Contractor program, a new Medicare program designed to detect and collect overpayments.[26]

In addition, there was a substantial shift from cases without the 90-day decision requirement to cases with the requirement from the first to third year of operation. As shown in Figure 1 on the next page, the number of cases with the 90-day decision requirement more than tripled, from 6,079 to 20,720 cases. In contrast, the number of cases without the 90-day requirement was reduced by almost half, from 14,688 to 7,641 cases. The shift to more cases with the 90-day requirement occurred because, in the third year, all Parts A and B claims appeals were submitted after the implementation of the BIPA and were therefore generally subject to the 90-day requirement. Conversely, in the first year, almost all of the Parts A and B claims appeals were submitted before the implementation of the BIPA and were therefore not subject to the requirement.

[26] The Recovery Audit Contractor program, initially authorized as a demonstration project in section 306 of the MMA, is designed to reduce Medicare improper payments through detection and collection of overpayments and to identify underpayments. It was made permanent in 2006, and authority for the program is now found at section 1893(h) of the Act. As of March 2008, the Recovery Audit Contractors identified $992.7 million in overpayments, $46.0 million (4.6 percent) of which was overturned on appeal. "The Medicare Recovery Audit Contractor (RAC) Program: An Evaluation of the 3-Year Demonstration," June 2008. Available online at http://racaudits.com/uploads/RAC_Demonstration_Evaluation_Report.pdf. Accessed on November 25, 2008.

Figure 1: Number of Cases With and Without the 90-Day Decision Requirement for the First and Third Years of OMHA Operation



Source: OIG analysis of the Medicare Appeals System, 2008.

There Was Little Change in the Hearing Formats Used and the Types of Primary Appellants From OMHA's First to Third Year of Operation

In its third year of operation, OMHA conducted 85 percent of its hearings by telephone. This was a slight increase from the first year of operation, when OMHA conducted an estimated 78 percent of its hearings by telephone. This estimate had a 95-percent confidence interval of 73 percent to 83 percent. In addition, OMHA conducted 8 percent of its hearings by video teleconference and 7 percent in person in its third year of operation. These percentages were not statistically different from those in OMHA's first year of operation.[27]

There were no significant changes in the types of primary appellants from OMHA's first to third year of operation. In the third year of operation, for 78 percent of the cases that had hearings, the primary appellants were Medicare providers or suppliers. Another 13 percent of these cases had primary appellants who were Medicare beneficiaries, and 9 percent were pursued by State Medicaid organizations. None of these percentages were statistically different from those in the first year of operation.[28]

In addition, in the third year of operation, 28 percent of the cases had on-the-record decisions.[29] An on-the-record decision is based only on the case file and does not require a hearing. In

[27] The 95-percent confidence intervals for the first year were 8.0 percent to 15.1 percent for video teleconference hearings and 6.1 percent to 13.9 percent for in-person hearings.

[28] The 95-percent confidence intervals for the first year were 71.3 percent to 84.4 percent for Medicare providers or suppliers, 8.5 percent to 20.5 percent for beneficiaries, and 4.3 percent to 10.9 percent for State Medicaid organizations.

[29] Less than 1 percent of decided cases in the third year of operation had no information about whether there were hearings or on-the-record decisions.

OMHA's first year of operation, there was no information for almost one-third of the decided cases. For the cases that had information, 13 percent were on-the-record decisions.

OMHA Improved the Timeliness of Its Decisions From Its First to Third Year of Operation

Although its caseload increased by 37 percent, OMHA improved the timeliness of its decisions from its first to third year of operation. Improvements in timeliness were found primarily in cases with the 90-day decision requirement, rather than in cases without the 90-day decision requirement. The cases with the 90-day decision requirement represented 73 percent of OMHA's caseload in its third year of operation, compared to 29 percent in its first year. In addition, OMHA scheduled hearings more quickly in its third year of operation compared to its first year.

For cases with the 90-day decision requirement, OMHA decided a greater percentage of cases on time from its first to third year of operation. During its third year of operation, OMHA had 20,616 cases that had a 90-day decision requirement and decision dates recorded in the appeals system.[30] (See Table 1.) OMHA decided 94 percent of these cases (19,377 of 20,616) on time. In contrast, during its first year of operation, OMHA had 3,275 cases that had a 90-day decision requirement and decision dates recorded in the appeals system. OMHA decided 85 percent of these cases (2,776 of 3,275) on time. See Appendix B for the percentages of cases decided within 90 days by quarter.

Further, the percentage of cases with the 90-day decision requirement that had been in the appeals system for longer than 90 days with no decision dates decreased from OMHA's first to third year of operation. Because the data for the first year of operation were incomplete, this change may reflect improvements in data quality as well as timeliness.

