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The Honorable Larry E. Craig
The Honorable Paul D. Coverdell
United States Senate

Subject: Medicare Managed Care Appeal Process for Denials of Care: A Comparison With Recommendations From the President's Quality Commission

Enrollment in managed care plans, such as health maintenance organizations, is expected to grow from 75 percent of the national workforce in 1996 to 85 percent in 2000. As more and more people receive their health care from managed care plans, public concern has grown that these plans sometimes inappropriately deny care or payment for services. As a result, the Congress and many states are considering legislation to ensure that health care consumers have adequate protections, such as appropriate and effective appeal processes to resolve disputes between patients and their health plans.

In November 1997, the President's Advisory Commission on Consumer Protection and Quality in the Health Care Industry (the Quality Commission) published a proposed Consumer Bill of Rights and Responsibilities. Its recommendations included a right to a fair appeal process, composed of both an internal appeal process conducted by the plan itself and an independent external appeal process to review the plan's decision in certain cases. Many commercial managed care plans have some internal process for reviewing appeals, but external review of appeal decisions is less common. A number of states have recently passed legislation mandating external review of some or all managed care appeal decisions. Several patients' protection bills that would require the external review of patients' appeals have also been introduced in the Congress this year.

This letter responds to your request for information on Medicare managed care appeals to help the Congress consider legislation on national appeal rights for private sector health care consumers. Specifically, you requested that we (1) compare the Quality Commission's recommended appeal process with that required by the Medicare program and (2) describe the appeals reviewed by Medicare's external appeals contractor. To address these objectives, we interviewed Health Care Financing Administration (HCFA) officials and staff

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from the Quality Commission and reviewed Medicare regulations and Quality Commission publications. We also analyzed statistics maintained by Medicare's external appeals contractor, the Center for Health Dispute Resolution (CHDR), interviewed CHDR staff, and reviewed most of the decisions CHDR made in February 1998. Further details on our scope and methodology are in enclosure I. We performed our work between February 1998 and April 1998 in accordance with generally accepted government auditing standards.

In summary, we found that the Quality Commission recommended an appeal process that is very similar in structure to the process used by the Medicare managed care program. Both require that individuals receive timely notification of appeal rights and appeal decisions. Both require an expedited process for certain kinds of cases for internal and external appeals. One significant difference is that virtually all internal appeals that are not completely favorable to the beneficiary are automatically subject to Medicare's external review process, while the Quality Commission restricts external review to appeals that involve experimental issues, circumstances that jeopardize the health or life of the patient, or services that exceed a significant financial threshold that has remained unspecified. In addition, disputes involving services a plan considers to be not covered would not be subject to external review. The effect of these differences on the number and types of appeals seen in the Quality Commission's appeal process would depend on how its recommendations are implemented.

While appeals from fewer than three-tenths of one percent of Medicare managed care enrollees actually reach the external review process in any given year, our review of CHDR appeals indicates that it provides an important protection for beneficiaries at a modest cost to the program. In 1997, there were about 7,800 external appeals for the 5.5 million Medicare enrollees in managed care plans. We reviewed 572 CHDR decisions made in February 1998. CHDR overturned or partially overturned 127 of these denials. In about two-thirds of the overturned cases, CHDR found that the plans made an inappropriate clinical decision and that the care involved in the appeal was medically necessary and met Medicare's clinical coverage criteria. Because of differences between Medicare enrollees and the commercially insured, however, Medicare's experience with external appeals may not apply to this population. Medicare enrollees can disenroll in any given month and therefore may choose to disenroll rather than appeal a dispute with their plans. Many commercially insured managed care enrollees, however, may not have this disenrollment option. The commercially insured population, which generally is healthier and uses fewer services than Medicare enrollees, may also have fewer appeals per capita. These differences make it difficult to predict the volume or type of appeals that would be seen in an

external appeals process for the commercially insured based on Medicare's experience.

BACKGROUND

Medicare Managed Care

As of April 1, 1998, 6.3 million of Medicare's 38 million beneficiaries were enrolled in a managed care plan. Managed care plans must provide all services covered by fee-for-service Medicare; in many instances, they provide additional services not included in fee-for-service Medicare. Managed care plans may require enrollees to use only providers under contract with the plan and to follow certain procedures to gain access to nonemergency care.[1] If an enrollee does not follow these procedures, the managed care plan is not responsible for paying for the service. Most managed care plans require enrollees to obtain prior authorization for nonemergency care either from their primary care physician or directly from the plan. If a plan does not authorize or provide medically necessary care, an enrollee may seek care without authorization and the plan will be liable for that care.