Table 1: Timeliness of Cases With the 90-Day Decision Requirement During the First and Third Years of OMHA's Operation

	Number of Cases in First Year	Number of Cases in Third Year
Cases With Decision Dates in Appeals System	**3,275**	**20,616**
Decided within 90 days	2,776	19,377
Not decided within 90 days	499	1,239
Cases Without Decision Dates in Appeals System	**2,804**	**104**
In appeals system for longer than 90 days	1,178	54
In the appeals system for 90 days or fewer	1,626	50
Total Number of Cases With the 90-Day Decision Requirement	**6,079**	**20,720**

Source: OIG analysis of the Medicare Appeals System, 2008.

In addition, OMHA decreased the average number of days to decide cases with the 90-day requirement from its first to third year of operation. On average, OMHA decided these cases in 69 days in its third year, compared to 82 days in its first year of operation. OMHA also achieved more consistency among its four field offices in the number of days to decision. During its third

[30] Another 104 cases had a 90-day decision requirement but did not have decision dates in the appeals system.

year, the average number of days varied from 65 to 76 days among its four field offices, whereas, during its first year of operation, the average number of days to decide these cases varied from 59 to 88 days.

For cases without the 90-day decision requirement, OMHA decided a slightly greater percentage of cases within 6 months; however, there was also a slight increase in the average number of days to decide these cases. For cases that were not subject to the 90-day decision requirement, OMHA decided a greater percentage of cases within 6 months in its third year, compared to its first year of operation. In its third year, OMHA decided 90 percent of these cases that had decision dates (6,582 of 7,305) within 6 months. In contrast, OMHA decided 88 percent of these cases (7,503 of 8,503) within 6 months in its first year. (See Table 2.)

Table 2: Timeliness of Cases Without a 90-Day Requirement During the First and Third Years of OMHA's Operation

	Number of Cases in First Year	Number of Cases in Third Year
Cases With Decision Dates in Appeals System	**8,503**	**7,305**
Decided within 6 months	7,503	6,582
Not decided within 6 months	1,000	723
Cases Without Decision Dates in Appeals System	**6,185**	**336**
In appeals system for longer than 6 months	2,142	63
In the appeals system for 6 months or fewer	4,043	273
Total Number of Cases Without a 90-Day Requirement	**14,688**	**7,641**

Source: OIG analysis of the Medicare Appeals System, 2008.

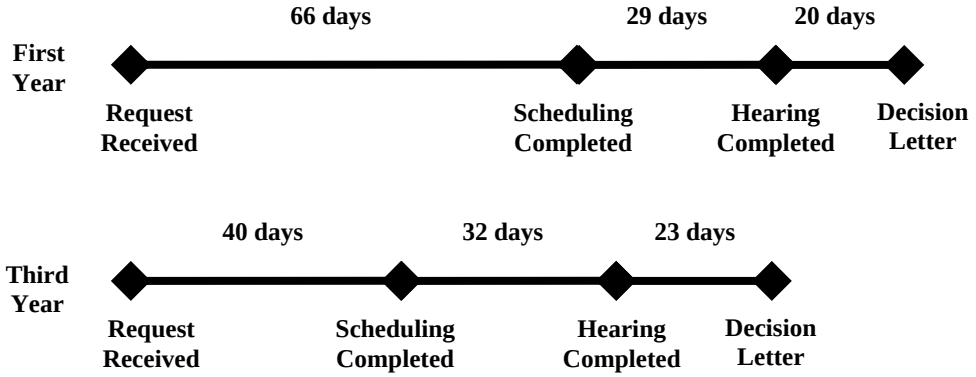
At the same time, there was a slight increase in the average number of days to decision for the cases without the 90-day decision requirement. In its third year, OMHA decided Parts C and D cases in an average of 89 days, compared to 82 days in its first year. Further, in its third year, OMHA decided Parts A and B cases that were not subject to the 90-day decision requirement in an average of 119 days, compared to 110 days in its first year. The increase in the average number of days for the Parts A and B cases may be because of changes in the composition of these cases. In the third year, these cases were not subject to the 90-day decision requirement because, for example, the appellants waived the requirement or requested and were granted in-person hearings. In contrast, in the first year, these cases were not subject to the 90-day requirement primarily because they had been received before the implementation of the BIPA.

OMHA scheduled hearings more quickly in its third year of operation, compared to its first year. For cases with and without the 90-day decision requirement, improvements in timeliness from the first to third year of operation were found early in the appeals process. As shown in Figure 2 on the next page, for the cases that had hearings during its third year of operation, OMHA took an average of 40 days to schedule hearings from the time when it received the appeals requests, compared to 66 days in its first year.[31] At the same time, the subsequent

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

stages—from scheduling the hearings to the completion of the hearings and from the completion of the hearing to mailing the decision letter to the appellant—each increased by 3 days from the first to third year of operation.

Figure 2: Average Number of Days To Complete Key Steps in the Appeals Process for the First and Third Years of OMHA Operation



Source: OIG analysis of the Medicare Appeals System, 2008.