Medicare enrollees may appeal a plan's refusal to provide health services or pay for services they believe are covered or medically necessary.[2] If a patient appeals the denial, the plan must reconsider its initial decision. The number of internal appeals filed by enrollees is unknown because HCFA does not collect these data.[3] If the plan's reconsideration is not fully favorable to the enrollee, the plan must forward the appeal for independent review by HCFA's contractor, CHDR, which makes the final decision. If dissatisfied with CHDR's decision and the amount in dispute is $100 or more, Medicare enrollees can take their appeals to an administrative law judge. CHDR has conducted external review for Medicare managed care appeals since 1989. The external appeal process is a

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[1]If emergency care is needed, an enrollee can seek care from any provider without prior authorization. In addition, if an enrollee is outside the plan's service area and needs urgent care, he or she may seek care from any provider without prior plan approval.

[2]Most Medicare managed care enrollees belong to risk contract plans, which receive a fixed payment per month per enrollee from HCFA. There are also cost contract plans, health care prepayment plans (HCPP), and demonstration plans.

[3]HCFA staff report that the agency plans to collect these data in the future and is working on an implementation plan at this time.

relatively small budget item for Medicare. In 1997, HCFA spent almost $2 million on CHDR services.

Since Medicare enrollees may disenroll from a plan in any given month, a Medicare enrollee who is dissatisfied with a plan decision may, rather than appeal, choose to disenroll from the plan and attempt to receive the same service in the Medicare fee-for-service program.[4] For this reason, the number of external appeals may underestimate the number of unresolved disputes that Medicare enrollees have with managed care plans. Further, studies have found that some Medicare enrollees may not be aware of their appeal rights. A December 1996 report by the Office of Inspector General for the Department of Health and Human Services found that one-third of the Medicare enrollees sampled were not aware of specific instances for which they had the right to appeal. The same report also found that a number of plans did not always issue an explanation of appeal rights or a denial notice to enrollees.

Quality Commission

In September 1996, President Clinton created the Advisory Commission on Consumer Protection and Quality in the Health Care Industry to recommend measures to protect health care consumers and improve the quality of health care. In November 1997, the Quality Commission published a proposed consumer bill of rights that included recommendations regarding appeals, access to emergency services, choice of providers, and other issues that are important to health care consumers.

QUALITY COMMISSION RECOMMENDS APPEAL PROCESS SIMILAR TO MEDICARE'S BUT WITH MORE RESTRICTIVE CRITERIA FOR EXTERNAL APPEALS

The appeal process proposed by the Quality Commission is very similar to that used by Medicare.[5] For instance, the Quality Commission's recommendations include both an external review process and an expedited appeal process for certain cases, as does Medicare. However, there is one major difference between the two. While virtually any denial of service or payment for services

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[4]The Balanced Budget Act of 1997 (BBA), however, restricts Medicare managed care enrollees' opportunities to disenroll from a plan beginning 2002.

[5]For the purposes of this letter, when we use the term Medicare, we are referring to the Medicare managed care program, since the Quality Commission's recommendations were based on this component of the Medicare program.

already rendered is subject to Medicare's appeal process, the Quality Commission recommendations restrict the type of appeals that are subject to external review.

Quality Commission's Appeal Recommendations Are Similar to the Medicare Appeal Process

According to a Quality Commission representative, the Quality Commission deliberately modeled most of its recommendations on the appeal process required by Medicare for managed care plans. Its recommendations tend to be less specific than the Medicare requirements but are generally consistent with them. Both have a two-step appeal process in which the plan internally reviews an enrollee's appeal of a denied service and that decision is subject to an independent external review if it is unfavorable to the enrollee.

Internal Appeal Process

As table 1 shows, the internal appeal process used by Medicare and recommended by the Quality Commission requires plans to inform enrollees in writing when they deny a request for care or payment and to clearly explain why the request was denied and how the enrollee can appeal the decision.[6] This requirement allows enrollees to be aware of a denial so they can take advantage of their appeal rights. Both Medicare and the Quality Commission also require that decisions be made in a timely manner and by staff with appropriate expertise.

[6]When we discuss denials in this report, we are including any decision by a health plan to deny, reduce, or discontinue services or deny payment for services.

Table 1: Medicare's Practices and Quality Commission Recommendations Regarding an Internal Appeal Process

Medicare managed care	Quality Commission
Criteria	
Current law defines appealable determinations as denials, terminations, and payment disputes. HCFA staff report that enrollees can also appeal reductions in ongoing services.	Any decision by a plan to deny, reduce, or terminate services or deny payment for services can be appealed.
Denial notices	
Plans must inform enrollees in writing when they deny a request for care or payment for services already rendered.	Same as Medicare.
Denial notices must clearly explain why the denial was made and how the enrollee can appeal the decision.	Same as Medicare.
Denial notices should generally be issued within 60 days of the request for payment or the request for care.[a]	Denial notices should be provided in a timely manner.
Qualification of plan staff making appeal decision	
– Staff must be familiar with Medicare procedures. – For services denied because they are not considered medically necessary, a physician with appropriate expertise must make appeal decision. This is a new requirement included in the Balanced Budget Act of 1997.	Health care professionals must be appropriately credentialed with respect to the treatment involved.
Staff must not have been involved in the initial denial decision.	Same as Medicare.
Timing	
Appeal decision must be made within 60 days of appeal request. However, HCFA is considering reducing this time period.	Appeal must be resolved in a timely manner.

[a]A denial notice for a request for services and for claims that are missing required documentation or otherwise involve special circumstances must be issued within 60 days of the request for services or payment. A denial notice for claims that have all the proper documentation and meet appropriate guidelines must be issued within 30 days.

The Quality Commission and Medicare also require an expedited process for certain types of appeals considered to be time sensitive.[7] As shown in table 2, both require the same time periods for making an expedited decision, but they have different criteria for determining which cases should be expedited. The Quality Commission calls for expedited consideration of appeals involving emergency or urgent care, while Medicare requires expedited decisions when a denial of service could seriously jeopardize the enrollee's life, health, or ability to regain maximum function. The Quality Commission's criteria may exclude certain cases that would meet the Medicare criteria. For instance, a patient may request rehabilitative services that are needed immediately to restore maximum function, but this might not be subject to expedited review under the Quality Commission's criteria.

Table 2: Medicare Requirements and Quality Commission Recommendations Regarding an Expedited Internal Appeal Process

	Medicare managed care	Quality Commission
Criteria	When delay in the appeal decision could seriously jeopardize the enrollee's life, health, or ability to regain maximum function.	Decisions involving emergency or urgent care.
Who determines that an appeal should be expedited	–Any request from a physician is expedited. –Any request from an enrollee that is supported by a physician is expedited. – For any other request, the plan determines if the request meets Medicare's criteria for expedited review.	No recommendation.
Timing	As appropriate for the condition but generally no more than 72 hours from the time of the request.	Same as Medicare.

[7]HCFA required Medicare managed care plans to offer this expedited process as of August 28, 1997.

Medicare managed care enrollees may seek emergency care or out-of-area urgent care without any prior approval from their plans. Consequently, HCFA officials state that enrollees do not need an expedited process for these types of care. In most appeals involving urgent or emergency care, enrollees obtain the care they need and the plan later denies payment because it did not consider the care to be urgent or an emergency. These appeals thus involve disputes over who will pay for care already provided. An expedited appeal process would not affect an enrollee's ability to obtain care in these situations and would not be necessary.

External Appeal Process

Both Medicare and the Quality Commission require the availability of an external review for enrollees who are dissatisfied with a plan's internal appeal decision. Table 3 compares Medicare and the Quality Commission's requirements for external appeals. In the Medicare program, plans are required to automatically forward to CHDR any appeals that are not fully favorable to enrollees--that is, if the managed care plan continues to deny any part of an enrollee's request for, or payment of, services. In addition, plans are required to automatically submit to CHDR any internal appeal if no decision has been made by the required time period (60 days for regular appeals and 72 hours for expedited appeals). The Quality Commission did not make a specific recommendation about whether its external process would work automatically like Medicare's or would require enrollees to specifically request an external review.

Table 3: Medicare Practices and Quality Commission Recommendations Regarding an External Appeal Process

	Medicare managed care	Quality Commission
How process is triggered	If the internal plan appeal decision is not fully favorable to the enrollee, the appeal is automatically sent to the external review contractor. Enrollee does not need to take any action.	No recommendation.
Who makes external appeal decision	CHDR, an independent organization under contract to HCFA.	No recommendation.
Qualification of staff making appeal decision	Same as internal appeal process. Staff are subject to conflict-of-interest prohibitions. CHDR employs nurses and lawyers to review appeals and contracts with physicians who have appropriate expertise.	Same as internal appeal process. Staff should also be subject to conflict-of-interest prohibitions.
Timing for nonexpedited appeals	CHDR policy is generally to make decisions within 30 days of receiving an appeal.	Resolve appeals in a timely manner.
Timing for expedited appeals	HCFA expects CHDR to issue its expedited decisions within 10 days. CHDR's internal policy is to complete such decisions within 3 to 10 days.	Timing consistent with Medicare requirements (i.e., 72 hours).