OMHA Improved the Quality of the Data in the Appeals System From Its First to Third Year of Operation

OMHA relies on the appeals system as the primary mechanism to collect data about the program and to manage its caseload. In the first year of OMHA's operation, we found that information in the appeals system was frequently inaccurate or missing. Our subsequent review of OMHA's third year of operation indicates that OMHA has improved the quality of the data in the appeals system.

Information about the primary appellant was more complete. From its first to third year of operation, the percentage of decided cases with no indication about which party was the primary appellant dropped from 71 percent to less than 1 percent.

Information about the hearing type and format was also more complete. The percentage of decided cases with no information about whether there were hearings or on-the-record decisions dropped from 31 percent to less than 1 percent. In addition, the percentage of cases that had hearings with no information about whether the hearings were conducted by telephone, by video teleconference, or in person dropped from 35 percent in the first year of operation to less than 1 percent in the third year.

Information about key dates was more complete and accurate. The percentage of decided cases with no dates indicating when OMHA requested and received the case files from the previous level dropped from more than 75 percent to less than 5 percent. In addition, the percentage of decided cases in which at least one date was out of chronological order dropped from 22 percent to 6 percent.

CONCLUSION

From the first to third year of operation, OMHA's caseload increased 37 percent and the proportion of cases subject to the 90-day decision requirement also increased. At the same time, there was little change in the hearing formats used and the types of primary appellants. In addition, OMHA improved the timeliness of its decisions from its first to third year of operation. For the cases that had a 90-day decision requirement, OMHA decided 94 percent on time in its third year, compared to 85 percent in its first year of operation. For the cases without the 90-day requirement, OMHA decided a slightly greater percentage of these cases within 6 months; however, there was also a slight increase in the average number of days to decide these cases. Lastly, OMHA improved the quality of the data in the appeals system from its first to third year of operation.

This report is being issued directly in final form because it has no recommendations. If you have comments or questions about this report, please provide them within 60 days. Please refer to report number OEI-02-06-00111 in all correspondence.

APPENDIX A

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 claims appeals.

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.[32] 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.[33] 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 (NCD), the Centers for Medicare & Medicaid Services (CMS) rulings, and applicable laws and regulations.[34] QICs are not bound by local coverage determinations (LCD); local medical review policies (LMRP); or CMS program guidance, such as program memoranda and manual instructions. QICs, however, do give substantial deference to those policies, if applicable.[35] Generally, a QIC has 60 days to make a decision from the date when the appellant filed an appeal.[36]

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).[37] [38] This request must be filed within 60 days from the receipt of notice of the Level Two reconsideration decision. At this level, the minimum

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

[33] 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).

[34] 42 CFR § 405.968(b)(1).

[35] 42 CFR § 405.968(b)(2).

[36] 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 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).

[37] ALJs also handle Level Three Medicare Parts A and B entitlement and enrollment appeals and Medicare Parts C and D appeals. For Parts A and B entitlement and enrollment, see 20 CFR §§ 404.900(a)(3), 404.929, and 404.933; for Part C, see 42 CFR §§ 422.600 and 422.602; and for Part D, see 42 CFR §§ 423.610 and 423.612.

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

amount in controversy is $120.[39] 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.[40] ALJs are not bound by LCDs; LMRPs; or CMS program guidance, such as program memoranda and manual instructions. ALJs, however, do give substantial deference to those policies, if applicable.[41] Generally, the ALJ must decide
Part A and Part B claims appeals within 90 days of the dates when appeal requests were 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)[42] within 60 days of receipt of the ALJ hearing decision.[43] 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. MAC is bound by NCDs, but MAC 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.[44] MAC is not bound by LCDs, LMRPs, or CMS program guidance, but MAC does give substantial deference to those policies, if applicable.[45] Generally, MAC must make a decision with respect to Medicare Part A and Part B claims appeals within 90 days of the filing dates. If the appellant disagrees with the MAC decision and the amount in controversy is at least $1,180,[46] the appellant may file a civil action in Federal District Court within 60 days of receiving the MAC decision.

[39] 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 amounts in controversy for 2008.
[40] 42 CFR § 405.1060(b).
[41] 42 CFR § 405.1062(a).
[42] Level Four review before MAC is also available for Medicare Parts A and B entitlement and enrollment appeals and Medicare Parts C and D appeals. For Parts A and B entitlement and enrollment appeals, see 20 CFR § 404.967; for Part C, see 42 CFR § 422.608; and for Part D, see 42 CFR § 423.620.
[43] 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).
[44] 42 CFR § 405.1060(c).
[45] 42 CFR § 405.1062(a).
[46] 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 amounts in controversy for 2008.

APPENDIX B

Percentage of Cases That Met the 90-Day Requirement, by Quarter, During the First and Third Years of OMHA's Operation

Quarter	Percentage of Cases That Met the 90-Day Requirement in First Year	Percentage of Cases That Met the 90-Day Requirement in Third Year
1st	63%	91%
2nd	79%	95%
3rd	82%	95%
4th	90%	95%
Total	**85%**	**94%**

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

Source: Office of Inspector General analysis of the Medicare Appeals System, 2008.