Quality Commission Imposes More Restrictive Criteria on External Appeals

There is one significant difference between the Medicare appeal process and the process proposed by the Quality Commission. The Quality Commission imposes certain criteria on the types of cases that are subject to the external review process, while Medicare enrollees may appeal a plan's denial for any service they believe they are entitled to. Since a plan must automatically forward to CHDR any internal appeals that are not fully favorable to an enrollee, almost all these Medicare internal appeals are subject to the external appeal process.[8] Medicare

[8]The one exception has been that optional supplemental benefits offered by managed care plans were not subject to the Medicare appeal process. BBA has revised some of the Medicare appeal requirements and HCFA staff believe that optional supplemental benefits are now subject to the appeal process. They plan

(continued...)

does not impose any financial criteria on the cases that are subject to the external process.

In contrast, the Quality Commission has recommended certain criteria to ensure that cases are appropriate for the external appeal process. It wanted to include cases in which the denial of care could have significant health implications. As a result, it proposed that any service denied because a plan considers it investigational or experimental is subject to the external appeal process. In addition, any service denied because the plan believes it is not medically necessary is subject to the external process if the patient's life or health is jeopardized.

However, a Quality Commission representative told us that it did not want the time and resources involved in conducting an external appeal to be used for relatively minor or inexpensive services. Consequently, it recommended that any service denied because the plan believes it is not medically necessary be subject to the external process only if the dollar amount of the service in question "exceeds a significant threshold."[9] The Quality Commission did not define significant threshold, although amounts ranging from $100 to $5,000 were considered. The effect of this criterion obviously depends on the dollar threshold. If a high financial minimum is established, the external appeal process the Quality Commission recommended may be much more restrictive than Medicare's.

Finally, the Quality Commission's report also stated that enrollees could not use the external process for services that are specifically excluded from their insurance coverage as established by contract, such as cosmetic surgery, which is specifically excluded from coverage by most plans. Medicare enrollees, in contrast, can appeal a decision that a service was denied because it was not covered by Medicare if they believe they are entitled to it. As the president of CHDR pointed out, insurance coverage provisions are not always completely clear and often require some interpretation. On a very broad level, many cases can be defined as coverage cases. For instance, at one time, CHDR found that some Medicare plans were not forwarding skilled nursing facility (SNF) cases for

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[8](...continued)
to publish a notice in the Federal Register implementing this and other changes required by the BBA in June 1998.

[9]However, as stated above, if a plan denied a service for reasons of medical necessity and the enrollee's life or health were jeopardized, the appeal would be subject to the external process, regardless of the dollar value of the services.

external review as required because the plans said that custodial care in a SNF is not covered by Medicare and is therefore not subject to external review. This illustrates how plans may define coverage issues very broadly. Whether a service meets Medicare's definition of skilled care is subject to interpretation, and CHDR overturns a number of SNF cases in which a plan incorrectly judges skilled care to be custodial. It is possible that these types of cases, which are frequently seen in Medicare's external appeals, would not be subject to external review under the Quality Commission's recommendations.

WHILE CHDR UPHOLDS MAJORITY OF PLAN DENIALS, A SIGNIFICANT NUMBER ARE OVERTURNED

Overall, the majority of CHDR's decisions uphold a managed care plan's denial of a service, but this has varied over time and among different types of service. Over the past few years, the most common services seen in CHDR appeals include requests for care from nonplan providers, durable medical equipment (such as wheelchairs and canes), SNF services, and non-Medicare covered services offered by some managed care plans, such as prescription drugs.

We reviewed a sample of CHDR decision letters to obtain more information about the types of issues involved in these appeals. A significant number of the denials overturned by CHDR involved inappropriate clinical decisions by the plan. While Medicare provides the best data available on external appeals, it may poorly predict the types of external appeals that would be seen in the commercially insured population, which generally has greater restrictions on disenrolling from plans.

Trends in Disposition and Types of Service in CHDR Appeals

Disposition of Cases

CHDR has been conducting external appeals for Medicare since 1989 and, as the number of Medicare beneficiaries enrolled in managed care plans has increased, so has the number of external appeals (see table 4). The rate of appeals per enrollee has varied somewhat during this period but remains quite low, ranging between about one-tenth and two-tenths of one percent. CHDR staff have noted a marked increase in the number of appeals filed since the new requirements for expedited review were implemented in August 1997. HCFA required managed care plans to distribute educational information on all appeal rights, including the new expedited process, to all enrollees by August 1997. It is possible that the statistics for 1998 will show an increase in the rate of appeals because of

greater enrollee awareness of the appeal process, in conjunction with the expedited process.

Table 4: Number of Managed Care Enrollees and External Appeals, 1990-97

	1990	1991	1992	1993	1994	1995	1996	1997
Number of enrollees in Medicare managed care plans[a] (in millions)	1.4	1.5	1.7	2.0	2.5	3.8	4.8	5.9
Total number of appeals	1,939	3,072	3,079	4,117	3,615	3,651	5,477	7,772
Appeals per 1,000 enrollees	1.4	2.0	1.8	2.1	1.5	1.0	1.1	1.3

[a]This is the count of Medicare beneficiaries enrolled in a managed care plan through a HCFA risk, demonstration, or cost contract as of December 1 of the indicated year. Enrollment in HCPPs is included in 1995, 1996, and 1997, because HCPPs were required to follow the Medicare appeal process as of May 22, 1995.

Since it began conducting external review for Medicare appeals, CHDR has generally upheld the plan denial in the majority of cases (see table 5). With the exception of 1994, CHDR has upheld the plan denials in 50 percent or more of its decisions each year. There seems to be a general upward trend in the percentage of denials upheld; in 1997, CHDR upheld 69 percent of the plan denials. Between 1990 and 1997, the rates of denials being overturned or partially overturned ranged from about 23 percent to 35 percent. A smaller number of appeals are also withdrawn or retroactively denied.[10]

[10]In some cases, HCFA may decide to retroactively disenroll a beneficiary from a managed care plan because the appeal indicates that the beneficiary did not realize that he or she had enrolled in a managed care plan or did not understand that he or she should obtain prior approval for most services. The enrollee returns to the fee-for-service Medicare program, which pays for all services provided before the enrollee's disenrollment.

Table 5: CHDR Disposition of Medicare Beneficiary Appeals, 1990-97
Numbers are in percent

	1990	1991	1992	1993	1994	1995	1996	1997
Uphold	52	57	51	50	49	57	59	69
Overturn	25	19	24	26	31	24	26	20
Partial overturn	9	4	6	6	4	4	3	3
Retroactive disenrollment	10	10	11	11	7	8	3	1
Withdrawn	5	9	8	7	9	8	8	7

Note: Percentages do not all add to 100 because of rounding.

However, the dollar value of CHDR appeals indicates that appeals involving more costly services tend to be overturned or retroactively disenrolled, reinforcing the importance of the external appeal process in protecting Medicare beneficiaries who have been improperly denied care.[11] In 1996, the dollar value of services that CHDR overturned was estimated at almost $3 million. While overturned or partially overturned appeals made up about 29 percent of CHDR's cases, the dollar value of these cases represented about 31 percent of the total value of appeals decided by CHDR. In the absence of CHDR's decision, Medicare beneficiaries would have to pay for these services themselves or possibly forgo needed care. Retroactive disenrollments seem to involve the most costly appeals, since they represented about 3 percent of total CHDR appeals but 12 percent of the total dollar value in 1996. In contrast, appeals upheld by CHDR in 1996 made up about 59 percent of total appeals but only 43 percent of the dollar value and were estimated to be almost $4 million.[12] In addition to actually overturning inappropriate plan decisions, the existence of an external appeal process itself may influence the decisions a plan makes. The knowledge that an external entity will review plans' decisions to uphold denials may cause them to be more careful in making those decisions.

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[11]Withdrawn cases also seem to involve more costly services. In 1996, withdrawn appeals constituted 8 percent of CHDR's cases, while their dollar value represented about 14 percent of the total value of appeals decided by CHDR.

[12]Medicare payments to managed care plans totalled almost $26 billion in fiscal year 1997.

There is some variation in the rates of upholding and overturning plan denials among different kinds of service. Table 6 provides disposition rates for selected services during 1997. Slightly less than half of the appeals involving inpatient hospital and SNF care are upheld, which is considerably less than the overall rate of 69 percent. Appeals involving durable medical equipment (DME), medical supplies, and non-Medicare benefits, such as drugs, are upheld more frequently than the overall average. The external review process provides Medicare enrollees with a way to override an inappropriate plan denial, especially for expensive services such as SNF and inpatient care, which are overturned more frequently on average. If SNF and inpatient cases are removed from CHDR's 1997 decisions, the overall uphold rate for the remaining cases increases slightly from 69 percent to 73 percent and the rate of being overturned or partially overturned is lowered from 23 percent to 19 percent.

Table 6: CHDR Disposition Rates for Selected Services, 1997
Numbers are in percent

	Nonplan practitioner	Emergency room	Inpatient hospital	SNF	Ambulance	Home health	DME/ medical supplies	Non-Medic benefits
Upheld	69.6	72.7	48.6	49.5	71.2	59.8	77.4	
Overturned	19.0	19.0	28.4	34.9	22.2	22.9	15.2	
Partially overturned[a]	1.9	1.7	2.6	12.4	3.3	2.1	1.2	

[a]In cases involving multiple services, CHDR may uphold the denial for some services while overturning the denial for others. In addition, for services such as SNF care, CHDR may overturn the denial for several days of the SNF stay while upholding the denial for the remainder of the stay. These are partial overturns.

Types of Service

CHDR uses several broad categories of service types. The predominant types of appeals seen by CHDR has shifted since 1991. As table 7 indicates, appeals involving nonplan providers have consistently been the most common type of case seen by CHDR. These cases generally involve enrollees who request to see a physician who is not under contract with the plan or enrollees who received services from a nonplan provider without seeking prior approval from the plan. Appeals involving SNF care have also been consistently among the top five service types. Medicare coverage rules for SNF care are complicated and based on clinical judgment in many cases, which can lead to different interpretations about whether an enrollee meets Medicare's criteria. In addition, plans frequently fail to comply with Medicare's requirement to notify an enrollee in

writing when coverage for SNF care is going to be terminated. These factors probably make SNF care more prone to dispute than other services.

Table 7: Top Five Service Types Represented in CHDR Appeals as a Percentage of Total Cases

1991		1993		1995		1997	
Service type	Percentage (Number)	Service type	Percentage (Number)	Service type	Percentage (Number)	Service type	Percentage (Number)
Nonplan practitioner	25% (775)	Nonplan practitioner	28% (1,157)	Nonplan practitioner	35% (1,280)	Nonplan practitioner	32% (2,474)
Emergency room	24% (748)	Emergency room	22% (904)	DME/medical supplies	14% (505)	DME/medical supplies	21% (1,609)
Inpatient	17% (508)	Inpatient	13% (523)	Emergency room	11% (392)	SNF	12% (947)
Clinic	13% (384)	SNF	10% (391)	Inpatient	10% (379)	Non-Medicare	12% (930)
SNF	7% (216)	Clinic	8% (341)	SNF	9% (335)	Therapy	6% (437)

Other frequently appealed services in 1997 have not always been so common. Appeals involving durable medical equipment, such as wheelchairs and crutches, represented only 4 percent of CHDR's appeals in 1991 but jumped to 21 percent in 1997. Commonly appealed services in 1991, such as emergency room services and inpatient hospital care, however, no longer represent a large proportion of CHDR's appeals. In 1997, emergency room claims represented only 4 percent of CHDR appeals, compared to 24 percent in 1991. Until recently, coverage of emergency room services had long been a source of contention between plans and enrollees. Plans sometimes denied coverage for emergency room claims because the ultimate diagnosis did not indicate that the patient was in an emergency situation. For instance, a patient with chest pains may believe they indicate a heart attack and may seek care at an emergency room, where it is discovered that the patient has severe indigestion instead. In the past few years, HCFA has instructed plans to judge emergency room claims based on the enrollee's presenting symptoms, not the diagnosis established after medical evaluation.[13]

[13]Coverage for these claims was recently clarified in the BBA, which requires plans to cover emergency room claims if the symptoms are such that a prudent layperson would believe that his or her health would be in serious jeopardy without immediate medical attention.

Expedited Appeals

Medicare plans were required to offer expedited appeals beginning in late August 1997. Table 8 shows the number and disposition of expedited appeals CHDR received. The disposition of these appeals is similar to that of nonexpedited appeals. Table 9 shows that the types of services involved in expedited appeals differ somewhat from nonexpedited appeals, with a greater percentage of SNF cases. The Federal Register notice announcing the new expedited process states that requests for expedited appeals of SNF services should be granted, which may account for the large number of these cases.

Table 8: CHDR Disposition of Expedited Appeals, January 1997 to March 1998

	Number of expedited cases[a]	Percentage	Number of nonexpedited cases	Percentag
Upheld	912	76%	5,823	7
Overturned	270	22	1,770	2
Partially overturned	24	2	269	
Total	1,206	100%	7,862	1

[a]Plans were not required to offer expedited appeals until August 28, 1997.

Table 9: Top Five Service Types Represented in CHDR Expedited Appeals Compared to Nonexpedited Appeals, January 1997 to March 1998

Service type	Service type as a percent of appeals	
	Expedited[a]	Nonexpedite
SNF	42	
Nonplan practitioner	17	
Non-Medicare benefits	12	1
DME/medical supplies	10	
Therapies	6	5

[a]Plans were not required to offer expedited appeals until August 28, 1997.

Appeals Sample Shows Both Inappropriate Plan Denials and Enrollee Misunderstanding of Plan Rules and Benefits

In our review of 572 CHDR decisions, we found that CHDR overturned plan denials in 127 cases because the plan should have provided the service to the Medicare enrollee. The majority of these cases involved inappropriate clinical decisions by the plan, in which the plan wrongly determined that the services either were not medically necessary or did not meet Medicare's clinical coverage criteria. CHDR upheld the remaining 445 denials for a variety of reasons. These upheld cases suggest a lack of enrollee understanding about how the plan operates. For instance, some appeals involved requests for care from nonplan physicians or appeals of copayments required by a plan.

Overturned Denials

CHDR overturned 127 denials in our sample, and the decisions in 83 of these cases were based on clinical considerations. In these cases, CHDR found that the plans made inappropriate medical decisions and overturned the plan denials because the services were medically necessary and met all Medicare's clinical coverage criteria. Many of these cases involved denials of SNF care in which the plan stated that skilled care, which is required by Medicare to cover SNF services, was no longer needed. CHDR's review of the medical records indicated that patients did need skilled care and overturned the denials. In one case, for example, CHDR found that the enrollee was prematurely discharged from skilled rehabilitative therapy. In other cases, CHDR overturned denials involving manual manipulation or chiropractic care, which Medicare covers only if an x-ray reveals evidence of a particular back problem. CHDR's review of the medical records indicated that the patients did have the particular condition required by Medicare. As we noted earlier, it is possible that these kinds of appeals, which involve clinical judgement, could be defined as coverage issues and could be excluded from the Quality Commission's external process. As these CHDR appeals illustrate, however, some interpretation can be involved in defining whether services are covered, and a plan's interpretation may not be correct.

The services that were denied because a plan did not consider them medically necessary included such services as cataract surgery, a referral to a rheumatologist, and payment for emergency room services when the patient had symptoms of stroke. In these cases, CHDR's medical review indicated that the care was necessary and appropriate. In one case, a plan denied a referral to an ear, nose, and throat specialist because the plan believed the patient's primary

care physician could provide the needed care. CHDR's medical review found that an evaluation by a specialist was medically appropriate and necessary because the patient had been under his physician's care without relief. In two cases, plans denied the requested service because it was considered experimental and therefore not covered by Medicare. CHDR overturned these cases because it found that the requested service was not experimental. If CHDR had not overturned these denials, the enrollees would have had to forgo the needed care or pay for it themselves.

The remaining 44 denials were overturned for procedural reasons. A procedural determination is based on whether rules were properly followed, not whether the care was medically necessary. About 40 percent of these cases were overturned because a plan did not provide enough information to support its denial. For example, in several cases involving manual manipulation, the plans denied service because it did not meet Medicare's clinical criteria, but CHDR overturned these denials because the plans failed to provide the x-rays to support their denial. CHDR overturned another 30 percent of these denials because the plans did not provide an appropriate notice to enrollees when terminating coverage of SNF care as required by Medicare.

The 44 overturned denials made on procedural grounds are grouped into the following categories:

- 18 overturned because a plan did not provide sufficient information to support its denial;
- 13 overturned because a plan did not provide a notice of noncoverage when terminating SNF care;
- 5 overturned because either (1) advice from a plan provider led enrollees to believe that the plan would cover the service or (2) enrollees were not informed by plan providers that the plan would not cover the service; and
- 8 overturned for miscellaneous reasons.

Upheld Denials

CHDR upheld 445 denials in our sample, and 272 of these cases were decided for procedural reasons. There were several issues within these cases, many of which involved enrollee misunderstanding of, or disregard for, plan rules. About 40 percent of the cases involved beneficiary requests to obtain care from a nonplan provider–that is a provider, such as a physician or hospital, that did not

have a contract with the enrollee's plan–or to pay for care already received from a nonplan provider. CHDR upheld the denials because the services requested could be provided by a plan provider or because the enrollee did not seek the prior authorization required by the plan for services already furnished by a nonplan provider.

In another group of denials upheld for procedural reasons, representing approximately 30 percent of these cases, CHDR determined that the care was not covered by Medicare and was not covered by the plan, such as nonprescription drugs and durable medical equipment. A number of these cases involved requests for shower seats or shower rails. CHDR upheld these denials because Medicare considers these items to be convenience items rather than medical equipment, and Medicare does not cover convenience items. CHDR also upheld a number of denials involving noncovered Medicare benefits. Although Medicare does not cover most prescription drugs, many plans offer this coverage as an additional benefit. However, plans frequently restrict coverage to specific drugs listed on a formulary. In many cases involving non-Medicare benefits, patients requested nonformulary drugs and CHDR upheld the plan denial because plans are allowed to establish their own coverage criteria for non-Medicare benefits they offer.

The 272 denials upheld on procedural grounds are grouped into the following categories:

- 112 cases involving services from nonplan providers upheld because the necessary care was available from in-plan providers or because the enrollee did not obtain prior authorization from the plan before receiving such services;

- 75 upheld because the services requested or provided were not covered by Medicare;

- 35 upheld because the patient did not meet the plan's administrative criteria for coverage of non-Medicare benefits or the patient exceeded plan coverage for such benefits;

- 20 upheld because the patient did not meet Medicare's administrative coverage criteria for the services involved;

- 14 upheld because the appeal involved a copayment required by the plan;

- 8 upheld because the patient had exhausted Medicare's covered SNF days; and

- 8 upheld for miscellaneous reasons.

The remaining 173 upheld cases were decided for clinical reasons, primarily because the services did not meet Medicare's clinical coverage criteria or were not medically necessary. About 45 percent of these cases involved SNF services. In these cases, CHDR upheld the plan denial because the patient did not meet Medicare's clinical criteria for SNF coverage. A number of appeals that were upheld because the services were not medically necessary and therefore not covered by Medicare involved expensive diagnostic tests, such as magnetic resonance imaging and bone density studies. CHDR upheld another 30 cases involving primarily durable medical equipment because Medicare's clinical coverage criteria were not met.

The 173 denials upheld on clinical grounds are grouped into the following categories:

- 86 cases (primarily SNF services, with a few home health and therapy cases) upheld because the patient did not need skilled services or did not need daily skilled care in a SNF as required by Medicare;

- 30 upheld because the patient did not meet Medicare's clinical coverage criteria for the services involved;

- 22 upheld because the services involved were not medically necessary;

- 15 upheld because the patient needed care but the requested service was inappropriate;

- 7 emergency room and related inpatient stay cases upheld because the care needed was not emergency and the patient did not seek authorization for services from the plan;

- 5 upheld because the services involved were experimental or not proven effective and therefore not covered by Medicare; and

- 8 upheld for miscellaneous reasons.

AGENCY COMMENTS

We provided a draft of this correspondence to CHDR and HCFA officials, who suggested a number of technical clarifications, which we have incorporated. In addition, we provided a draft to a representative of the President's Quality Commission, who agreed that we provided an accurate description of the Quality Commission's recommendations.

As agreed with your office, unless you publicly announce the contents earlier, we plan no further distribution until 30 days from the date of this letter. We will then make copies available to others who are interested.

Please call William Scanlon, Director, at (202) 512-7114 or James Cosgrove, Assistant Director, at (202) 512-7029 if you or your staff have any questions about this letter. Other contributors to this study were Michelle St. Pierre and Carolyn Hall.

Laura A. Dummit

for William J. Scanlon
Director, Health Financing
and Systems Issues

Enclosure

SCOPE AND METHODOLOGY

To collect information on Medicare's appeal process for managed care plans, we reviewed pertinent Medicare regulations and interviewed Health Care Financing Administration (HCFA) officials and Center for Health Dispute Resolution (CHDR) staff. Similarly, to obtain information on the Quality Commission's recommendations, we reviewed its publications and interviewed its staff. We also analyzed aggregate data on Medicare external appeals maintained by CHDR. HCFA staff consider CHDR's data systems to be reliable so we did not independently verify CHDR's statistics nor did we examine its internal controls.

In addition, we reviewed a sample of external appeal decisions made by CHDR. We reviewed a total of 547 CHDR decision letters, which represent the vast majority of CHDR's decisions for February 1998. We were not able to review 11 missing CHDR letters. Because a decision letter can include decisions on multiple services, the total number of decisions reviewed is greater than the total number of decision letters. Our sample of 547 decision letters represents a total of 572 decisions. The February sample is similar to decisions made in a typical month with a few differences. The February sample has fewer decisions than CHDR makes in a typical month and includes a higher percentage of expedited cases. It also includes a higher percentage of SNF appeals and fewer appeals involving inpatient care, durable medical equipment, and medical supplies than an average month.

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